IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

JEFFREY THELEN, Plaintiff, v. SOMATICS, LLC; AND ELEKTRIKA, INC., Defendant.	)	Case No.: 8:20-CV-1724

VOLUME VI OF VII (pp. 1-175)

JURY TRIAL PROCEEDINGS
BEFORE THE HONORABLE THOMAS P. BARBER

June 7, 2023
9:02 a.m. to 3:40 p.m.

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INDEX

DEFENDANT'S WITNESSES	PAGE
C. EDWARD COFFEY, MD	
Direct Examination by Ms. Cole	5
Cross-Examination by Mr. Esfandiari	80
Redirect Examination by Ms. Cole	130
Motion for Directed Verdict	154
Plaintiff Rests	161
Defendant Rests	161
Jury Charge	161

DEFENDANT'S EXHIBITS (ADMITTED INTO EVIDENCE)

NO.	DESCRIPTION	PAGE
1014	10/25/12 Faith Regional Psychiatric Services Treatment records regarding Jeffrey Thelen	148
1016	11/12/14-11/13/14 admission, Faith Regional Behavioral Health Unit Discharge summary	148
1025	4/10/08-5/22/08 Seekers of Serenity records, notes prior suicide attempts and alcohol and prescription drug abuse	148
1027-2	6/2/14-7/27/16 Patient treatment records Jeffrey Thelen	148
1027-3	6/2/14-7/27/16 Patient treatment records Jeffrey Thelen	148
1027-4	6/2/14-7/27/16 Patient treatment records Jeffrey Thelen	148
1027-5	6/2/14-7/27/16 Patient treatment records Jeffrey Thelen	148
1027-6	6/2/14-7/27/16 Patient treatment records Jeffrey Thelen	148
1027-7	6/2/14-7/27/16 Patient treatment records Jeffrey Thelen	148

DEFENDANT'S EXHIBITS (ADMITTED INTO EVIDENCE) (CONTINUED)

NO.	DESCRIPTION	PAGE
1027-8	6/2/14-7/27/16 Patient treatment records Jeffrey Thelen	148
1059	5/30/14-7/25/16 Consents regarding ECT treatment of and signed by Jeffrey Thelen	148
1070	7/7/16 Initial Inpatient Evaluation by Dr. Alsakaf, Thelen hospitalized for a week, improved after ECT	75
1075	6/5/17 Consultation by Dr. Herman (Faith Regional), Thelen hospitalized after burning his hand	75
1084	9/28/18 History and Physical by Nathan Herman (Faith Regional), Thelen admitted for worsening depression, reported feeling worse after TMS	75
1086	9/12/19 History and Physical by Nathan Herman (Faith Regional), Thelen committed under EPC after suicide concerns, [redacted]	75
1087	4/30/20 History and Physical by Dr. Herman for EPC due to suicide concerns	75
1089A	American Psychiatric Association Task Force Report on the Practice of ECT, 2d Edition - Excerpt	146

(Call to Order of the Court at 9:02 a.m.)

THE COURT: Morning, everybody. Anything urgent we got to talk about before we knock out this first witness?

MR. ESFANDIARI: Nothing from the plaintiff, Your Honor.

MS. COLE: Not crazy about the word knock out, but no, sir.

THE COURT: Good. Let's have his testimony, and we'll visit and see where we are.

Bring the jury out, please.

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury in at 9:03 a.m.)

THE COURT: Have a seat. Good morning, everybody. Nice to see you back again. We're moving along at a pretty good speed, as I mentioned the other day.

This morning, we have a live witness for you, who's now ready to go. That is?

MS. COLE: Good morning, Your Honor. The defense would call Dr. Edward Coffey to the stand.

THE COURT: All right. Have him come up, please. Go ahead and put your stuff down there and then raise your right hand, please.

WHEREUPON,

C. EDWARD COFFEY, MD,

was called as a witness and, after having been first duly sworn, testified as follows:

DIRECT EXAMINATION

THE COURT: All right. Have a seat right there. Tell us your name and how to spell it, please.

THE WITNESS: Charles Edward Coffey, C-o-f-f-e-y.

THE COURT: Go ahead whenever you're ready.

MS. COLE: Thank you, Your Honor.

BY MS. COLE:

Q. Good morning, Dr. Coffey.

A. Good morning.

Q. Please introduce yourself to the jury and tell us where you live and what your occupation is.

A. My name is Ed Coffey. I am a neuropsychiatrist, a health-care leadership adviser, and affiliate professor of psychiatry and behavioral sciences at the Medical University of South Carolina in Charleston, where I currently live.

Q. Could you tell us, sir, a little bit about your educational background, starting with college.

A. Yes. So I attended Wofford College, which is a small liberal arts school in South Carolina where I earned a Rhodes Scholarship. I then spent two years at St. John's College in Oxford. I got a degree in psychology at Wofford and a degree

in psychology, philosophy, and physiology at Oxford. After Oxford, I attended Duke Med. I finished medical school in three years. Tried to catch up on some time there. And then stayed at Duke for my residencies in neurology and psychiatry. So I'm board certified in both neurology and psychiatry.

Q. So you're double boarded?

A. Correct.

Q. After medical school, what did you do?

A. I was recruited to stay at Duke for six years where I started the Duke ECT program and a neuropsychiatry service as well. There for about six, six and a half years.

Was then recruited to lead a neuropsychiatry hospital in Pennsylvania, the Allegheny Neuropsychiatric Institute. That was another great job.

From there, after about six years, I was recruited to Henry Ford Health system, based in Detroit, Michigan, a very large, vertically integrated health-care organization that owns many hospitals. They don't just own an insurance company. It owns its own HMO. And I led the mental health enterprise for that organization, the Henry Ford Health system. I was there for 18 years.

Afterwards, I was recruited to Houston, Texas to become president and CEO of the Menninger Clinic. Menninger is a very famous name in psychiatry, you may know. It was based in Topeka originally. They relocated to Houston, and I helped

with that relocation.

After three and a half years there, I began the transition, I'm calling it, to semi retirement. I'm back in Charleston for five and a half years. I now consult primarily. I'm not in a position to take care of patients full-time. But I do teach. I do consulting and learning sailing.

Q. Dr. Coffey, I understand that you are a fellow of the American Psychiatric Association, along with a whole list of other prestigious medical organizations. Can you tell us a little bit about what is a fellow and what it is that you do for the psychiatric association?

A. Yes. At the risk of sounding overly self-important, I'm a distinguished life fellow, which means I've spent some time trying to help the organization and the profession improve its quality of care. That's been mainly the focus of my career, is trying to design health-care systems that can deliver reliable quality, the care that the patient wants and needs when they want and need it. That's sort of been our motto.

Q. Are you also a fellow of the American Neuropsych Association?

A. I am, yes.

Q. And the American Academy of Neurology?

A. Yes.

Q. Can you tell the ladies and gentlemen of the jury, what is -- we've heard a lot about psychiatry. Could you tell them

what is neurology and what a neurologist brings to the field.

A. Well, it's sort of an artificial separation, neurology and psychiatry. Back in the day, they were one and the same. And the training was the same for both paths, regardless of which path you ended up on. You shared joint training.

In the late '50s and '60s, they sort of separated, became a turf issue really. There was no good reason otherwise to separate the two. We both deal with the brain and the nervous system as our central organ of focus. Psychiatry tends to focus more on the behavioral and cognitive emotional manifestations of a brain disorder, whereas neurologists tend to focus more on the sensory motor manifestations of a brain disorder. That's a crude distinction. Many of us do both. But that's a general categorization.

Q. Dr. Coffey, have you performed research in the field of psychiatry and/or neurology?

A. Yes.

Q. Tell us about the research that you did at Duke involving an MRI.

A. We did lots of research using MR imaging. So by way of background, after I finished my neurology training, the chairman of psychiatry at Duke at the time pulled me aside and said, look, I'd like you to join the department. Because you're a neurologist, I think it's a good idea for the neurologist in the department giving the patients seizures. So

I want you to start the ECT program.

I was a little bit taken aback. I really didn't know much about ECT, but I was happy to stay at Duke, so I took on the challenge. And so we started the ECT service at Duke. Created the model which today is used, think, in most institutions, not just in this country, but throughout the world, a consultative model, a dedicated service to providing the treatment and following the patients over the course of a treatment.

So part of that model involved examining patients when they were referred for ECT, taking a history, and doing not just a mental status exam, like psychiatry would do, but doing a neurology exam as well.

And in the course of that examination, we discovered that many, many patients referred for ECT had abnormal findings on their neurological examinations. And these would be patients who didn't have any history of any neurological illness. They wouldn't be gross findings. They weren't walking around with, like, a paralyzed limb as if they had a stroke, but they were subtle reflex asymmetries or a subtle sensory motor coordination asymmetries.

Q. You're going to need to talk a little slower, please.

A. Oh, sorry, please. Getting excited.

And as a result of those observations, we were obligated to obtain brain imaging to try and understand what was accounting for this abnormal finding on the examination.

First, with CT, but then eventually with MR, magnetic resonance imaging, we discovered subtle findings on their brain imaging studies. Basically, cortical atrophy, shrinkage of the brain, ventricular enlargement, enlargement of the fluid filled spaces deep in the center of the brain, and then a third finding, subcortical hyperintensity, which is an area of tissue change around small blood vessels.

All three of these changes are seen in all of us as we get older. But they were being seen -- we were seeing them in patients with depression at a much younger age. So this led to a series of investigations around a theme of does depression cause the brain to age prematurely, to age earlier than it would if we weren't otherwise depressed?

So we did a lot of work on quantifying. But what does normal aging actually look like? How much does the brain shrink when we get older? How much do the ventricles enlarge as we get older? How much of subcortical hyperintensity do we see as we get older? We had to establish how much of that normative picture looked like and then compare that to a variety of persons with various psychiatric illnesses.

Q. I understand, Dr. Coffey, you did the first prospective study of ECT and long-term cognitive effects?

A. Well, six-month cognitive effects and brain imaging follow-up. So that really is what qualifies it first. No one has done that since. It's a -- it was a pretty intensive

study. But, yes, we -- we took a cohort of patients that had been referred for ECT, did a detailed evaluation pretreatment, including brain MR imaging, repeated those evaluations during the course of treatment and at the end of that acute course of treatment and then again six months after the acute course of treatment.

Q. When you say the acute course of treatment, what does that mean?

A. You can tell I'm a little bit long-winded. I apologize in advance for that.

When we treat an episode of depression, there are two phases to our treatment, an acute treatment phase and a continuation slash maintenance phase. Must do both. You must do both.

The acute treatment phase has as its goal the elimination of symptoms. We call that putting the condition into remission, so getting rid of the symptoms. And you do that with medications, with talk therapy, with ECT, other brain stimulation procedures, or some combination of those.

Now, if you're successful, and if you indeed induce a remission in the depressive episode, if you stop the treatment at that point, there is a 75 percent chance, at least, that the depression is going to come right back in the next two to six months. That's why we need continuation therapy. So whatever worked acutely must be continued for at least six to nine, in

some cases longer, to prevent the disease from recurring.

So acute treatment, continuation treatment. This need for both is not unique to ECT. It's true regardless of what treatment you've chosen for the acute episode.

Q. Dr. Coffey, I notice on your curriculum vitae that you also serve on -- as a reviewer in review panels for scientific literature. Can you tell us what that is and what you do?

A. Yes. I served as the reviewer for the National Institute of Mental Health to review grant applications in the fields of neurology and psychiatry. And I also serve on several -- on the editorial board of several medical journals. That role involves producing the journal as well as reviewing articles that are submitted for publication to the journal.

Q. How long have you been researching in the field of ECT and the associated neurology?

A. Since the beginning of my career.

Q. So that's 40 years?

A. Forty years.

Q. I'm looking at your CV here. You have about 196 invited presentations that you've been asked to give. Is that right?

A. If that's what it says, yes.

Q. Are most of them on ECT?

A. Most on ECT, yeah, but not solely ECT.

Q. Have you published articles that have been peer reviewed in the scientific and medical literature?

A. Sure.

Q. And how much -- about how many articles have you published in the peer-reviewed literature?

A. I don't know what the CV says, but --

Q. It says 110.

A. 110.

Q. I don't know how up to date that is. Have there been any more recently?

A. Uh-huh.

Q. And 53 book chapters you've written?

A. Yes.

Q. And you've also edited a book, got your name on it.

A. Yes.

Q. What is that?

A. That's the Clinical Science of ECT. It's a book I did early in my career that kind of tried to bring together an update on the science of the treatment at that time for clinicians.

Q. And by editing that book, what does that mean in terms of your contributions to the book?

A. Well, you -- the editor recruits the authors. The editor comes up with the concept for the book, organizes the chapters, what we want to talk about, who should talk about it, and then reviews each of the chapters. I don't know if I wrote a chapter myself in that book. I may have. It's common for that

to be the case. And then see the work through to production.

Q. Are you also an advocate for mental health education in this country?

A. Very much so, yes.

Q. Tell us about that.

A. Well, we wrestle not just in this country, but worldwide, with profound stigma around mental health and mental illness in particular. That's the number one impediment to coming up with cures and better treatments for these conditions. So I made an important part of my career to try and combat that stigma. And as one way of doing so, to try and make treatments better and to try and design systems of care that can reliably provide better treatment to our patients with mental illness.

Q. Have you performed ECT for patients?

A. Yes.

Q. About how many times have you performed -- about how many patients have you performed ECT over the years?

A. It's been thousands. I couldn't give an exact number of patients. And many, many thousands of treatments.

Q. What's the difference between modern ECT and the older iterations of ECT?

A. Yes. That's a good question. It's an important question.

Part of that stigma issue is very acute with regard to ECT. That derives from books and movies like Cuckoo's Nest, where we have this very frightening image of a person, in this

case, Jack Nicholson, being drug into the treatment suite, kicking and screaming, so it's being done against his will. He's then pinned down on a stretcher, again, involuntary. Electrodes are applied to his head. He's awake. He has no muscle relaxation. He's not getting oxygen. And he's given a stimulus with a very crude ECT device that, in turn, induces a very violent, convulsive movement, a grand mal seizure, after which he's groggy and confused and sleeps for the rest of the day.

That's the old, outmoded version of ECT. That's the way it was done back in the '30s and '40s, when it was first discovered. Beginning with the introduction of anesthesia and muscle relaxation, the treatment changed very dramatically in the '70s and '80s, going forward.

First of all, among the changes, number one, it's a voluntary procedure. We don't do ECT unless the patient agrees to the procedure. And that consent process must conform with all of the applicable laws and statutes and policies that are in place. It's a voluntary procedure. In our case, the patient walks into the suite, often accompanied by family. We have family in the treatment room throughout the entire procedure.

Q. When you do it at your hospital?

A. At places I've -- we started this at Henry Ford. We were the first ever to do this. Family are in the room and

participate in the entire procedure. It has a profound impact on the procedure and the patient.

Q. Is there a difference between the kind of cognitive effects that existed in the '30s and the '40s and the '50s from that old kind versus the modern ECT that was performed in Mr. Thelen's case?

A. Yes. I should go back and complete how the procedure has changed. In addition to being voluntary and walking in, not being drug into the suite, once the patient is on the stretcher, we attach a variety of monitoring equipment, blood pressure, EKG to monitor the heart, pulse oximetry to monitor oxygen concentration during the procedure, and then EEG electrodes to monitor the seizure.

Once all of that has been completed and we complete a time-out, so all that members of the treatment team present confirm who the patient is, what we're there to do, we have the right details, et cetera, then the patient receives a very short-acting rapidly acting anesthetic through a little catheter which has been inserted. And within 10 to 15 seconds, the patient is asleep.

As soon as they are asleep, they receive a second drug that relaxes all of the muscles, all the while receiving oxygen through a mask being applied by an anesthesiologist.

Once the person is asleep, fully relaxed, we then administer the stimulus. It's a brief electrical stimulus,

usually less than eight seconds in duration, that induces a brain seizure. We know the seizure occurs, because we're monitoring the EEG tracing. You might not know it occurs, though, if you're just standing at the table, because the muscle relaxation has abolished all of the convulsive activity. So there's no risk of fracture anymore, because there's no shaking. There's no convulsing.

The entire seizure lasts about 30 to 60 seconds, depending on a variety of factors, after which the muscle relaxation begins to wear off and then the anesthesia begins to wear off. So from start to finish, you're looking at about a 30-minute procedure.

Once the person is awake and breathing on their own, they go to a recovery area, where they're offered something to drink. And usually within an hour and a half or two hours, they can be discharged home.

The procedure is so straightforward today and so safe, that the majority of people can receive their treatments -- their entire course of treatment as an outpatient. You don't need to be in the hospital to have this procedure.

Q. Let me ask you this. In those old procedures and the old papers that studied those old procedures, was there damage, physical damage, structural damage to the brain?

A. Well, we don't know, because we didn't have great brain imaging back in the '40s and '50s. The best we had was x-ray.

You don't get a very good look at the brain that way. And studies weren't really done. But we do know that the combination of the old devices, the so-called sine wave devices --

Q. S-i-n-e?

A. S-i-n-e. So the sine wave is that imaginary curve of the electron that comes out of the wall socket. Right? That's your electricity coming out of the wall socket. Back in the day, these old devices just passed along to the patient the same wave form that's coming out of the wall socket at 60 cycles per second.

The new devices are called pulse devices. And what they have done -- what we've done is taken that sine wave, and at the peak of its amplitude, we chopped off the sides on -- the sides on both sides. So instead of a sine wave, there's now just a pulse, a sliver of that wave, taken at the peak of the amplitude of the current.

By doing that, we have reduced the amount of stimulation, the electricity that's used from anywhere from 15 to 80, 75 percent. So it's less stimulation, and it's more efficient stimulation. So that peak, that sudden rise to the full maximum current is very effective at depolarizing neurons. The stuff on either side of that wave, either side of that pulse is not so effective at depolarizing neurons. So it's wasted electricity.

So by filtering that out, we can induce a seizure, controlled seizure with much less electrical stimulation. And as a result, the cognitive side effects are dramatically reduced with the pulse stimulation than with the old sine wave stimulation.

Q. Does modern ECT cause structural brain damage?

A. There is no evidence that contemporary ECT causes structural brain damage, none.

Q. Now you mention pulse ECT, what is ultrabrief pulse ECT?

A. Well, in the field, the question is, well, if short is good, is shorter even better? So we're trying to discover what is the optimal width of that pulse at that peak of that wave. How low can we go? And so ultrabrief pulse is essentially around .3 milliseconds, .25, depending on the device. Brief pulse is anywhere from .5 to around one millisecond. That's the current definition.

These are arbitrary. People use them slightly differently. We don't know if there's a big difference between a half a millisecond and .3 milliseconds. But there does appear to be a difference between one millisecond and the half or the .3.

Q. What's the difference?

A. The difference is more efficient seizure induction, i.e., we're able to trigger a seizure with less electricity, and as a result, cognitive side effects are fewer.

Q. Now, we've heard about a seizure from several witnesses that have testified earlier. Is a seizure of the kind that is induced in ECT the same kind of seizure that you see in somebody that has epilepsy?

A. Yes and no. We are inducing with ECT a generalized brain seizure, we think. That is to say it is activating a number of brain regions on both sides of the brain. But we're doing so under very controlled conditions. That induced seizure is brief. I mentioned a moment ago, it's 30 to 60 seconds, typically. And it's taking place under controlled conditions of oxygen and muscle relaxation and physiologic monitoring. So the body and brain are well protected during a period that the brain is firing at about twice its typical metabolic rate.

Now, in contrast, a major motor seizure, a grand mal seizure that you might see someone on the street developing, is very, very different. In this case, the patient is not breathing. In fact, if you looked at them, you'd see they're turning blue. So now the brain is firing, it's seizing, but they're not getting oxygen. They're also consuming energy through the violent convulsive movement of the seizure. That seizure could last for several minutes. In some cases, it can go on for hours, and we can't stop it.

So that's a very different situation. That seizure is very, very different than a controlled brief seizure that we induce with ECT.

Q. Has there been studies that looked at the seizure activity during ECT and looked at its safety?

A. Well, there -- that's a complicated question. There are a variety of things that take place during the seizure. The autonomic nervous system is activated. So heart rate will change. Blood pressure will change. You need to watch that and make sure that's being carefully monitored and controlled as necessary.

But, in general, the seizure itself is fairly straightforward. It goes to a predictable cycle of morphology. It stops very predictably without any major events at all. It's a straightforward kind of process.

Q. We've heard testimony about neurotransmitters and a seizure. What does a seizure do in terms of timing of the neurotransmitters in the brain?

A. Well, that's also a complicated question. We know a lot about what the ECT seizure does to the brain. It alters a variety of neurotransmitters, both in terms of their activity, their timing of release, their quantity of release. It also alters the endocrine systems in the brain. It alters inflammatory systems in the brain. It alters what's called synaptogenesis, the growth of new connections in the brain.

So ECT actually results in the formation of new connections in a number of different brain regions. ECT alters blood flow to the brain. It alters metabolism of the brain.

It alters connectivity of brain regions. And in almost every case, the nature of the alteration is in the direction of reversing what we think was wrong in the depressive episode.

So if there was a transmitter that we think, like serotonin, that wasn't working properly, the direction of the change that we see with ECT is in the direction of correcting that abnormality.

Q. Do those changes last for a long period of time or are they transient?

A. It depends on which change you're talking about and how long you're talking about. We don't know the answer to that question in every case. And I was just going to say that although we know a lot about what's going on, we can't draw a straight line. We haven't been able to draw a straight line from any one of those things that's going on and why the person gets better.

We don't really know how ECT works. Now, we know the seizure is critical. If you don't have the seizure, you don't get better. So something is going on magically with the seizure to bring about the improvement. It is an enduring improvement. Once -- as I mentioned earlier, once the symptoms are in remission, as long as you continue effective treatment, the symptoms will stay in remission. After about nine months, you can -- nine to 12 months, depending, again, on the particular case involved, you can stop that continuation

treatment. So those changes are enduring.

Q. Are those changes -- do those changes cause permanent structural damage to the brain?

A. No. There's no evidence of that.

Q. How do we know that?

A. Well, we know it through a variety of means. First, we know it through studies in humans that have looked at both enzymes that are produced when brain tissue is damaged. Or in our case, when we look at imaging studies over time, including detailed imaging with MR, and we don't see any evidence of any brain dysfunction or brain destruction using those techniques.

Now, admittedly, scanning in live humans isn't as sensitive, isn't as detailed as looking at an individual cell under the microscope. But we can't do that in humans. So we have to rely upon animal studies to look at that domain.

And in animal studies, the evidence is very clear that if you induce a seizure, let's say in a monkey or in a rodent, under conditions of controlled muscle relaxation, oxygen, and the seizures are brief, there is no neuronal cell death. In fact, to create neuronal necrosis, you have to induce a seizure that lasts at least 90 minutes, maybe longer, without oxygen and without muscle relaxation to see brain changes under the microscope.

Clearly, those conditions don't pertain in clinical ECT. The seizures are brief. The patient is receiving oxygen,

muscle relaxation. So any way you cut this, any way that you can look at it feasibly, there is no evidence that ECT causes brain damage.

Now, some critics will point to very old research in animals back in the '40s and '50s that claims to have found tissue damage. And they did, but these were animals that were not in controlled seizure inducing conditions. They were animals that had not been anesthetized, provided oxygen. The seizures were very long. And in some cases, they were mishandled. It turns out that handling the animals is very critical to what you see under the microscope. You can create hemorrhages, for example, from the handling and the shaking of the seizure, which was one of the early findings in the studies. But if you control it properly for the conditions, you don't see tissue destruction, even in animals under conditions that are similar to ECT.

Q. We've had this pretty blue book bandied about pretty much this whole trial. Are you familiar with this practice of electroconvulsive therapy, recommendations for treatment, training, and privileges by the American Psychiatric Association?

A. I am.

Q. What's your associate -- what's your connection with this book?

A. I was a member of the Task Force that wrote the book.

Q. And that's your name on number one up there?

A. Yes. I think it's just advertised. I don't think number one means anything.

Q. Tell us about the preparation of this book.

A. Yes. This was a long-standing project. There has been an earlier version of this document many, many years ago. But there was a time and need for an update. So under the leadership of Task Force Chair, Richard Weiner, Dr. Weiner, a group of experts was convened at the request of the American Psychiatric Association to update the report and to provide recommendations for how to do the treatment, how to train individuals to do the treatment and how to privilege practitioners to administer the treatment. And that's what we did.

Q. Does the book contain various chapters authored by individuals?

A. No. There's no individual chapter author listed. The process involved a lead or a colead for each of the topic areas that we chose, and those individuals would prepare the first draft. But then all of us would review that draft. And after many, many hours of back and forth, we would eventually reach some consensus on the contextualization, really.

The science was pretty clear. We agreed on the science. It's just how to interpret that. And that's the process that took the longest time. Essentially, every member of the Task

Force had input, more or less, into every question and every chapter in the book.

Q. What's the -- what was the purpose of putting together the book? Who was supposed to read this thing?

A. Well, anyone would be invited to read it. Certainly general psychiatrists would be encouraged to read it, even if they weren't themselves administered ECT. But we felt it would be a very important, indeed, maybe a critical resource for the actual ECT practitioner and his or her team. It's not just a one-person show. It's the nursing staff that's involved. It's the anesthesia team that's involved. It's the waiting room staff. All of these people play an important role in the safety and the quality of the treatment. So we recommend it to all.

Q. Now, this book was published in 2001.

A. Correct.

Q. Does it have a chapter on cognitive side effects?

A. Yes, it does.

Q. Tell us about that.

A. Well, it reviews the data, the science on what we know about the cognitive side effects of ECT. And basically the bottom line there is that there are several types.

First, right when the person awakens from the anesthesia, there will be a brief period of confusion. It's a lot like if you were falling asleep in the afternoon when you're not used

to taking a nap, and you wake up and it takes you a couple of seconds to figure out what time it is and where you are. If you've ever had anesthesia, you've had that same experience.

This brief period of disorientation and confusion clears within an hour or so of having awakened from the procedure. The major cognitive side effects are on memory. And there are two basic domains of memory that are affected, anterograde memory, the memory for things that we learn after the ECT and then retrograde memory, memory for events that happened before the treatment.

Both are effective. Both, as far as we know, are temporary, short lived, at least as far as we can measure them. And there's no permanent loss of ability to learn and to remember.

The area that remains unclear is the area of retrograde autobiographical memory, memory for events that are specific to us as individuals, some of our personal history, but also episodes in our lives. What did the guy -- what color was the shirt the guy was wearing yesterday on the plane when I flew down here, as an example. So those kinds of memories are very, very hard to measure and very hard to quantitate.

I spent some time on this, because there are a minority of patients who report that the autobiographical memory remains impaired for extensive periods of time after ECT. Most people don't. Most people report the memory to be improved. But

there is a proportion who purport the opposite. When we encounter that complaint, we take it very seriously. We evaluate the patient. We examine the patient. We try to understand what's going on. And the bottom line here is that it's very, very difficult to find an objective correlate of that complaint.

That is to say, when you do detailed testing of the memory, in most of these individuals, the memory tests normal. So we can't find an objective measurable correlate of this sense that my memory is not working. What we do observe, however, the best predicter of having this complaint is the mood of the individual. If the depression is active, that is a very strong predicter that the person will have the sense, the complaint that the memory isn't working.

And so after we complete that workup, the first thing that I look for in a patient that's having this complaint is, okay, how is your depression doing? And maybe it's not that we should back off on the ECT. Maybe we should do more of the ECT to get your mood back into a normal state.

So this whole area of retrograde autobiographical memory is very challenging. The field is spending a lot of time trying to understand it. But it does not appear to be, you know, universal. In fact, it's rare. And more work is to be done.

MR. ESFANDIARI: Your Honor, can we have a very brief

sidebar on publication of documents?

THE COURT: Okay.

[redacted]

BY MS. COLE:

Q. Doctor, go ahead to where we are -- is there language in this book that is read by psychiatrist, Dr. Sharma, in this case about people experiencing a belief that their memory has been lost?

A. Yes.

THE REPORTER: Go ahead. I'm sorry. The microphones aren't on.

THE WITNESS: So, yes. The answer is yes. As you've highlighted here, out of respect for those few patients that complain of this persistent loss, we acknowledged that, in some cases, the complaints could indicate the loss is permanent. They have not been able to -- at least the sensation is that I can't recover that memory. Again, we don't have any objective

data that that's the case. But the person certainly feels like that's the case. So that's what is meant -- that's what we're trying to capture with this.

BY MS. COLE:

Q. Is that sort of a psychological overlay?

A. Well, certainly, there is a psychology to it. I'm sure that's distressing to the individual. And the problem is that if a person becomes convinced that their memory isn't working and becomes invested in that belief, it could be very, very difficult to change it.

Q. And is that why the language was put in the book so that psychiatrists who do ECT and use this book will be aware that persistent -- the persistent feeling of loss of memory may occur in one of their patients?

A. Yes. And to remind us, as investigators, that we've got to keep working on this. We've got to figure out some way to get a better understanding of what's going on around such beliefs.

Q. Does this feeling of persistent or permanent memory loss mean that the individual has suffered brain damage?

A. No. In no way. And we never meant to imply that at all.

Q. How do we know that?

A. Well, we just briefly reviewed the evidence about the safety of ECT and the issue of brain damage. There is no evidence in animals or in humans that ECT, at least

contemporary ECT properly performed, causes any brain damage. So it just doesn't happen. Memory can change without there being damage to the brain. The formation of new synapsis, the pruning of old synapsis, and so on, that's not brain damage.

Q. If there were brain damage in an individual, would it show up -- if it were extensive enough to cause this kind of a loss, would it show up on MRI or CT scans?

A. Well, it depends on what the nature of the damage is, how extensive it could be. So the answer could be possibly, but not always. The other critical issue here is that every known amnestic syndrome in neurology, when someone has a severe memory disorder, let's say caused my temporal lobe encephalitis. So the temporal lobe hippocampus is infected by herpes virus and the temporal lobe is shot. These people can have very profound amnestic syndromes. And there are other causes. Trauma to the area can also cause amnestic syndromes. With amnestic syndromes, there's always an anterograde component to the retrograde component. You just don't see pure retrograde autobiographical amnesia for a complete wipeout of time. That doesn't happen in nature.

Q. Does this book also show where in what kind of patients and what kind of situations ECT should be used? This is in Chapter 2.

A. Yes, it does. The diagnostic indications, correct.

Q. Tell us about that.

A. Well, there are a couple of key diagnostic indications for the treatment, the first of which is the mood disorder, typically that hasn't responded to other treatment, medications, often, or -- and/or one that's in need of very, very rapid improvement. They need to get better yesterday.

This might be a person with acute suicidal behavior, a person with profound melancholia who is not eating and not drinking and who is going to die if we don't do something. By the way, there is a mortality with major depression of anywhere from 10 to 20 percent. This disease can kill you. It can kill you. So it's important to treat you and to treat it early.

So treatment refractory, a need for rapid response, a history of good response to ECT. So if you had this in the past and ECT worked, yep, that's a good reason to go ahead and start. And then, finally, you don't have to have failed treatment. You might just opt to begin treatment right away with ECT.

So those are the essential indications in people with major depression, either from unipolar or bipolar disorder and mania, as well, responds very, very well to ECT. And then, thirdly, syndrome of catatonia. Those are sort of the key indications.

There are some general medical conditions that also can be treated with ECT. So a condition called status epilepticus, uncontrolled continuous seizures. Sometimes nothing works.

The patient will be on -- in a coma on IV barbiturates. We can't stop the seizure. We'll actually give them a couple of ECT treatments and that breaks the status.

Q. Does ECT continue to be studied?

A. Of course, yes.

Q. This book is dated 2001. Is it still up to date as far as the research goes?

A. It's pretty much up to date. The Task Force is revising the report. And we should have a new report, if not this year, sometime next year.

Q. In terms of the issues that we're dealing with in this case, in other words, the risk factors and the possible adverse effects from ECT, is that changing?

A. No. The basic theme is the same, that is to say that the objective memory side effects are short term and have resolved within a matter of days to a couple of weeks past a completion of the treatment. We still are struggling with this notion of retrograde autobiographical memory. We don't have good information on that even today. Indications have changed a little bit in that the FDA has approved ECT for certain specific indications.

Q. What I want to ask you is do you keep current on the research that is going on that will be in this next edition of the book?

A. Yes. Yeah.

Q. Are you on the Task Force again? Did they drag you out of retirement to do it again?

A. They tried. I'm providing input to the Task Force, but I'm not on the Task Force per se.

Q. Are there any large scale studies that have been done that you're aware of that have tried to look at retrograde amnesia, persistent memory loss and see what it is that's actually going on?

A. There have been studies done, most of the studies having looked at nonpersonal memory. And you would do this, for example, by using scales of famous events, who shot John Kennedy, or faces of famous people, or recent TV shows in the past year or two or three. So that's called semantic memory. It's nonpersonal. It's factual. It's out there.

So there are scales that have looked at that, and as we say in the -- in the Task Force Report, those memories again tend to occur weeks to months after completion of the treatment.

But we don't have yet a good metric, a good tool for measuring autobiographical memory. How do we know what your memory was a week ago or a month ago or six months ago, and how do we line that up with what you think it is today? You can see that's quite difficult.

Q. You mentioned objective things, like something you can check on. What's the difference between objective things when

you're trying to test for whether people who have ECT have permanent or persistent memory loss and what percentage versus subjective?

A. Well, the events that you're trying to check for are all objective. The color of the shirt the guy was wearing yesterday on the airplane is an objective fact, but it's my personal memory that's tied to a place and a time. So it's context dependent, essentially, as opposed to a fact of the world, if you will.

Q. Do the studies that have been attempted vary in quality?

A. Very much so. It's a tough thing to study.

Q. There's been some testimony here about a study that was published, I think, in 2007 by a researcher named Dr. Harold Sackeim. Do you know of Dr. Sackeim?

A. I know Dr. Sackeim very well. He's a friend of mine.

Q. Are you familiar with his 2007 paper?

A. Would you show me the specific paper, so I can be clear?

Q. Sure.

MS. COLE: May I approach, Your Honor?

THE COURT: Yes.

THE WITNESS: Yes.

MS. COLE: Your Honor, may I publish the front page of the study?

THE COURT: The cover, yeah, sure.

BY MS. COLE:

Q. What can you tell us about the Sackeim study? First of all, tell me what you think of the Sackeim study. Is it a good study?

A. Well, as I said earlier, Harold is a good friend of mine. And all of us congratulated him for trying to take on this challenging task by doing a survey of sort of a naturalistic survey of patients in the New York area. That's the good news.

The bad news is that it's a very, very poor study. And this is not just Ed Coffey's opinion. This is a -- it had been formally rated using objective criteria as a low quality.

Q. Tell us why.

A. There's several reasons why. The most critical of which is that the tool that Sackeim and -- that Harold and his team used to measure personal autobiographic memory is not standardized. It hasn't been -- at the time, it wasn't validated. We don't -- it hasn't been proven what it's actually measuring. Its reliability had not been established. You get the same results under the same test conditions every time. There were no normative data.

Q. What is that?

A. How do normal people perform on this metric? How do people, importantly, with depression perform on this metric?

Q. What do you mean there were no -- he didn't test depressed people?

A. We don't established normative data on this scale. That's correct. If he tested them, he didn't report them. Depressed, nonECT. I'm sorry. Depressed nonECT. Yes. Obviously, the ECT folks were. For the most part, depressed. Not all were. Some had other diagnoses, which is another issue.

Q. So who did he compare his ECT reportees with?

A. It's a before and after. So it's a consistency of the measure. So if I said, blue before ECT, and I'm answering the question blue now, then that answer is consistent. If it's inconsistent, that was supposed to be an indication of an error.

Q. How do you know if a personal off the street would do the same thing?

A. That's the issue. We didn't -- he didn't establish normative data for the metric. This metric would never have been accepted as an established neuropsychological tool for those reasons. Everything that we do in neuropsychology, all the tests that Dr. Bilder talked about earlier with this patient have passed those tests.

Q. You read Dr. Bilder's report?

A. I did. So we have validity, we have reliability, we have normative data. We know what the test is trying to tell us. We don't know that with Harold's tool. And, again, this is not just my opinion. Papers have been written about this matter.

Q. So --

A. That's the biggest issue. There's several other issues.

Q. Go ahead. I don't mean to cut you off.

A. Well, it's a prospective study. It's not looking back. It's looking forward, but it wasn't planned. So there was no specification of what exactly are we looking for. If you don't do that, then whatever pops up could have occurred just by chance. You can't -- you can't -- it's like throwing out a net and catching a bunch of fish saying, yeah, I was trying to catch that fish. Maybe yes, maybe no. It's got to be planned. The patients were not randomized to the types of ECT. The raters were not blinded.

Q. Hang on a second. When you say randomized as to the types of ECT, you mean they were using the old kind as well as the new kind?

A. He was and was making a claim about a particular type of ECT, mainly bilateral, being the one that's associated with this chronic complaint. Well, you can't say that unless the patients were randomized to electrode placement. There could have been something about the fact that those patients were getting bilateral that led to the change, not the ECT itself.

And then, finally, as you point out, a number of these patients were receiving the outmoded sine wave type of ECT we talked about earlier. They are included in the same study. So you can't apply those results to contemporary ECT.

Q. And how long after ECT did he test these people?

A. I think it was up to six months. Yeah, six months.

Q. And he didn't follow them for years?

A. That's not reported in this paper. I don't know if he did do some later follow-up, but not in this paper.

Q. So if it's been represented in court by another witness that this study showed that 12 and a half percent of all people who receive ECT are going to have persistent long-term memory loss. Is that -- tell us your opinion about whether that's --

A. That's not a valid finding. This paper does not prove that fact.

Q. Why not?

A. For the reason I just mentioned.

Q. Have there been other studies that have been attempted?

A. Of the studies --

Q. By other authors?

A. Of autobiographical memory?

Q. Yes, sir.

A. Yes.

Q. Ask another one that was mentioned here, I believe by Dr. Read, a Dr. Rose, are you familiar with that study?

A. Most likely. But I -- let me be sure by seeing which one you're referring to.

Q. I'll see if it can find it for you.

MS. COLE: May I approach?

THE COURT: Yes.

THE WITNESS: This is not the actual study. This is a review page abstract, yeah.

BY MS. COLE:

Q. Are you familiar with the study?

A. I do know the study.

Q. All right. Let's talk about the study. Tell me about Dr. Rose's study.

A. Rose did a selective review of, I believe, seven studies that were looking at patients' complaints of memory from ECT and concluded that there was a high frequency of persistent complaints. That study also has been officially rated as a very poor quality, low quality for some of the same reasons we talked about earlier.

One, the metrics that are used to assess this complaint are in question, but equally important is the selection methodology that was employed. So of the seven studies that she reviewed, two of those studies sampled individuals from groups that are known to be opposed to ECT. So they -- those people are coming into a study with a bias against the treatment.

Q. Okay.

A. Not my opinion.

Q. What about the other studies that she looked at?

A. Well, and then some of the other studies -- so you need to set those aside, obviously, at least look at them separately.

Don't add them into the same group.

Two additional -- so we have five studies remaining. Two of those remaining five studies -- and I think my math is correct here -- no, three of them did not actually follow patients out for six months. They were much briefer periods of follow-up. Obviously, someone is going to have more memory complaints early in the course than later.

So you can't claim it's a six-month follow-up if you're including follow-up metrics much sooner. So you need to set those three studies aside. That leaves two studies of the seven that you can make an argument, okay, yeah, there's a reasonable number there. But in each of those two studies, patients got sine wave ECT, the old sine wave ECT. So those data are not applicable to contemporary brief pulse ECT.

Finally, there were six other studies in the literature at the time that Rose could have included in her review. She did not include them. Why? Who knows. But of those six studies, two found no change in memory complaints at six months. Four found patients described a better memory performance, not worse.

So there was some selective inclusion, some would say cherry-picking of the studies that were included for her review.

Q. Has her study been criticized in the scientific literature?

A. It has. And I say, again, it's not just me raising these issues. These issues have been formally raised in the medical scientific literature.

MR. ESFANDIARI: Your Honor, can we take a break? We've been going for an hour. There's some issues -- or a sidebar. I'll defer to you.

THE COURT: We'll do it as a break. So leave your tablets on the chairs. And we'll see you in five minutes.

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury out at 10:06 a.m.)

THE COURT: Just wait out in the hall. We'll let you know when we need you.

THE WITNESS: Thank you.

THE COURT: I don't know what I'm missing. I thought that was going pretty smoothly. What's the issue?

MR. ESFANDIARI: I'm controlling my anger here, Your Honor.

THE COURT: You're doing a good job. You don't seem angry.

MR. ESFANDIARI: Controlling it. We had an MIL that FDA was not to be mentioned.

THE COURT: Did he say FDA? I must have missed that.

MR. ESFANDIARI: He said ECT has been approved by the FDA. Not only is that a violation of the motion in limine, it's a lie. ECT has not been approved by the FDA.

THE COURT: I wasn't listening carefully enough to hear him say it. His voice, to me, is hard to hear. Hold on. What's going on with that? Why did he say FDA?

MS. COLE: He was told before he came on the stand not to mention FDA. I steered him away from it immediately, Your Honor. It was a slip-up on his part. He was instructed about not using the term FDA. He didn't give it any context. I moved on and directed him away.

THE COURT: I think he did a good job, because I didn't -- I don't remember hearing it. But maybe not, because I kind of tuned him out just because of the tone of his voice. But -- so it wasn't an intentional act by the defense. I don't think she's playing games here. What do you want to do with it?

MR. ESFANDIARI: I fully agree. I don't think this was a malicious move by Ms. Cole. I think it was a blurt-out by Dr. Feigal -- I'm sorry, Dr. Coffey. However, the problem is, it's a lie. ECT, this device is not approved by the FDA. So not only do we have a violation of the motion in limine, Your Honor, but we have somebody perjuring himself. This product is not approved by the FDA. If Somatics went and said that my -- our product is approved by the FDA, it would be subject to --

MR. BENKNER: He didn't say the Thymatron was approved by the FDA. He said ECT is approved, which is not a

lie.

THE COURT: Now you're piling on. Now you're piling on. You're double-teaming here. Just a second, though.

Whatever he said, my question to you is, what do you want to do about it? Just think about this for a second. You know, if the jury is like me and kind of missed it and wasn't paying, you know, attention to it, you want to draw more attention to it? Or -- I mean, it's a judgment call. I mean, what do you want to do?

MR. ESFANDIARI: Yeah. So that's why I didn't object contemporaneously because I did not want to draw any attention to it. I'm not asking for a mistrial. I think the case is going smoothly. I don't want to waste everyone's time.

I do want to contemplate, perhaps after Dr. Coffey's testimony is concluded, instructing the jury that ECT is not approved by the FDA. But I'm not sure yet whether I want to do that or not. But that's something I would think would be remedial is that that factual and consistency needs to be corrected.

THE COURT: All right.

MR. ESFANDIARI: I haven't decided that, Your Honor.

THE COURT: So then you're going to -- remind Coffey not to --

MS. COLE: I'm going to do that right now.

THE COURT: Yeah. And then we'll talk about what you

think you might want to do with that.

[redacted]

[redacted]

[redacted]

MR. ESFANDIARI: May I make one other comment, Your Honor --

THE COURT: Sure.

MR. ESFANDIARI: -- just real quickly? A, my colleagues informed me -- I didn't notice it. My colleagues informed me when Dr. Coffey mentioned the FDA approval, a few jurors were taking notes of that. So we do know that they heard it or at least some of them heard it.

Number two, another MIL violation, and this was before trial, they told me I'm not allowed to make any reference to the Cuckoo's Nest and movies -- to One Flew Over The Cuckoo's Nest, the Jack Nicholson movie.

MS. COLE: That was another thing I had spoken to him about and --

MR. ESFANDIARI: And then he makes reference to it. There's been multiple violations of MILs, agreements by the parties, and, basically, what I consider perjury on the stand.

THE COURT: Okay.

MS. COLE: The mentions of the movie was inadvertent. I did talk to him about that yesterday, and I will talk to him about it again. But, again, I steered him quickly away from that.

THE COURT: Okay. One thing at a time here. So

[redacted]

THE COURT: Okay. More thoughts on our situation.

MR. ESFANDIARI: So, Your Honor, on the issue -- The Cuckoo's Nest, I'm not as concerned about. I think I may have a remedial option to that. As to the FDA, I'm going to think over it after the full examination is concluded to decide what I want to request on that or suggest.

[redacted]

THE COURT: All right. Dr. Coffey, have you testified in court previously?

THE WITNESS: Yes.

THE COURT: How many times, roughly?

THE WITNESS: Very small number.

THE COURT: Sometimes expert witnesses do more time testifying in court than they do in their real jobs. Others testify less. Sounds like you're a less frequent flyer. You

caused some problems for us by talking about the Cuckoo's Nest and the FDA thing. That's a big deal to the lawyers.

Did your lawyer tell you not to bring that up?

THE WITNESS: Not to bring it up?

THE COURT: Or not -- not even to speak the words. I mean, what were you told?

THE WITNESS: Yes, she did. And I just lost track of it, so it's my bad.

THE COURT: Yeah. There are situations, I don't think this is one of them, but I think you should understand, we've been here since last Wednesday. We've got a jury of eight people who don't get paid. They've got to come and sit here all day and listen to basically somebody else's problem. Have you ever been on jury duty?

THE WITNESS: Yes, I have.

THE COURT: All right. What kind of case?

THE WITNESS: Well, I --

THE COURT: Car crash?

THE WITNESS: It was a murder case.

THE COURT: Murder? How long did it go for?

THE WITNESS: About a week.

THE COURT: All right. So you know what I'm talking about.

THE WITNESS: Yes.

THE COURT: Right. Most of your fellow -- criminal

cases, they're a little more happy to be here than civil cases, because they find crime interesting, because we all watch criminal shows on TV and stuff.

But you blurting -- you mentioning what you mentioned could, in some situations, cause me -- or cause the judge to tell everybody to go home and say the last week of your life that you sat here on jury duty, the week that the lawyers spent here, they're paying several hundred dollars an hour for all these lawyers, it's all gone. Adios. Go home. Because that witness poisoned the well by bringing up something they weren't supposed to bring up. That's what a big deal it is.

So it's very important that you listen to what your lawyer tells you, and you do not cross those lines. And if you think you're getting close to maybe needing to cross that line, or you think you need to say that, ask me for a break, and we'll take a break and we'll talk about it. Because that -- that's just the way trials work. All right?

THE WITNESS: Understood.

THE COURT: Thank you.

THE WITNESS: Thank you.

THE COURT: All right. Go ahead.

[redacted]

[redacted]

(The reporter read as requested.)

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury in at 10:47 a.m.)

THE COURT: Have a seat, everybody. Are we ready to keep going now? That break was longer than usual, but it will save us some time in the long run.

All right. Go ahead.

MS. COLE: Thank you, Your Honor.

BY MS. COLE:

Q. Dr. Coffey, we were talking about some of the other articles that were out there. And I want to talk to you about a couple of them. Are you familiar with any articles or studies that look at people who have been autopsied and their brains have been looked at for damage after they have had a number of ECT treatments?

A. Yes.

Q. Tell us about that.

A. Well, there's several published studies that have looked at patients who, for whatever reason, died and came to autopsy and who had a history of having received many, many ECTs, dozens, even hundreds.

And those autopsy studies, while not perfect, of course, don't show any evidence that ECT has damaged the brain.

Q. Let me show you an article by Dr. Anderson. And without actually reading from the article, tell us what that article is about.

A. This is a case report of a brain examination, postmortem, that was conducted roughly a month after the patient's last ECT treatment. Now, this person had received 422 ECT treatments in their lifetime, and, basically, there were no identifiable structural brain changes.

Q. Thank you, sir. I'm not going to show you all of them. But there are several of these, aren't there?

A. Yes.

Q. The next article I want to ask you about, I'll preface it. It's -- this book was written in the blue book was written in 2021 -- 2001. Have there been more recent articles that have looked at the effects of electroconvulsive therapy, the benefits, the contraindications, the adverse effects?

A. Yes. Yes. The short answer is yes.

Q. Let me show you an article here by a Dr. Kellner and a Dr. Espinosa in the New England Journal of Medicine and ask you

if you are familiar with that article.

A. I am, yes.

Q. When was that -- that was published in?

A. February of '22.

Q. Are you -- in that article -- you've read that. Right?

A. Yes.

Q. In that article, it talks about cognitive effects, and it talks about adverse effects. Does anything in that brand-new article that's a review article contradict change or update anything that's in this blue book?

A. No. No. The general themes and trends are the same.

Q. Does the medical profession, especially with psychiatrists and neurologists, require doctors to keep up to date in their specialty?

A. Yes.

Q. Why is that?

A. Because knowledge is provisional, we're always learning new things that impact what we have learned before. Information is always improving and accumulating, and we need to have that information to provide the best possible care.

Q. Do clinicians, such as yourself, and the doctors that took care of Mr. Thelen, do they use their experience and their own knowledge that they've acquired from the literature in the conduct of their practice?

A. Sure.

MR. ESFANDIARI: Objection. Calls for speculation.

THE COURT: Overruled.

BY MS. COLE:

Q. You can answer.

A. Sure. Yes, they do. Of course.

Q. Tell us why or how. How does that happen?

A. Well, it happens in lots of ways. Through reading of scientific literature, through attending scientific conferences, through informal conversations with colleagues, through reading of textbooks, all of the above. There are many, many sources of information that come into the equation.

Q. And does -- do you, as a clinician, evaluate the quality and the thoroughness of reports and other studies that you see?

A. Yes, you have to. And then you have to make a decision, how does this aggregate information apply to this particular patient that's sitting here with me today? So there's a lot of thinking that goes into taking the science and applying it to the individual.

Q. Getting a little bit closer to Mr. Thelen's case. Can you tell me, sir, when you're talking about memory, does -- is long-term alcohol use, does that have an effect on memory?

A. Absolutely, of course.

Q. Why?

A. Well, alcohol is directly toxic to the brain. It injuries brain cells, and as a result, a variety of brain regions are

exposed to this toxin and potentially to damage from it.

Q. And is that the kind of damage that would show up necessarily on a CT scan or an MRI?

A. It could. For some individuals, chronic heavy use can result in actual shrinkage of the brain that's visible on brain imaging. Not always.

Q. What about depression? Does depression have an effect on the brain?

A. Yes, it does.

Q. Tell us about that.

A. In addition to the short-term functional disturbances it creates, attention, concentration, memory, and so on, executive function, and so on, it has a direct effect on brain structure, as I mentioned earlier. So, again, to summarize those effects, it is as if the brain has gotten older than it should for an individual of that particular age. That is to say, there's shrinkage of the surface of the brain, the cortex. There's enlargement of the ventricular surfaces deep in the brain. There's this issue of subcortical hyperintensity around brain, microvascular, micro blood vessels. So all of those happen with aging and happen with increasing frequency with people with depression.

Q. Can there be changes in cognition or memory with depression that wouldn't show up on a CT or an MRI, but would still affect a person's ability to call up memories?

A. Well, of course, a brain scan is not going to see a person's difficulty with memory. That's a functional issue. But, yes, depression is associated in the acute phase, when someone is sick with difficulty with cognition, memory included, but we now know that some of those difficulties can persist after the depression is in remission.

Q. I sent you some records on Mr. Thelen. Right?

A. Quite a few.

Q. I think it was in excess of 12,000 pages.

A. That sounds about right.

Q. You're charging me money to review that stuff. Right?

A. Yes, please.

Q. How much money do you charge per hour to review medical records and come here and give us the benefit of your opinions?

A. 550.

Q. 550 an hour?

A. (Moving head up and down.)

Q. Do you have any estimate about how much you -- I don't think I've ever gotten a bill from you in this case. Do you have any estimate how much you intend to bill for this case?

A. I don't. I think I have sent you a bill or two.

Q. Oh, hopefully I've paid it then?

A. You did. Someone did. Yes. Thank you.

Q. Do you have any idea how much that was?

A. No. I'd be guessing.

Q. Okay. Don't guess. You -- we don't do guesses here.

Tell me what you found out about Mr. Thelen's history as a -- as a young -- as a child and as a teenager into young adulthood from the medical records?

A. Yes. Well, the records I reviewed began around 2000 and -- the early teens, but the history that was relayed to his doctors at that time revealed that since at least the teenage years, Mr. Thelen had struggled with a mood disturbance [redacted] And all of these illnesses were impacting his functional status, such that he couldn't -- he didn't perform well in school, was unable to attend or complete his first part of college, and also impacted his work performance, apparently.

Q. Now, can depression ever be cured by medication or by ECT?

A. No. We don't have a cure for depression. We can treat the syndrome. We can treat the symptoms. We can maintain control over those symptoms with appropriate maintenance therapy, as I mentioned earlier, but we don't cure the underlying illness.

The same is true, of course, for hypertension. We treat high blood pressure. We control it. But we haven't cured the underlying disease of hypertension. The same is true of diabetes. We can control it with insulin, but we haven't fixed the basic problem. We haven't cured the pancreas problem that leads to diabetes in the first place.

So there are lots of conditions in medicine that we can treat effectively, but not necessarily cure.

Q. Now, in those records -- and I don't want you to, you know, recite them, because the jury has heard some about them. Are they -- can you characterize for us what your impression of his alcohol use and the depth of his depression was?

A. I think they were both very severe. They would meet formal criteria for being severe in each case. So with regard to his depression, he was -- it was creating dysfunction. He couldn't perform as he wanted to or might be expected to. And treatments were not working for him. The out -- the substance use, likewise, was beginning to spiral. And as you can imagine, those two are very much bad for each other. And so increasing substance misuse is going to likely worsen the depression, which in turn can lead to worsening of the substance use. So it becomes a very vicious cycle.

Unfortunately, this comorbidity of substance use and depression is common. Many, many, people have this. It makes the treatment of each of them separately very, very difficult.

Q. Did you see where Mr. Thelen had experienced something called sleep apnea?

A. Yes.

Q. Tell us what that is, please.

A. Sleep apnea is a condition wherein during sleep the person stops breathing. And there are two basic causes. There's a

central type of sleep apnea, which is felt to be due to some disturbance in central brain respiratory regulation that causes the periods of lack of breathing, of stopping breathing during sleep.

Then there's the obstructive type, wherein, typically, overweight, obese individuals will have a relaxation and collapsing of their pharynx that obstructs the airway. That's what snoring is, you know, when the throat becomes partially obstructed during our relaxation during sleep.

And so for either or both reasons, individuals can have many, many periods during the night where they're not getting oxygen to their brain. And if you have enough of those periods, as measured by a sleep study, you then meet formal criteria for the disorder. It's not good for you. It's not good for the brain. It can create cognitive difficulties and chronic cognitive impairment, so it needs to be treated.

Q. Where was Mr. Thelen treated for his sleep apnea?

A. He was prescribed CPAP. That's the positive pressure that keeps the airway open. You see the big mask that people wear. Now, I don't know how adherent he was to the treatment. [redacted]

[redacted]

And I don't know that I saw any records that measure whether the CPAP brought about improvement. You can do that. You can repeat the sleep studies and assess the impact of the

CPAP and get a number that quantitates the level of improvement. I don't recall seeing that in his records.

Q. Tell us about the effect of ECT or -- let's confine it to ECT on suicidality. Mr. Thelen did have quite a few suicide attempts before he started ECT and then several after?

A. Yes. Well, it's a complex issue because suicidal behavior is very complex. To the extent that the suicidal behavior is being driven by the depression, and to the extent that the ECT will improve the depression, then the suicidal behavior should improve. And we have evidence that that's the case.

Now, as I mentioned earlier, it's not always that simple. Patients often will have substance use at the same time. If the depression is getting better but now the substance use is flaring up, that can alter the equation very dramatically.

It's a very complicated thing to study. But there is evidence that suicidal behavior in the near time does improve after effective ECT.

Q. Mr. Thelen had quite a few psychiatric admissions to the hospital after he started ECT and quite a few before he started ECT. Can you tell us, please, during a psychiatric admission of a individual to the hospital -- let me back up. Are you familiar with that?

A. Yes.

Q. Do you treat people that have been psychiatrically admitted to hospital?

A. Sure.

Q. Are there measures that are taken of somebody's neurological status whether his memory is good in the short-term and in the long-term?

A. Yes.

Q. In Mr. Thelen's case, he stated that he lost his memory in 2015. I think it was summertime, June or so, in 2015?

A. Yes.

Q. Are you -- did you read records on Mr. Thelen that showed that his memory status was tested during different hospitalizations after 2015?

A. Yes.

Q. I want to go through a series of records with you. And, Counsel, these are Exhibits 1070, 1075, 1084, 1086, and 1087.

Let me show you first -- I'll put it up on the screen so I don't have to come up there -- a record from the CHI Hospital in 2016 with Dr. Alaskaf, and I want to show you over here where -- let's see. Where it says, "Recent Memory/Remote Memory," do you see that?

A. Yes, I do.

Q. Let me make it bigger. What does that mean when it says, "Recent Memory/Remote Memory," and then "fair and intact"?

A. Well, I assume the fair refers to the first item, recent memory, and the intact refers to the second item, remote memory.

Q. And this is a period of time when Mr. Thelen was still having ECT treatments. This is the 6th of July of 2016. Would you expect, because he's undergoing ECT regularly, that his recent memory would be less than perfect?

A. Yes. I don't know exactly how fair -- how the conclusion of fair was arrived at here. But, yes, I would not be surprised if there were some transient disturbances of recent memory in the middle of a course of ECT.

Q. What does remote memory mean for this test?

A. I don't know what exactly it means here. There's several ways of testing remote memory at the bedside.

It could be everything from what did you have for breakfast yesterday, so it could be autobiographical memory, to did you hear about the train wreck last weekend in Boston or wherever. So -- or it could refer to a duration of recall of items that may have been presented to the individual.

So I can't say for sure what it means here. But it is clear he's trying to distinguish between immediate recall or recent memory and something a bit more distant.

Q. Is there anything that Mr. Thelen -- and I'm going to actually show you the record here, so you can see it up close. Is there anything in this record that Mr. Thelen ever said anything to his doctors about --

THE REPORTER: I'm sorry, about what?

MS. COLE: About his losing all of his memory.

Sorry.

THE WITNESS: Do you want me to read this now?

BY MS. COLE:

Q. Glance at it. If you don't recognize it, just tell me and we'll skip it.

A. I recognize it. And I can say that, in general, both at the time that Mr. Thelen claims later to have had a wipeout of his prior memory, his autobiographical retrograde memory, there's no indication in the record that that wipeout was clearly articulated to any of the providers.

I mean, if someone walked in the office one morning and said I can't remember anything about my life from this point back, that's a five-alarm fire. We're going to get on that immediately. We would begin an immediate investigation of what's going on and try to understand what's happening and obviously try to address it based on that understanding. That never happened ever.

Q. Now --

A. Which is -- would be bizarre.

Q. Let me get this back from you.

In the record that you reviewed from 2016, 2017, 2018, 2019, in any of those records, was Mr. Thelen -- did Mr. Thelen's medical records ever reveal that he disclosed this loss of memory to any of his treating doctors?

A. No. Now, to be clear, he would complain of -- especially

during the ECT course, of the expected short-term disturbances. But he never -- to use my vernacular, never raised the fire alarm, five-alarm fire alarm. Never raised that issue.

Furthermore, as you pointed out, he had several hospitalizations and several surgeries over this time period for which he had to give informed consent, for which he had to follow complicated preop and postoperative instructions, including rehabilitation. And there was never any indication from any of the physicians or treatment team that he was unable to do that.

So, again, that stands in marked contrast to claiming that I have no memory at all of anything since a particular date in time, mid June of 2015.

Q. Now, you've seen the deposition of Mr. Thelen, and he does claim, and he claims here, that he had a complete wipeout of all of his memories in 2015?

A. Yes.

Q. And is there anything that you disbelieve about his belief or do you --

A. I've never seen Mr. Thelen. I watched his video. I -- he seemed sincere to me in his belief. I -- giving him the benefit of the doubt, I believe that he believes it. But it's not --

Q. Not documented?

A. It's not otherwise credible in the medical record. It was

never expressed at that time to any of his clinicians.

MS. COLE: At this time, I'd like to admit Exhibit 1070, 1075, 1084, 1086, and 1087 into evidence.

THE COURT: Any objections.

MR. ESFANDIARI: No objection, Your Honor.

THE COURT: Admitted.

(Defendant's Exhibits 1070, 1075, 1084, 1086, 1087 admitted into evidence.)

BY MS. COLE:

Q. Does that mean that Mr. Thelen himself didn't feel like he experienced a memory loss in 2015, as he says he did?

A. I'm sorry. Would you repeat that?

Q. Does that mean that he didn't actually experience an injury, a claimed injury in 2015, that he himself can't remember things?

A. I'm still not sure about your question. I'm not sure what you're asking me.

Q. Maybe I can ask it a better way. He testified that he lost all of his memory in 2015 and those memories still remain lost.

A. Yes.

Q. Do you have any reason to disbelieve him?

MR. ESFANDIARI: Asked and answered, Your Honor.

THE COURT: I'll allow him to answer it.

THE WITNESS: If I understand the question, I believe

he believes it.

BY MS. COLE:

Q. Okay.

A. That's as far as I can go.

Q. In all of those 12,000-some-odd pages of medical records that you read, did you ever find one of his doctors, one of his medical doctors, that uses the term brain damage in his -- in the 12,000 pages of medical records?

A. I don't think so. Whether he himself may have used the term, but I don't think so. He certainly was never diagnosed.

Q. In the article that we talked about earlier by Dr. Sackeim, does Dr. Sackeim use the term brain injury or brain damage to refer to any of the people that he put in his study?

A. I didn't follow that again. Sorry.

Q. Sure. In Dr. Sackeim's study -- and I have it here if you want to look at it.

A. Okay.

Q. He talks about memory loss that's reported. Does he ever use the term brain damage or brain injury in that article?

A. I say no, he does not.

Q. What about Dr. Rose?

A. I don't think so.

Q. Did you look at the reports of the MRIs and CT scans that were done of Mr. Thelen?

A. Yes.

Q. Did he have any evidence of brain damage on any of those scans?

A. Two normal head CT scans, and I believe three at least normal brain MR images.

Q. Looking at all of the evidence, including the test results and scans and tests that were done of Mr. Thelen, as a neurologist and a psychiatrist, did Mr. Thelen have dementia?

A. No, clearly did not. And that was -- sorry.

Q. How can you say that?

A. Well, it was explicitly ruled out on a couple of occasions, and it was never diagnosed otherwise.

Q. None of his medical doctors diagnosed dementia?

A. Dr. Duffy for a while there may have had -- may have had -- said something about that matter. I'd have to go back and double-check that, but no one else did.

Q. Is there any evidence from a neurological or a psychological -- psychiatric standpoint in the records that leads you to conclude that Mr. Thelen has dementia?

A. As of the testing overseen by Dr. Bilder in March of 2022, there was absolutely no evidence of a dementing disorder, what we now call major neurocognitive disorder. That was explicitly ruled out by that assessment. I can't speak to today. I don't know what's happened to him since then.

Q. What does dementia look like?

A. Well, dementia is a syndrome. Again, we call it major neurocognitive disorder now, which is basically defined as a decline in your cognitive functioning that leads to functional impairment. Now, it's usually memory, but it doesn't have to be memory. It could be language. It could be visual spatial functioning. It could be social functioning or some combination of the above.

And so the example that we often see or hear about is Alzheimer's disease, a particular cause of dementia wherein the primary cognitive function impacted his memory. And so the person begins to gradually lose memories. And as we said earlier, this is not only past memories, it's the inability now to learn new information going forward. Always see those in tandem.

Q. Was Mr. Thelen tested by Dr. Bilder? And did you get Dr. Bilder's -- or Dr. Hoffnung's report?

A. I think he was tested by Dr. Hoffnung for Dr. Bilder. Yes, I did see that report, yes.

Q. Can you tell the ladies and gentlemen of the jury whether the findings on that report, in your professional opinion, equal dementia.

A. No. It was explicitly ruled out and appropriately tested for.

Q. The type of memory problem that Mr. Thelen describes, is that something that ECT has the capacity to even do?

A. I don't think so. I'm not sure what else outside of ECT could even do it, as I mentioned a moment ago. That sort of picture doesn't appear in nature.

Q. What about a psychological overlay. Is that -- can that cause this kind of a syndrome?

A. Well, I guess depends on what you're calling the syndrome. As I said earlier, I don't have any reason to question the sincerity of Mr. Thelen's belief about his memory difficulties. I also believe that he at this point in his life is very invested in this issue. It is, after all, going to trial. And in my clinical experience, once that train sort of leaves the station, it's almost impossible to fix it, to correct it.

Q. Psychologically?

A. Psychologically. Dr. Bilder refers to this in his report. This is the difference between focusing on, okay, what can you do and how can we start to get this problem better for you versus an exclusive focus on you're toast, this is not going to ever get better. You can imagine what the prognosis is going to be under those two situations. I think he's in the latter situation.

MS. COLE: Thank you, Dr. Coffey. I appreciate your coming out here for us.

THE WITNESS: You're welcome.

THE COURT: Cross-examination.

MR. ESFANDIARI: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. ESFANDIARI:

Q. Bear with me.

All right. You wrote an expert report in this case. Correct?

A. I did.

Q. Okay. And in that report, you stated that none of Mr. Thelen's ECT providers did anything wrong. True?

A. I think I -- to that effect, yes, correct, the treatment was performed appropriately, and there were no adverse complications from the treatment.

[redacted]

[redacted]

THE COURT: Okay. Just as a point of guidance on cross-examination, attorneys are allowed to ask leading questions. Those are frequently yes or no answers. Give a yes or no answer, if you can. Sometimes things -- they're not possible to be answered in that way. Most of the time, you can answer a question in yes or no fashion. So do that if you can. You can explain later. And if there's further explanation, the lawyer, Ms. Cole, can redirect and get more information that way.

All right. Go ahead.

THE WITNESS: Thank you. Thank you.

BY MR. ESFANDIARI:

Q. All right. It's your opinion that none of Dr. -- none of

Mr. Thelen's ECT providers breached the standard of care. True?

A. True.

Q. So when the jury is deliberating, you're going to -- based upon your opinions, they should not place any fault on Dr. Sharma or anyone who administered ECT. True?

A. True.

Q. Now, it's your testimony, if I heard it correctly, that -- that dementia is a neurocognitive disorder?

A. It is a type of neurocognitive disorder, yes.

Q. It's your testimony that Mr. Thelen has never been diagnosed with a neurocognitive disorder?

A. That's not my testimony. I think there are a couple of references in the chart to a possibility of a neurocognitive disorder or dementia, but my testimony was that that had been clearly and explicitly ruled out.

Q. And you said it was only by Dr. Duffy. Correct?

A. No. It wasn't ruled out by Dr. Duffy. It was ruled out by several other clinicians.

Q. Your testimony in terms of who -- did anybody diagnose Mr. Thelen with neurocognitive disorder? Yes or no?

A. I think there was a rule-out of a neurocognitive disorder or consideration of neurocognitive disorder, but it was never substantiated.

Q. I don't think you understand what a leading question is.

Did any -- let me give you an example. Is my tie --

MS. COLE: Your Honor, excuse me. If he needs -- it's improper for --

THE COURT: Time out.

MS. COLE: -- counsel to instruct the witness.

THE COURT: Go ahead and finish the question. If there's an objection, I'll rule on the objection to the question. What is the question?

BY MR. ESFANDIARI:

Q. Am I wearing a blue tie?

MS. COLE: Objection, Your Honor. Relevance.

THE COURT: Overruled.

THE WITNESS: I think so.

BY MR. ESFANDIARI:

Q. You think so. Am I wearing a blue suit?

A. I think so.

Q. My suit is blue.

A. As best I can see.

Q. So that's a leading question. All right. If I was -- am I wearing a red suit. Is my suit red?

MS. COLE: Your Honor.

THE COURT: Do you have an objection?

MS. COLE: Objection.

THE COURT: Overruled.

BY MR. ESFANDIARI:

Q. Is my suit red?

A. It is not.

Q. Okay. All right. So now we understand what a leading question is.

Did any -- is it your testimony that none of Mr. Thelen's providers diagnosed him with neurocognitive disorder?

A. I would have to look at the chart to be sure about the none piece. But the general gist in the record is that he does not have such a diagnosis. It has not been confirmed, substantiated by multiple, multiple caretakers.

Q. I still don't think you understand what a leading question is.

Has any doctor diagnosed Mr. Thelen with neurocognitive disorder? Yes or no?

A. I don't know.

Q. You don't know?

A. I don't know.

Q. You don't know. But you told her no one has?

MS. COLE: That was not -- Your Honor, that was not my question.

THE WITNESS: I don't think --

THE COURT: Time out.

BY MR. ESFANDIARI:

Q. Is neurocognitive disorder the same --

THE COURT: Stop. Is there objection to the last question?

MS. COLE: Your Honor, he's misstating my question, which related to physicians and not just any healthcare provider.

THE COURT: That objection is sustained. Okay. Ask a different question, please.

BY MR. ESFANDIARI:

Q. Has any doctor diagnosed Mr. Thelen with neurocognitive disorder? Yes or no?

MS. COLE: Objection, Your Honor, my word was physician.

MR. ESFANDIARI: A doctor -- we're parsing doctor and physician?

THE COURT: Time out. Time out. Members of the jury, please go back to the jury room right now. All right?

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury out at 11:26 a.m.)

THE COURT: We're not doing this. Here's how future objections are handled. Objection, and we come up here and we talk about it. And I may dismiss the jury every single time. All right? And what they will take away from that is that you are wasting their time. All right? That's how we're going to do it going forward. All right? That's the procedure.

So I think we may just break for lunch now to allow

everyone to contemplate that procedure and understand how we're going to proceed. All right? So it's 11:30 now. I intend to tell the jury to come back at, let's see, 11:30, 12:30, 12:45. All right?

So bring everybody back, and that's what we're going to do.

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury in at 11:28 a.m.)

THE COURT: All right. So what we're going to do now is take an early lunch break to help everyone continue to maintain focus. It's 11:30. That's -- take an hour, that would be 12:30. Let's make it 12:45. All right? Hour and 15 minutes. I think when you come back, things will go smoothly, and we'll be ready to land the plane. All right?

So we'll see you at 12:45. Thank you.

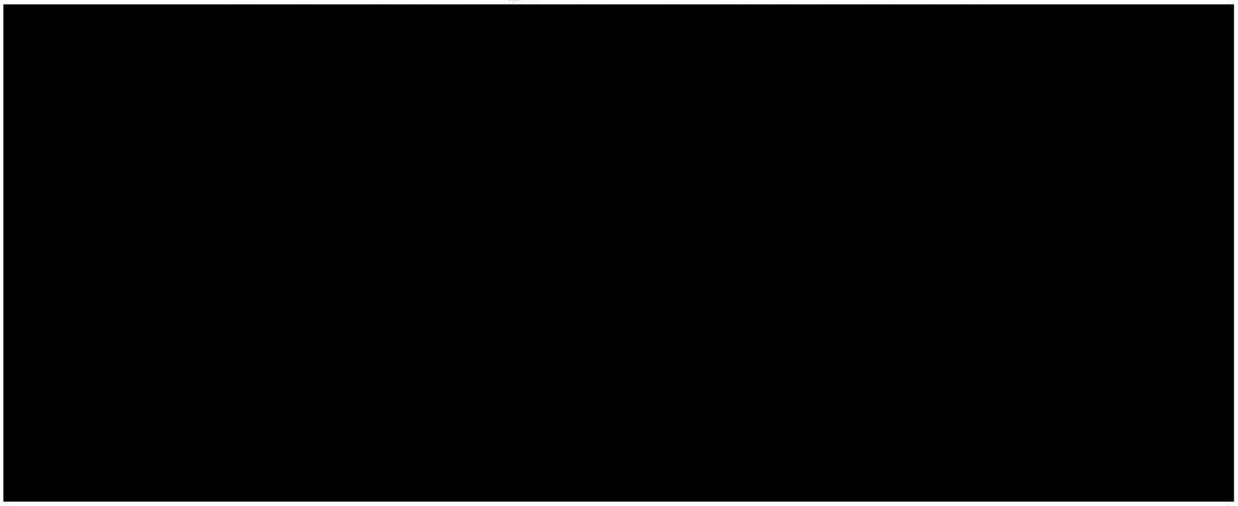
THE COURT SECURITY OFFICER: All rise for the jury.

(Jury out at 11:29 a.m.)

THE COURT: All right. Dr. Coffey, you are still testifying. That means you are not allowed to talk to any lawyers during your lunch break about the case. I would suggest you don't talk to lawyers about anything, because if you do, somebody will say you're talking about the case. So do not talk to any lawyers, and we'll see you back right here, right there, 12:45. Thank you.

THE WITNESS: Thank you.

[redacted]



THE COURT: Okay. Good. The witness is here? There's the witness. We good?

MR. ESFANDIARI: I'm ready, Your Honor.

THE COURT: Yes?

MS. COLE: Yes, Your Honor.

THE COURT: Okay. Remember the rules on objections. Bring the jury back, please.

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury in at 12:55 p.m.)

THE COURT: All right. I think we're good to go. Hope you had a good lunch. Ready to roll?

Go ahead.

MR. ESFANDIARI: Thank you.

BY MR. ESFANDIARI:

Q. Ready, Dr. Coffey?

A. I think so.

Q. Okay. All right. So we had a little bit of a problem with the questioning before lunch. So I thought to make it

easy, I'd write out my question, the first four, to get us started and warmed up. All right.

You see the screen, Doctor?

A. I do.

Q. Okay. So this morning you testified that neurocognitive disorder is the same as dementia. True?

A. I don't know exactly what I testified to. The new term, major neurocognitive disorder, is the term that's used in place of dementia. Major neurocognitive disorder. I think that's what I said.

Q. So is neurocognitive disorder the same as dementia. True?

A. No. Major neurocognitive disorder is dementia. Mild neurocognitive disorder is a different category.

Q. I follow you. So let me correct this here. All right. So let's call the question major neurocognitive disorder is the same as dementia. True?

A. Dementia is a -- yes, a type of major neurocognitive disorder.

Q. If it's okay with you, I'll mark this as yes?

A. Yes.

Q. Okay. All right. Have any of Mr. Thelen's doctors diagnosed him with neurocognitive disorder? Yes or no?

A. By doctor, you mean MD, PhD?

Q. Has any medical doctor diagnosed him with neurocognitive disorder?

A. I do not think so.

Q. No? So your answer is no?

A. Correct.

Q. And you consider psychiatrists to be MDs. Right?

A. Of course.

Q. You're an MD?

A. Yes.

Q. Have any of Mr. Thelen's medical doctors diagnosed him with major neurocognitive disorder secondary to ECT?

A. I do not believe so, no.

Q. So no. Going to mark it.

All right. And you testified you received all the relevant medical records in this case. Correct?

A. I don't know if I've ever testified to that. I received a lot of medical records. I don't know if I received all of them.

Q. You testified you received about 12,000 pages of medical records.

A. I defer to Ms. Cole in terms of the absolute number. It was a lot, yeah.

Q. Okay. Did you come across a Dr. Nathan Herman, who examined Mr. Thelen?

A. I think so, yes.

Q. Okay. What kind of specialty is Dr. Herman?

A. I don't recall. I'd have to look at my notes to see.

Q. Do you have your notes?

A. I do.

Q. Go for it.

A. Or my report. What was the date, roughly?

Q. Dr. Herman is September of 2018. To speed things along, I can help you out.

A. That's okay.

Q. That's okay. All right. Let me put up a picture of Dr. Herman here. See Dr. Herman?

A. I do.

Q. All right. And his specialty is what?

A. Psychiatry.

Q. Okay. And I know board certification was very important to you. And does this indicate that Dr. Herman is board certified?

A. Yes.

Q. Okay. Let's go to Mr. Thelen's medical record. You see that? Doctor, you with me?

A. I am, yes.

Q. You see the date there, 9/27/2018?

A. Yes.

Q. Okay. The patient is Jeffrey Thelen. Do you see that?

A. Yes.

Q. And at the bottom, do you see Dr. Herman's name there?

A. I do.

Q. Let's see what Dr. Herman diagnosed Mr. Thelen with. Why don't you read the highlighted line, Doctor? Read it out loud, please.

A. Diagnoses, bipolar disorder type I, generalized anxiety disorder, major neurocognitive disorder secondary to previous ECT, alcohol use disorder in early remission.

Q. Okay. So I asked you to read the highlighted one, but you wanted to read all three.

A. I'm sorry.

Q. But let's focus on the highlighted one. Can you read the highlighted one again for us?

A. Major neurocognitive disorder secondary to previous ECT.

Q. Okay. Let's go back to the written questions here.

Do you still think the answer to this question is true?

A. That is no longer true. That is the one doctor that you found that did diagnose him as such.

Q. A doctor that actually examined Mr. Thelen. Right?

A. Well, what's -- may I --

Q. Yes or no?

A. What's puzzling to me --

Q. There's no question pending, Doctor. There's no question pending.

This doctor actually examined Mr. Thelen. Correct? If you don't know, you don't know. Yes or no?

A. He did -- I haven't read that record in detail, but my

notes here are that --

Q. If you don't know, Doctor, Ms. Cole, well-qualified attorney, she's going to ask you all the questions you want.

My simple question is, Dr. Herman examined Mr. Thelen. Correct?

A. I assume he did, yes.

Q. Okay. Have you ever laid eyes on Mr. Thelen in person?

A. I have not.

Q. You have not. Has Dr. Bilder ever laid eyes on Mr. Thelen in person?

A. No.

Q. In fact, to do the neurocognitive testing that Dr. Bilder wanted, he had another doctor perform it because he didn't want to bother himself to go from California to Nebraska. True?

A. I can't speak to that.

Q. You can't speak to that.

All right. Doctor, I have actually on -- that also means that this question you answered incorrectly as well. Right? Have any of Mr. Thelen's doctors diagnosed him with neurocognitive disorder, the answer should be yes.

A. Yes.

Q. All right. I need to change it. You were wrong. And this one also you were wrong.

All right. Okay. Fourth question. This morning in response to Ms. Cole's questioning, and I reviewed the

transcripts, you basically testified that there's no indication in the medical records that Mr. Thelen's memory wipeout was clearly articulated to any of his providers. Did you provide that testimony?

A. Correct.

Q. Yes. Mark yes here.

Sonya, you're going to kill me, and I apologize.

THE COURTROOM DEPUTY: Did you just write on that?

MR. ESFANDIARI: No, it bled a little bit.

BY MR. ESFANDIARI:

Q. Let's see what the records have to say about that.

MS. COLE: Objection, Your Honor.

THE COURT: Counsel, approach, please.

(Bench conference begins.)

MS. COLE: Question was medical providers. This is a psychologist.

THE COURT: Overruled.

(Bench conference concluded.)

BY MR. ESFANDIARI:

Q. Back to this question I've written here, providers, in your definition of the medical community, is it only doctors that provide medical assistance to patients?

A. No. Could be staff as well.

Q. Could be staff as well?

A. Sure.

Q. For example, Dr. Bilder, who was here on behalf of Somatics testifying, he's not an MD. Correct?

A. Correct.

Q. But if he's providing counseling to patients in his clinical practice, is he a medical provider?

A. Yes.

Q. He is. Okay. And that would be the same for Mr. Thelen's medical providers who are perhaps not MDs but PhDs and clinical psychologists, they're providers. True?

A. Correct, yes.

Q. So in this testimony when you were giving about providers, were you limiting this to just MD doctors or were you saying to any of his, you know, clinical psychologists, psychiatrists, the full spectrum of people who examined Mr. Thelen?

A. What I was trying to say is that the start of the medical record is such that the medical providers, all-inclusive, were not reacting as if there was a five-alarm fire. Here's a patient who is saying their memory is completely wiped out, that didn't happen.

Q. You testified, though, that Mr. Thelen never articulated that clearly to his medical providers. That was your testimony.

A. That's what I'm saying, yes.

Q. Drawing your attention to this record from October 18th -- October 8th, 2016. Do you see that, Doctor?

A. I do.

Q. Okay. And this is a visit with -- a report by a licensed psychologist, John Curran, PhD. Do you see that?

A. I do.

Q. Can you --

A. This is 2017.

Q. This is 2016.

A. 2016?

Q. Yes. You see that, 10/8/2016?

A. Yes.

Q. Would you like me to read the highlighted language, or do you want to take a stab at it?

A. Go ahead.

Q. "Mr. Thelen moved into Kirkwood House in Wayne, Nebraska on August 30th, 2016. He previously lived in his parents' basement in Norfolk. They told him he was no longer able to live there. He was once married and divorced, but does not remember the details of this relationship. He does not remember much of his past, and that is believed to be an effect of his serial ECT treatments."

Did I read that correctly, Doctor?

A. Yes.

Q. You think he adequately articulated the fact that he was having autobiographical memory problems to this provider?

A. Well, I haven't seen this document.

Q. You haven't seen this document?

A. Right.

Q. All right. Drawing your attention to -- this is Plaintiff's Exhibit 121. It's a visit of June 17th, 2017 with a Dr. Langenfeld. Do you see that, Doctor?

A. Yes. Did you say June 17th?

Q. Yes, sir.

Okay with you if I read it -- have you seen this before?

A. I have not.

Q. Let's read it together then.

"The patient had questions about memory loss from his ECT treatments. He stated he thought he may have had 40 or more, but he cannot have the records released because it costs too much money, and he states it is difficult to fill out the paperwork. His best recollection is that he thinks he had weekly ECTs for approximately three quarters of the year. He states it has since been difficult for him to keep any job. When questions of his memory impairment come up, he is not accepted for positions he would really like to get."

Did I read that correctly?

A. Yes. The date, again, is June -- who is the author of this note.

Q. The author we just took a look at, Robert Langenfeld?

A. Thank you.

Q. You hadn't seen this before coming to court?

A. I don't have note of it. I may have seen it, but I don't have note of it. This was to do with the hospitalization.

Q. Doctor, you're the one who read the records and came here to testify, under oath, telling us how Mr. Thelen is doing. Do you remember the note or not?

A. I'm asking you to give me the context.

Q. I am not on the stand to testify.

THE COURT: That's not a question. Next question, please.

MR. ESFANDIARI: Thank you.

BY MR. ESFANDIARI:

Q. Drawing your attention to -- I'm sure you've seen this record, Plaintiff's Exhibit 30. My eyes are not that good. I think it's 36 or 30. 36. Thank you.

All right, Doctor. This is a record from August 2nd, 2017. Do you see that?

A. I do.

Q. And this is Dr. Hannappel's report, and the jury has had the benefit of Dr. Hannappel's videotaped deposition. You've seen this record. Correct, Doctor?

A. Yes, I have.

Q. Do you recall what Dr. Hannappel diagnosed Mr. Thelen with?

A. I believe he said neurocognitive disorder.

Q. That, he did.

A. Unspecified.

Q. That, he did.

A. Dr. Hannappel later --

Q. There's no question.

A. -- reversed that. Right?

Q. There's no question pending.

You think Dr. Hannappel reversed it?

THE COURT: Time out. Time out. Guys, it's not a conversation. You don't get to ask him questions, and he's not supposed to be, you know, just talking to you.

THE WITNESS: Yes.

THE COURT: It's question and answer. Go ahead.

BY MR. ESFANDIARI:

Q. And just for the record, on Dr. Hannappel's diagnostic impression, neurocognitive disorder primarily related to another medical condition. Do you see that?

A. I do.

Q. Let's move on. So that was August of 2017. Let's advance to August 30th of 2017. Did you review the records of a Megan Basnett?

A. If that was part of the hospitalization, I probably did see it, yes. I'm sorry. August 30th or June 30th?

Q. This is August.

A. August 30th.

Q. 2017?

A. Give me one second.

Q. Are you familiar with it, Doctor?

A. I don't see that report, no.

Q. Okay. Let's take a look at this report together. I'll read it.

"Jeffrey reported concerns with his memory. He stated he does not remember his siblings or his ex-wife and stated, quote, all of my memories are gone. Jeffrey noted that short-term memory is also poor. He stated, if I don't concentrate on something, I will forget it. He noted that he has noticed memory loss since ECT treatments, with his last treatment in 2016. Collateral information from his psychiatrist indicated he displays memory impairment, difficulty learning new information, difficulty recalling previously learned information, and executive function impairment."

Did I read that correctly, Doctor?

A. Yes.

Q. But prior to this moment, you never saw this record before?

A. Don't recall seeing this record, no.

Q. Let's move forward. Drawing your attention to a record from October 16th, 2017. Do you see that, Doctor?

A. Yes.

Q. And this is by a nurse practitioner, Mary Kuehler. Do you

see that?

A. Yes.

Q. And she's seen him in this visit and indicates, Mr. Thelen -- "Jeffrey Thelen is a 37-year-old male seen today for an initial visit, evaluation, and medication management of bipolar depression, severe with psychosis, neurocognitive disorder, generalized anxiety disorder, alcohol dependence in remission."

Did I read that correctly, Doctor?

A. Yes.

Q. Let's go see what Mr. Thelen reported to Nurse Practitioner Kuehler.

See the highlighted language, Doctor?

A. Yes.

Q. Read it together. By the way, did you see this record previously?

A. What date is this again?

Q. This one is from October 16th, 2017.

A. I don't have a record of that particular note. I have many notes from Nurse Kuehler.

Q. Okay. Let's look at this one.

"With regards to cognitive function memory loss, Jeff reports that memory and cognition continue to be a problem. Reviewed results of neuropsychiatric testing and updated diagnosis accordingly. He reports that short-term memory is

the same. He continues to forget things and gets lost easily. Long-term memory, he reports historically that he remembers only things that have occurred in about the last one and a half years. He believes this to be related to ECT that he had in the past. In the past, Jeff lived in a group home in Wayne until it closed. Plan is to initiate" -- I'll let you pronounce that word -- "Memantine"?

A. Memantine, yes.

Q. "Initiate methylfolate" -- I'll give you a chance on that one.

A. Methylfolate.

Q. "Methylfolate related to reduce the ability to metabolize folate and folic acid to L-methylfolate."

Did I read that correctly?

A. You did. And I have seen this note.

Q. You have seen this note. Okay. What is that drug name that I butchered, Memantine?

A. Memantine.

Q. What is that?

A. A drug used for Alzheimer's disease.

Q. A drug used for Alzheimer's. So Ms. -- Nurse Practitioner Kuehler is planning to prescribe a medication for Alzheimer's disease to Mr. Thelen?

A. Yes. Yes.

Q. Does that drug go by the brand name of Namenda?

A. It does.

Q. Drawing your attention to the PDR for Namenda, which is confirming your testimony that Namenda initiated for the treatment of dementia and Alzheimer's. True?

A. It says dementia of the Alzheimer's, not and.

Q. Okay. That's correct. You're absolutely right. Dementia of the Alzheimer's type. Correct?

A. Correct.

Q. Now, was a -- was Jeff able to immediately initiate Namenda?

A. He was not.

Q. Why not?

A. I don't think it was approved by the insurance company, because it wasn't an approved indication.

Q. You don't know that for sure. Right? You just know it wasn't -- do you have insurance records?

A. I don't have the records. Somewhere I saw it wasn't approved for the indication.

Q. It wasn't approved by the insurance. And insurance companies, many times, because they care about their bottom line, will not approve certain medications. True?

MS. COLE: Objection.

THE COURT: Yeah. Rephrase the question, please.

BY MR. ESFANDIARI:

Q. Well, the reason that insurance companies refuse to

approve medications or pay for medications is costs are taken into account sometimes?

MS. COLE: Objection. Form, lack of foundation.

THE COURT: Overruled.

THE WITNESS: I'm sure costs are taken into consideration, yes. That's not the only reason that they would choose to approve or disapprove a medication.

BY MR. ESFANDIARI:

Q. Right. But did you speak with the insurance company to find out why they decided not to approve this product?

A. Of course not. That was years ago.

Q. Okay. Thank you. So you're simply speculating as to the reason why the product was not approved by the insurance company. True?

A. Correct.

Q. Let's move on to a month later. This is a November 1st 2017 visit with Nurse Practitioner Kuehler again. Do you see that?

A. I do.

Q. And I think this is the note you're referring to, that he started on Namenda, and he was subsequently started on Aricept, as insurance won't cover Namenda. True?

A. True.

Q. What is Aricept, Doctor?

A. It's another drug for Alzheimer's disease. Works in a

different way.

Q. And this is the product insert for Aricept. It's indicated for the treatment of dementia of the Alzheimer's type. Correct?

A. Correct.

Q. So you were right on that. Now, after the visit with Dr. Hannappel and after getting prescribed the Alzheimer's medication or dementia medication by Nurse Practitioner Kuehler, did Mr. Thelen ever have what's called an EEG?

A. After the visit in November with Nurse Kuehler?

Q. Yes. So do you recall -- let me ask you this. In 2018, do you recall Mr. Thelen having an EEG?

A. With whom?

Q. Receiving an EEG. I don't know who the provider --

A. I would have to look at my notes to check.

Q. All right. Let me help you out here. Do you see this date, June 28th, 2018?

A. Yes.

Q. Okay. And this is a Dr. Duffy performing an EEG. True?

A. Yes.

Q. Okay. And an EEG result, did you review this?

A. I did, yes.

Q. All right. Since you reviewed it, I'll have you read the highlighted language, please.

A. "Abnormal study based on a comprehensive" --

THE REPORTER: I'm sorry, could you slow down.

THE WITNESS: Yeah. Sorry.

"Abnormal study, based on a comprehensive digital analysis of this task-specific EEG, there is electrophysiologic evidence of dysfunction in neuronal processing circuits responsible for attention networks. There is evidence of significant changes in the following neuronal processing centers, attention, working memory. There is evidence of mild changes in the following neuronal processing centers, sensory."

BY MR. ESFANDIARI:

Q. Now, at some point after this, Mr. Thelen also was initiated on TMS treatment to help attempt his treated depression. True?

MS. COLE: Objection. Form.

THE COURT: Overruled.

BY MR. ESFANDIARI:

Q. True?

A. Would you repeat the question, please.

Q. Sure, sure, sure.

After this visit of June 28th, 2018, Mr. Thelen eventually started TMS treatment. True?

A. Yes. I believe the date of the first treatment was July 23rd.

Q. And TMS is basically another attempt at therapy to treat depression. Correct?

A. Correct.

Q. Drawing your attention to a record from July 23rd, 2018. So this is about a month after the June record that we looked at. Right?

A. Okay.

Q. And we see that TMS session 1 of 36. So on that date, he started his TMS. True?

A. Correct.

Q. Okay. So prior to starting TMS, the EEG that was performed showed an abnormal study with the deficits and the attention and working memory that you read to us. Correct?

A. According to this report, yes. This is an atypical type of --

Q. You answered the question, Doctor. Thank you.

A. Okay.

THE COURT: Time out. Time out. He can finish his answer. Go ahead.

THE WITNESS: I was just going to say this is not a standard routine EEG. This is a computerized EEG that is a bit idiosyncratic and not considered mainstream.

BY MR. ESFANDIARI:

Q. Okay. But, apparently, that's what his providers, who were actually seeing him on a regular basis, decided to do. True?

A. That's what Dr. Duffy decided to do. That's what he does.

Q. Okay. And what you do is come to court, not having reviewed all the records, and make a diagnosis of my client?

MS. COLE: Objection.

THE COURT: Sustained. Argumentative question.

BY MR. ESFANDIARI:

Q. Now, you mentioned -- I think one of the last things you testified to with Ms. Cole was your opinion that somehow the litigation is the cause of Mr. Thelen's memory deficits and that's the reason he's complaining. Is that your testimony? Did I understand you correctly?

A. It was a contributor.

Q. It was a contributing factor. When was this lawsuit filed?

THE COURT: Let's save some time. Isn't it true the lawsuit was filed on?

BY MR. ESFANDIARI:

Q. Isn't it true that the lawsuit was filed in July of 2020?

A. I accept that as true.

Q. Okay. The records we reviewed preceded, predated that. Correct?

A. Correct.

Q. By many years. We were looking at records from 2016, 2017, 2018.

A. Correct.

Q. Correct?

A. Correct.

Q. And your testimony still is today that it's the lawsuit that is contributing to Mr. Thelen's memory problems?

A. Yes.

Q. A lawsuit that hadn't occurred until three years later?

A. Well, he was surely planning for it.

Q. Oh, you think he was planning for a lawsuit in 2017?

A. He was planning sometime before it was filed. Wouldn't you agree?

Q. In 2017, you think he was planning for a lawsuit?

A. I don't know.

Q. You don't know. But why do you say it then? Why do you take the oath -- you swore under oath to tell the truth, and you just told us that in 2017 Mr. Thelen was planning a lawsuit?

A. I didn't just say that.

Q. You didn't just say that?

A. That's incorrect.

Q. That's incorrect. So in your opinion, was Mr. Thelen in 2017 planning to file a lawsuit?

A. That's not what I said, and that's --

Q. I'm asking you the question.

A. That is not my opinion. At some point prior to the actual filing, he was planning to do the filing.

Q. Right? Was it --

A. That's my testimony.

Q. Was it in 2017, though?

A. I don't know.

Q. Was it in 2018?

A. I don't know.

Q. Was it in 2019?

A. How long does it take to file a lawsuit? I don't know.

Q. You don't know.

All right. And then Mr. Thelen also treated with Dr. -- and is currently treating with Dr. Hannappel. True?

A. I don't know if he's still with Dr. Hannappel.

Q. You don't know if he's still with Dr. Hannappel. If I tell you that Mr. Thelen took the same chair you're sitting in and told us every Tuesday he goes and visits Dr. Hannappel, you think he's lying?

A. No. I'm just saying I have no information on that matter one way or the other.

Q. But you're aware that he did regularly, according to the records you reviewed, was treating with Dr. Hannappel?

A. Correct.

Q. And I'll represent to you that he also continues to treat with Dr. Hannappel.

A. Okay.

Q. And that's a good thing. Correct?

A. Therapy is good. Yes.

Q. Let's take a look at -- this is a progress note from Dr. Hannappel from June 22nd, 2020. Have you seen this document?

A. Perhaps. Give me a second.

Q. We can just read the record, Doctor, in the interest of time.

A. Yes, I've seen it. Correct.

Q. Okay. And he writes, "His parents have told him he had a lot of friends. He noted that he tried to reconnect with friends on Facebook after" -- I assume it should be "he lost his memory. His experience trying to contact people in the way that was quite disappointing to him, which felt like significant rejection. He lost his memory in 2015 because of ECT."

MS. COLE: Objection, Your Honor.

BY MR. ESFANDIARI:

Q. He noted that --

THE COURT: Time out. There's an objection.

Counsel approach, please.

[redacted]

[redacted]

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury in at 1:36 p.m.)

THE COURT: Have a seat, everybody. I think we're ready to move forward again.

What's the next question?

BY MR. ESFANDIARI:

Q. All right. Doctor, so we're looking at some records, drawing your attention to the next record from Dr. Hannappel, progress note. This is from March 29th, 2021, a year later. Do you see that?

A. I do, yes. Thank you.

Q. And he writes, this is what Mr. Thelen is relaying to Dr. Hannappel. "He does not trust doctors because he was told that he would be better after ECT, but it cost him 35 years of his life. He was also told TMS would be helpful, but he did not benefit at all from that. He discussed how his short-term memory within the day and between the days is not good.

"He was told by someone with dementia that should not talk to therapists or doctors about his limitations as then his driving privileges will be removed. He uses technology devices to help with recall, mostly on the phone. He uses the calendar on his phone. He also uses reminders and the Alexa app to assist in his schedules, lists, et cetera.

"He discussed how he has done some pretty embarrassing things because of his cognitive change. For example, he went to the veterinarian in his underwear. July -- January 11th, 2021, he had problems finding his parents' home. He became so

confused that he just went home. He could not recall his parents' home address or how to get there. His parents have lived there since he was about six years old.

"He is worried about losing his thinking abilities and that other people will think that he is crazy. He noted there are many things that happen like this, but he will not tell me some of the things because he worries that he will be sent to the hospital. He noted that such things are also embarrassing."

Did I read that correctly, Doctor?

A. Yes.

Q. So we went through a number of medical records, starting from 2016 until 2020, wherein Mr. Thelen is telling a number of providers that he's having cognitive issues. True?

A. True.

Q. So your testimony previously that you did not see any reference to that in the medical records, you still adopting that testimony?

A. Well, my testimony is that there's no five-alarm fire. I acknowledge that Mr. Thelen continues to complain of memory difficulties. But his behavior and every other reference in the medical record doesn't react as if he had a complete wipeout of his memory. So during this time frame that you just read, he's seen physicians, he's had surgery, he's driving his car. These actions aren't -- giving consent to the surgery,

following postoperative care plan. These behaviors aren't consistent with a complete wipeout of your autobiographical memory.

Q. We looked at records where he says he couldn't remember where his parents lived, and he walks out of the house in his underwear, that he's lost friends, that he is isolated in light of not being able to recall anybody, and that he is seeking help, and you're telling me that that is not clearly articulated by Mr. Thelen to his providers. Is that what you're telling me?

A. No, no. What I said was --

Q. You --

THE COURT: No.

THE REPORTER: Wait a minute.

THE COURT: Time out. You asked him a long question. He may have more than a yes or no answer. Go ahead.

THE WITNESS: Thank you. Yes. What I'm saying is that I accept that he is complaining of such. But that complaint is not consistent with the entirety of his medical record and with the actions that he's currently engaged in. He may be losing friends in part because he's having fights with them and drinking.

BY MR. ESFANDIARI:

Q. Doctor --

A. Which is also --

Q. -- Doctor, Doctor, he was prescribed dementia medication or Alzheimer's medication, whatever term you want to use. Right? He was prescribed that. True?

A. He was prescribed, yes.

Q. And he took some of that. True?

A. I don't know if he took anything. He never got the Namenda, because he wasn't approved.

Q. He got the other one, though, Aricept.

A. I don't know.

Q. You don't know?

A. I don't know.

Q. You don't know. Would it surprise you to learn that he did take it?

A. He wasn't on it for very long if he took it.

Q. How do you know that?

A. Well, because it doesn't show up as a recurring medication in his records.

Q. How long did he take it?

A. I don't know.

Q. Why did he stop taking it?

A. I don't know.

Q. You don't know. And you think -- do doctors go around prescribing dementia and Alzheimer's medication to people who don't need them?

MS. COLE: Objection.

THE COURT: Overruled.

THE WITNESS: I don't have any way of answering that question. How would I know that? I don't do such.

BY MR. ESFANDIARI:

Q. You don't do such. Okay. But you think people in Nebraska do that?

A. Do what?

Q. Prescribe medication that is unnecessary to people?

A. I have no way of knowing that.

Q. Having reviewed all the medical records, you told me that it's your opinion that Dr. Sharma and the providers that provided ECT complied with the standard of care. True?

A. Correct.

Q. Okay. And in your report, you did not identify any shortcomings -- strike that. I'll take that back. Do you feel that any of the providers, whose records we just looked at, breached the standard of care?

A. Breached the standard of care?

Q. Yes.

A. No.

Q. Does ECT cause brain damage?

A. No.

Q. Does ECT cause neurocognitive decline?

A. It causes temporary cognitive decline, yes.

Q. Long-term?

A. Define long-term.

Q. Need help with what long-term means?

MS. COLE: Objection, Your Honor.

THE WITNESS: I find that pejorative.

THE COURT: Time out.

MS. COLE: I'll rephrase, Your Honor.

THE COURT: Thank you.

BY MR. ESFANDIARI:

Q. Does ECT cause persistent memory decline?

A. It can persist for days to weeks to months, depending on the type of memory that you're referring to.

Q. Does it cause a loss of autobiographical information?

A. Say again.

Q. Does ECT cause a loss of autobiographical information?

A. Information or memory?

Q. Yeah. Autobiographical memory.

A. Yes.

Q. It does?

A. It causes a complaint of a loss of autobiographical memory, yes. That's how we define it.

Q. Okay.

A. Measuring it is a different issue.

Q. Is it your testimony -- for how long does that autobiographical loss typically last for?

A. Well, complaints are from days -- first of all, many

patients complained of no such --

Q. I wanted the number, Doctor.

A. There is no number.

Q. There's no number. Okay. You agree with me that there are journal articles that talk about ECT causing brain damage. Correct?

A. Yes.

Q. And you agree with me that there have been autopsies performed on patients that found that ECT had caused brain damage or cell death. Correct?

A. I do not agree with that.

Q. You don't agree with that?

A. No.

Q. Let me ask you, when was the last time an autopsy had been performed on a person who had received ECT?

A. How would I know the answer to that?

Q. I thought you've been studying ECT for 40 years, that you've written books, we saw a couple of your books, that you authored the APA Task Force book. And your testimony, you came here and told us that ECT doesn't cause brain damage or neurocognitive decline is permanent. And you're telling me that you don't remember the last time somebody did an autopsy of a patient who had ECT?

A. First of all, I find your tone insulting, number one.

And, number two, how could I possibly know --

THE COURT: Stop. Stop. Stop.

Members of the jury, please retire to the jury room. Thank you.

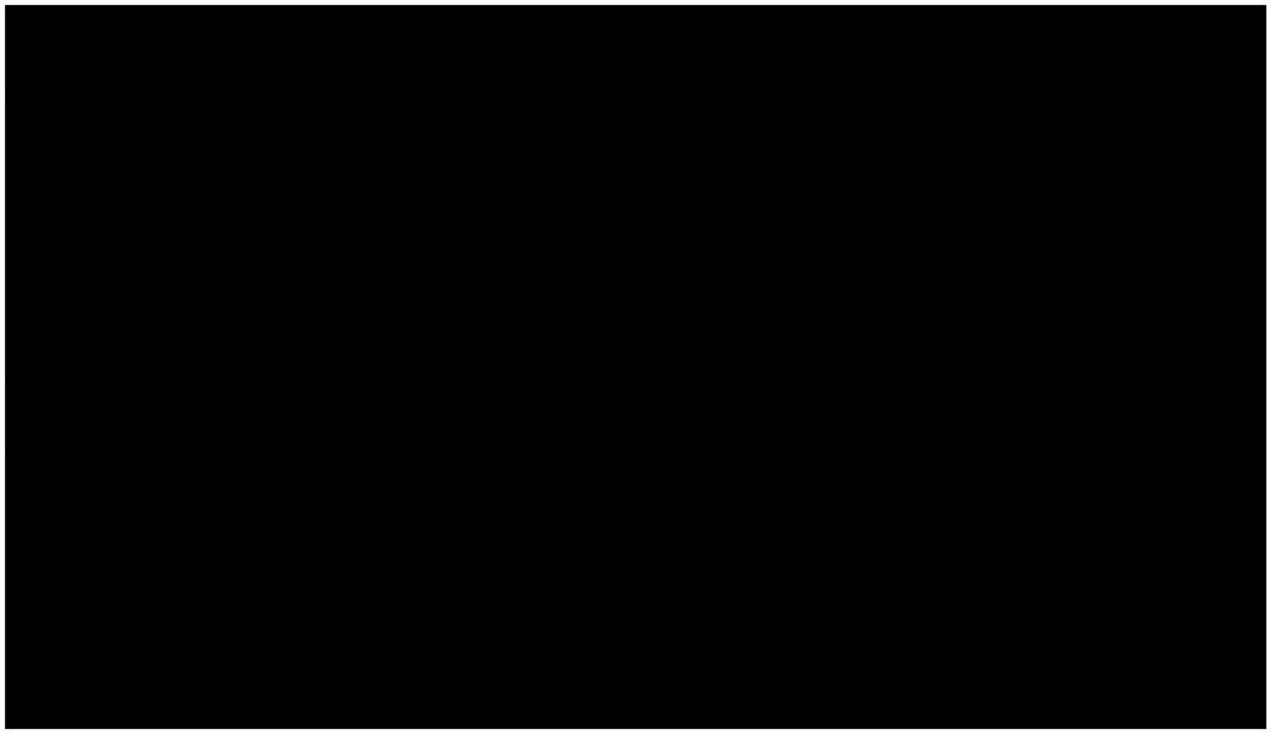
THE COURT SECURITY OFFICER: All rise for the jury.

(Jury out at 1:45 p.m.)

THE COURT: This is not a conversation between you and him. Your opinion of his questions being pejorative or insulting is not relevant evidence in a case.

THE WITNESS: Yes, sir.

THE COURT: All right. You've already done two things. You've said something about the FDA, which was against what your lawyer said to do, and you did another thing, which escapes me now. All right? I'm trying to get you out of here to make your plane. I'm not sure that's going to happen if this continues.



[redacted]

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury in at 1:52 p.m.)

THE COURT: Have a seat, everyone.

Please proceed.

MR. ESFANDIARI: Thank you, Your Honor.

BY MR. ESFANDIARI:

Q. Dr. Coffey, we were talking about autopsies. To your knowledge -- you referenced in your direct examination a paper about an autopsy of an 83-year-old man who had undergone ECT. What was the date of that publication?

A. Don't recall.

Q. I'm sorry?

A. I do not recall.

Q. Did -- have you yourself ever performed any autopsy?

A. Yes.

Q. How many?

A. Oh, a handful.

Q. What's a handful, Doctor?

A. Less than a dozen.

Q. Less than a dozen?

A. Yeah.

Q. So you agree with me that Dr. Omalu, who testified he's done more than 10,000 autopsies, has done more autopsies than you have?

A. Yes.

Q. And do you consider yourself as an expert on the issue of brain injury?

A. In general?

Q. Yes.

A. Not necessarily, no.

Q. The Anderson paper that you discussed with Ms. Cole, did they do any neuronal count of the region of the brain?

A. I don't recall. I'd have to have the paper in front of me to answer that.

Q. Did they do any immunohistochemical stains?

A. I don't recall.

Q. Did they do any bilio fibrillary acidic protein stains?

A. Don't recall.

Q. Did they do any silver stains?

A. Don't recall.

Q. Do you know what those things are?

A. Yes.

Q. Was there a finding of neurofibrillary tangles in the hippocampus in the Anderson study?

A. I don't recall.

Q. When was -- you had some discussion with Ms. Cole about -- I don't know if you use the term modern ECT or modified ECT, but you recall that discussion?

A. No.

Q. No. Okay. You said they used to do ECT in the past without anesthesia and muscle relaxants. Do you recall that?

A. Correct. Yes.

Q. When did they begin to introduce anesthesia and muscle relaxants in ECT procedures in the United States?

A. Well, it varied across the country, but '70s, '80s.

Q. Are you aware they were introducing them in the '50s as well?

A. I said it varied across the country. But if you're looking at when did the general practice change nationwide, in the US, which I thought was what you were asking, I would say '70s, '80s.

Q. When was the first time they began using muscle relaxants and anesthesia in administering ECT in the United States?

A. '60s, experimentally, I think.

Q. Any time before that?

A. Could be. I don't recall.

Q. And do you have any objection to psychiatrists doing bilateral ECT?

A. No.

Q. Do you yourself do bilateral ECT?

A. Of course.

Q. And you agree with me that Somatics actually advertises its machine as being one of the more effective treatments for machines for use doing bilateral ECT. Do you agree with me on that?

MS. COLE: Objection. Beyond the scope.

THE COURT: Overruled.

THE WITNESS: Would you repeat the question again, please?

BY MR. ESFANDIARI:

Q. Sure, sure. Do you agree with me that Somatics informs doctors and practitioners that its machine is capable of performing bilateral ECT?

A. Sure. Yeah.

MS. COLE: Your Honor, may we come sidebar?

THE COURT: Sure.

(Bench conference begins.)

MS. COLE: I believe that counsel is going to show an

advertisement, undated, that this witness has not seen and has no knowledge of.

MR. ESFANDIARI: Sorry to interrupt you, Sue. I was not planning on showing you. Jason told me what the --

THE COURT: Here we go again. Trying to predict what everybody is going to do.

MS. COLE: He had it on the podium, and he took it out.

MR. ESFANDIARI: Answer questions based upon it.

THE COURT: So you're not going to do it.

MR. ESFANDIARI: I'm not going to show, no, no, no.

(Bench conference concluded.)

BY MR. ESFANDIARI:

Q. All right. Doctor, so we're talking about bilateral ECT. It's perfectly acceptable for doctors and psychiatrists to perform bilateral ECT. True?

A. True.

Q. It's perfectly acceptable to perform the ECT at a hundred percent setting for the machine, the Thymatron machine. True?

A. True.

Q. And you saw that Dr. Thelen -- Mr. Thelen's practitioners started the ECT at a lower percentage and then gradually escalated it to a hundred percent.

A. Correct.

Q. Correct?

A. Correct.

Q. And you don't fault them for that. True?

A. No.

Q. And they were doing that in compliance with the instructions provided by Somatics and the APA Task Force. True?

A. I don't know why exactly they were doing it. I think they were doing it in part because of ensuring adequacy of the seizure.

Q. But in terms of it complying with the standard of care, it complied with what is in the manual as well as what is in the textbook you authored?

A. It adheres to that. There's no compliance about that matter.

Q. Now, you agree with me that in the APA Task Force book, the blue book we've been seeing, it specifically informs doctors or suggests to doctors they should not warn about brain damage to patients. True?

A. I don't think that's correct. You just said that we should not warn about brain damage?

Q. Yeah.

A. I don't think that we would word something that way. Could be mistaken.

Q. Had it open to the page, and I was looking at other pages.

Doctor, does this look like the text of the APA Task Force book?

A. I can't tell, but it could be.

Q. Could be?

A. Yes.

Q. Do you have any reason to dispute this being from the --

A. No, I think it's great that it's there. I just didn't recall that it's there.

Q. Okay. You agree with me, specifically says that brain damage should not be included as potential risk of treatment?

A. Yes.

MR. ESFANDIARI: Doctor, you might make your flight.

THE WITNESS: That would be great.

THE COURT: Redirect.

REDIRECT EXAMINATION

BY MS. COLE:

Q. Doctor, I want to ask you a few things about what you and Mr. Esfandiari discussed. When you were talking about a five-alarm fire and alerting somebody right away to a complete loss of memories or wipeout, were you talking about 2015 when he first felt that way?

A. Yes.

Q. How is that different from the records two, three, and four years later that Mr. Esfandiari showed you where Mr. Thelen, after the fact, told other people about what his

perception was?

A. I had trouble following that one.

Q. Okay. Let me simplify it. Because I -- I'll try and get it right. When you were talking about a five-alarm fire being not documented in the records, what period of time were you talking about?

A. Well, it was never really documented as such. The event was purported to have happened in June of 2015. So you would expect certainly that some concern would be -- would have been raised in a major way at that time. If that concern persisted, you would expect that eventually it would also be raised. But it wasn't.

Q. Now, in 2015, Mr. Thelen was telling other people that he had lost some long-term memories. Right?

A. Yes.

Q. And in 2015, he was telling his treating doctors that he had lost some memories in 2015. Right?

MR. ESFANDIARI: Objection. Leading, Your Honor.

THE COURT: I'll allow it for now. Go ahead.

BY MS. COLE:

Q. Did those doctors do any testing of Mr. Thelen to find out if what he was perceiving and telling them was supported by medical evidence?

A. Yes. Well, the clinical and bedside testing didn't show any concerns that were anywhere close to that level of

impairment. So that's why there was no five-alarm fire.

Q. So there are records showing that Dr. Sharma, Dr. Alaskaf did bedside testing to see if Mr. Thelen's long-term or remote memory was intact.

A. Yes.

Q. And what did they find?

A. They found it was normally, generally intact. In addition, there were scales that were used that also showed that it was functioning, as would be expected during the course of the ECT.

Q. We've got a bit of a conundrum there, that Mr. Thelen is perceiving that his long-term memory is gone, but the doctors tested and didn't find evidence, medical evidence that that was the case. Is that what you're saying?

A. Yes.

Q. So when you said that it was puzzling when you looked at Dr. Herman's records, were you talking about the fact that it was being vocalized by Mr. Thelen, that he felt that he had lost all of his memories, but that Dr. Herman didn't do any follow-up testing?

MR. ESFANDIARI: Objection, Your Honor. Leading and vague and ambiguous.

THE COURT: Yeah. I'm allowing a little leading now to save some time. I think that's appropriate and fine. Overruled. But don't lead on every question. Go ahead.

THE WITNESS: Yes. That's essentially correct. There's some other comments I'd like to make about the Herman.

BY MS. COLE:

Q. Sure.

A. Would you remind me of the date of that again, please?

Q. That was 9/27 of '18.

A. Right. During the Herman hospitalization, the examination confirmed that the memory was intact. So I realized that there were notations about cognitive impairment. But my sense is, that that's more history and less actual deficit. Again, on exam, the memory was recorded as being perfectly intact. And the follow-up, there was nothing done beyond going back to his usual care.

Q. When you say history, what are you talking about? Is that history that the patient is giving Dr. Herman?

A. Correct, yes. Yes. So the complaints.

Q. On the issue of you're not seeing certain medical records, I apologize, that's probably the fault of my office not transmitting those records to you. And for that, I apologize to you. But you were talking about the Dr. Duffy EEG being atypical.

A. Yes.

Q. Can you tell us what you mean?

A. Yeah. There's several companies out there that are marketing these EEG devices and claiming -- making lots of wild

claims about how they can diagnose ADD or this or that or the other, claims that have not been substantiated. And so you certainly -- and the recommendations are not to base any treatment on those kinds of findings or reports.

Q. This EEG that counsel showed you, that showed it was -- before the first treatment of -- I think it was TMS that was being given.

A. Yes.

Q. What is TMS?

A. Transcranial magnetic stimulation. So it uses magnetism applied to the scalp as opposed to electricity, which is used with ECT.

Q. So the EEGs that are taken in conjunction with that are atypical?

A. Yes. And there's no one-to-one connection between what you see on the EEG and what you should or shouldn't do with TMS. That's --

Q. I see. Does any of this change your opinions about whether ECT causes structural brain damage to the brain?

A. Does any of what?

Q. Do you believe that EEG -- oh, I'm sorry. Do you believe that ECT causes structural damage to a patient's brain?

A. No.

Q. Do you believe that ECT given with bilateral electrodes causes brain damage to a person?

A. No.

Q. Do you believe that a -- the settings to put on a course of treatment is up to the doctor?

A. Yes. Of course, it's discussed with the patient, and you make a decision together, but yes.

Q. And would you as a doctor look to Somatics, a manufacturer, for how to decide how to treat your patient?

MR. ESFANDIARI: Objection, Your Honor. Beyond -- irrelevant, 403, 402.

THE COURT: I'll sustain it. Keep moving, please.

MS. COLE: Yes, Your Honor.

BY MS. COLE:

Q. What does a doctor consider when she or he is deciding how to put the settings when dealing with a patient?

A. Basically you're trying to weigh two considerations, how much improvement is occurring versus how much in the way of short-term side effects, cognitive side effects are occurring. You're constantly trying to thread that needle. You'd like to use sets that will give you an intense enough seizure to bring about improvement, but not so much that you're going to have unnecessary side effects. You're trying to strike that balance.

Q. And from your view of the records of Dr. Sharma and his partners, did they follow normal standard practice in trying to treat Mr. Jeffrey Thelen?

A. They did, yes.

Q. And did the Task Force book and the other journal articles and the other books that are out -- that were out there at the time when Mr. Thelen received his treatments give a wide variety of adequate information to the treating doctors who have testified, who -- Dr. Sharma testified that they reviewed all of the literature and the books and went to conferences and the like?

MR. ESFANDIARI: Objection, Your Honor. Outside the scope.

THE COURT: I'll allow that one. Overruled.

THE WITNESS: Yes.

MS. COLE: Thank you very much, Doctor. We appreciate your coming out here.

THE COURT: You're welcome.

MR. ESFANDIARI: Your Honor, may I ask one question of the witness?

THE COURT: One question.

MS. COLE: I would object, Your Honor.

THE COURT: You object.

All right. Objection sustained. You can go. Thank you.

Members of the jury, I know you just took a break, but we do need to take another break. So if you leave your tablets on the chairs, I'll let you know when we need you

again.

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury out at 2:11 p.m.)

[redacted]

[redacted]

MR. ESFANDIARI: On the FDA issue, Your Honor, I think we do need to read a curative instruction to the jury.

THE COURT: What do you think it should be?

MR. ESFANDIARI: My suggestion is, and I'm just going back to exactly what Dr. Coffey testified to.

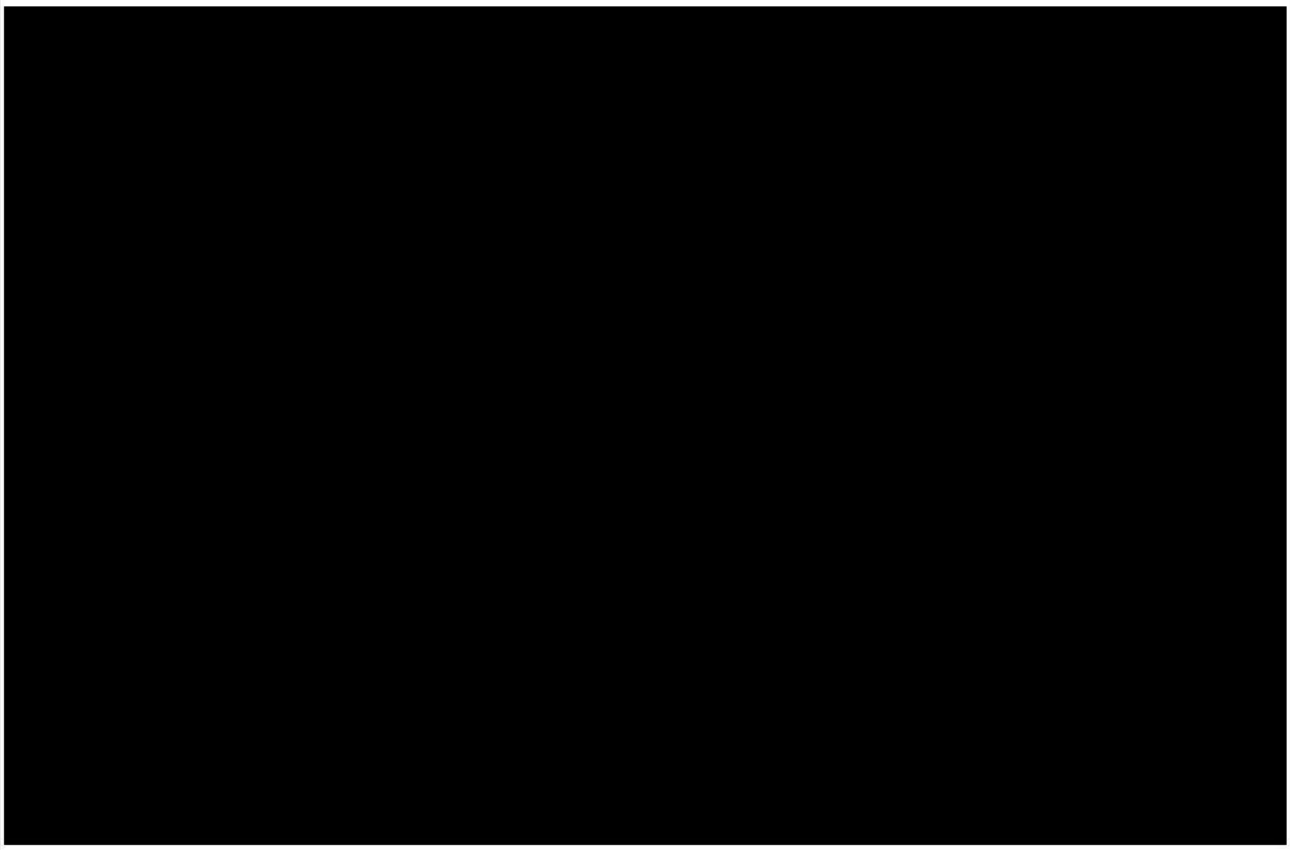
THE COURT: I have exactly what he testified to.

MR. ESFANDIARI: I think the instructions should be the last witness, Dr. Coffey, testified that the FDA has approved ECT. That statement is factually incorrect and should be disregarded by the jury.

MS. COLE: I object to that, Your Honor.

THE COURT: Of course you do. But what else are you going to do?

[redacted]



THE COURT: So put this -- Sue, somebody put this on the Elmo for me. I would be prepared to say something close to this. If you want to wordsmith it, you can, but not too much. On the FDA thing, if not -- I'm not telling the jury that anybody's testimony was inaccurate or anything like that. I would say this. If you don't want me to say that, if you have something close to that, if you have issues with my phraseology, fine, but that's the way I think it needs to be handled.

MR. ESFANDIARI: How about you are instructed?

THE COURT: Or I could put a period after the word case. Has no relevance in this case, if you want. Again, doesn't matter.

MR. ESFANDIARI: And should be disregarded.

THE COURT: Okay. I can live with that. And should be disregarded. Fine.

MR. ESFANDIARI: Yeah. I like that, Your Honor. That's fine.

THE COURT: All right.

You guys care?

Jason gives it the thumbs up. I need that back.

MR. ESFANDIARI: You are instructed that -- Sue, can you leave it up?

MS. COLE: The judge told me to take it down.

MR. ESFANDIARI: I'm sorry. You are instructed that information related to the FDA has no relevance in this case and should be disregarded.

THE COURT: Yeah.

MR. ESFANDIARI: Perfect. Thank you, Your Honor.

MS. COLE: You want -- we need to know that it was during the last witness's testimony.

THE COURT: I thought about that. But I think -- I think we need to say that, otherwise they're going to start wondering, was it mentioned other places and we weren't listening, and I think we need to isolate it this way. Most of this stuff is not going to change the outcome.

MR. ESFANDIARI: Your Honor, just to make the record, can I state what I propose the instruction to be?

THE COURT: Absolutely. Go ahead.

MR. ESFANDIARI: Thank you, Your Honor. So plaintiff would have proposed that the Court instructed the jury that the last witness, Dr. Coffey, testified that the FDA has approved ECT. That statement is factually incorrect and should be disregarded by the jury.

Thank you, Your Honor.

THE COURT: Okay.

[redacted]

THE COURT SECURITY OFFICER: All rise for the jury.

(Jury in at 3:19 p.m.)

THE COURT: Have a seat, everyone. I apologize for that longer delay. But we've reached the point in the trial, I think you're about to see, that's sort of a major turning point

in the case. So we had to do some things that take a little bit longer than we normally would.

All right. So at this time, plaintiff has some additional material. Yes?

MS. ALARCON: Yes, Your Honor. The National Vital Statistic Reports of 2022, Mortality Table for Non-Hispanic White Males states that the life expectancy of someone of Mr. Thelen's age is 35.7.

THE COURT: All right. So that last statement from an attorney is actually evidence in the case. We didn't write it in the form of a written stipulation, but it counts as evidence in the case. So say it one more time.

MS. ALARCON: The National Vital Statistics Reports of 2022, Mortality Table for Non-Hispanic White Males of Mr. Thelen's age states that the life expectancy is 35.7 years.

THE COURT: All right. And, members of the jury, at some point in the last witness's testimony, a reference was made to the FDA, also known as the Food and Drug Administration. You are instructed that information relating to the FDA has no relevance in this case and should be disregarded. All right?

So now at this time, what says the plaintiff?

MR. ESFANDIARI: Your Honor, the plaintiff rests with the exception of admitting the evidence we're going to do later this afternoon.

PLAINTIFF RESTS

THE COURT: Defense?

MS. NUNN: Your Honor, the defense rests with the exception of any evidence to put in this afternoon.

DEFENDANT RESTS

THE COURT: Members of the jury, both sides have now rested their cases. It is my duty to instruct you on the rules of law that you must use in deciding this case. After these instructions, the lawyers will present their closing arguments. I will then have one brief final instruction, and you will then go to the jury room and begin your deliberations.

I am required to read these instructions to you, word-for-word. You will have a copy for yourself to read when you go back to deliberate. So do not be concerned that this is the only time you'll hear this information. You may wonder, well, then, why do I have to read it, and why do you have to sit and listen, but that's what the law requires. This will probably take me the better part of 15 to 20 minutes to read to you. But please pay careful attention.

In this case, Plaintiff Jeffrey Thelen, claims that the Defendant Somatics, LLC, is liable for injuries he allegedly sustained in connection with electroconvulsive therapy treatments he received from medical professionals using a device manufactured by Somatics known as Thymatron System IV ECT machine or device. More specifically, Thelen claims that

the ECT machine was not accompanied with sufficient warnings, and because of that, he sustained injuries.

Somatics denies that warnings in connection with the ECT machine were insufficient and further denies that Thelen sustained injury as a result of its actions. Somatics further maintains that Thelen's claim is barred by the statute of limitations.

I will now explain the law you must apply to these claims in greater detail. Because the events in this case took place in the state of Nebraska, Nebraska law governs this case.

Failure to warn. Thelen's claims against Somatics is -- excuse me, Thelen's claim against Somatics is for failure to warn. To recover on this claim, Thelen must prove each of the following facts by a preponderance of the evidence:

First, that Somatics placed the ECT device on the market;

Second, that at the time the ECT device left Somatics' possession, it was not accompanied by adequate instructions or warnings to the physician who prescribed ECT treatment to Thelen;

Third, that the absence of adequate instructions or warnings was a proximate cause of damage to Thelen;

Fourth, the nature and extent of that damage.

In the verdict form that I will explain to you in a moment, you will be asked to answer questions about these

factual issues.

For purposes of this case, a product is not accompanied by adequate instructions or warnings if reasonable instructions or warnings regarding foreseeable risks of harm are not provided to prescribing physicians who are in a position to reduce the risks of harm in accordance with the instructions or warnings.

A proximate cause is a cause that produces a result in a natural and continuous sequence and without which the result would not have occurred. A proximate cause need not be the sole cause. It may be a substantial factor or a substantial contributing cause in bringing about the injury or harm.

In order to prove that inadequate instructions or warnings proximately caused Thelen's injury, Thelen must prove that his prescribing physician would have altered his conduct had adequate warnings and instructions been provided. If the prescribing physician had independent knowledge of the risks that adequate warnings or instructions should have communicated, then the manufacturer's conduct is not the proximate cause of the patient's injury.

Statute of limitations defense. If you find that a preponderance of the evidence supports Thelen's claim, you must then consider the defense raised by Somatics of the statute of limitation, which is a time limit for bringing a claim.

Thelen filed this suit on July 24th, 2020. To establish that statute of limitation bars Thelen's claim, Somatics must prove by a preponderance of the evidence that Thelen failed to file suit within four years after he discovered or in the exercise of reasonable diligence should have discovered the existence of the injury or damage. Thelen did not need to know the full nature or extent of the damages in order for discovery to occur.

Damages. If you find that Thelen has failed to prove his claim or that Somatics has proved its statute of limitations defense by a preponderance of the evidence, you won't consider the question of damages. If you find that Thelen has proved his claim by a preponderance of the evidence and that Somatics has not proved its statute of limitations defense, you must decide the issue of his compensatory damages.

I am about to give you a list of the things that you may consider in making this decision. From this list, you must only consider those damages and injuries you decide were proximately caused by inadequate warnings related to Somatics' ECT machine.

One, the nature and extent of the injury, including whether the injury is temporary or permanent;

Two, the reasonable value of the medical, hospital, nursing, and similar care, and supplies reasonably certain to be needed and provided to Thelen in the future;

Three, the wages and salary, and reasonable value of the working time Thelen has lost because of his inability or diminished ability to work;

Four, the reasonable value of the earning capacity Thelen is reasonably certain to lose in the future; and

Five, the physical pain, mental suffering, inconvenience, humiliation, injury to reputation, and loss of society, and companionship Thelen has experienced and is reasonably certain to experience in the future.

Remember, throughout your deliberations, you must not engage in any speculation, guess, or conjecture, and you must not award any damages by way of punishment or through sympathy.

There is evidence before you from life expectancy tables. This evidence may assist you in determining probable life expectancy. This is only an estimate based on average experience. It is not conclusive. You should consider it along with any other evidence bearing on probable life expectancy, such as evidence of health, occupation, habits, and the like.

If you decide that Thelen is entitled to recover damages for any future losses, then you must reduce those damages to their present cash value. You must decide how much money must be given to Thelen today to compensate him fairly for his future losses.

Of course, the fact that I have given you

instructions concerning the issue of Thelen's damages should not be interpreted in any way as an indication that I believe that Thelen should or should not prevail in this case.

Duty to follow the instructions, corporate party involved. Your decision must be based only on the evidence presented here. You must not be influenced in any way by either sympathy for or prejudice against anyone.

You must follow the law as I explain it, even if you do not agree with the law, and you must follow all of my instructions as a whole. You must not single out or disregard any of the instructions on the law.

The fact that a corporation is involved as a party must not affect your decision in any way. A corporation and all persons stand equal before the law and must be dealt with as equals in a court of justice. When a corporation is involved, of course, it may act only through people as its employees, and, in general, a corporation is responsible under the laws for the acts and statements of its employees that are made within the scope of their duties as employees of the company.

Consideration of direct and circumstantial evidence, arguments of counsel and comments by the Court. As I said before, you must consider only the evidence that I have admitted in the case. Evidence includes the testimony of witnesses and the exhibits admitted. But anything the lawyers

say is not evidence and isn't binding on you.

You shouldn't assume from anything I've said that I have any opinion about any factual issue in the case. Except for my instructions to you on the law, you should disregard anything I may have said during the trial in arriving at your own decision about the facts. Your own recollection and interpretation of the evidence is what matters.

In considering the evidence, you may use reasoning and common sense to make deductions and reach conclusions. You shouldn't be concerned about whether the evidence is direct or circumstantial.

Direct evidence is the testimony of a person who asserts that he or she has actual knowledge of a fact, such as an eyewitness. Circumstantial evidence is proof of a chain of facts and circumstances that tend to prove or disprove a fact. There's no legal difference in the weight you may give to either direct or circumstantial evidence.

Credibility of witnesses. When I say you must consider all the evidence, I don't mean that you must accept all the evidence as true or accurate. You should decide whether you believe what each witness had to say and how important that testimony was. In making that decision, you may believe or disbelieve any witness, in whole or in part. The number of witnesses testifying concerning a particular point doesn't necessarily matter.

To decide whether you believe any witness, I suggest that you ask yourself a few questions.

One, did the witness impress you as one who was telling the truth?

Two, did the witness have any particular reason not to tell the truth?

Three, did the witness have a personal interest in the outcome of the case?

Four, did the witness seem to have a good memory?

Five, did the witness have the opportunity and ability to accurately observe the things he or she testified about?

Six, did the witness appear to understand the questions clearly and answer them directly?

Seven, did the witness's testimony differ from other testimony of or other evidence?

Impeachment of witness because of inconsistent statements. You should also ask yourself whether there was evidence that a witness testified falsely about an important fact. And ask whether there was evidence that at some other time a witness said or did something or didn't say or do something that was different from the testimony the witness gave during the trial.

But keep in mind, that a simple mistake doesn't mean a witness wasn't telling the truth as he or she remembers it.

People naturally tend to forget some things or remember them inaccurately. So, if a witness misstated something, you must decide whether it was because of an innocent lapse in memory or an intentional deception. The significance of your decision may depend on whether the misstatement is about an important fact or an unimportant detail.

Expert witnesses. When scientific, technical, or other specialized knowledge might be helpful, a person who has special training or experience in that field is allowed to state an opinion about the matter.

But that doesn't mean you must accept the witness's opinion. As with any other witness's testimony, you must decide for yourself whether to rely upon the opinion.

When a witness is being paid for reviewing and testifying concerning the evidence, you may consider the possibility of bias and should view with caution the testimony of such witnesses where court testimony is given with regularity and represents a significant portion of the witness's income.

Burden of proof, responsibility for proof, plaintiff's claim, preponderance of the evidence. In this case, it is the responsibility of the Plaintiff, Jeffrey Thelen, to prove every essential part of his claim by a preponderance of the evidence. This is sometimes called the burden of proof or the burden of persuasion.

A preponderance of the evidence simply means an amount of evidence that is enough to persuade you that Thelen's claim is more likely true than not. The proof fails to establish -- if the proof fails to establish any essential part of a claim or contention by a preponderance of the evidence, you should find against Thelen.

In deciding whether any fact has been proved by a preponderance of the evidence, you may consider the testimony of all the witnesses, regardless of who may have called them, and all of the exhibits received in evidence, regardless of who may have produced them.

If the proof fails to establish any essential part of Thelen's claim by the preponderance of the evidence, you should find for the Defendant Somatics, as to that claim.

Burden of proof, responsibility for proof, affirmative defense, preponderance of the evidence. In this case, Defendant Somatics, asserts the affirmative defense of statute of limitation. Even if Plaintiff, Thelen, proves his claim of failure to warn by a preponderance of the evidence, Somatics can prevail in this case if it proves its affirmative defense of statute of limitations by a preponderance of the evidence.

I caution you that Somatics does not have to disprove Thelen's claim, but if Somatics raises an affirmative defense, the only way it can prevail on that defense is if it proves

that defense by a preponderance of the evidence.

A verdict form has been prepared for your convenience, and I will explain it to you now.

You will take the verdict form with you to the jury room when you deliberate. When you've all agreed on the verdict, the foreperson must fill in the form, sign it, date it, and bring it back when you return to the courtroom. It will be read out loud by the clerk or myself.

The verdict form is two pages. It says at the beginning, do you find from a preponderance of the evidence, one, that Somatics placed the ECT device on the market without adequate instructions or warnings to the physician who prescribed ECT treatment to Thelen? Answer yes or no. And there's a spot to write yes or no.

If your answer is no, this ends your deliberations and your foreperson should sign and date the last page of this verdict form. If your answer is yes, go to the next question.

By the way, there's a total of six questions.

Question two, that the absence of adequate instructions or warnings was a proximate cause of damage to Thelen. Answer yes or no.

If your answer is no, this ends your deliberations, and your foreperson should sign and date the last page of this verdict form. If your answer is yes, go to the next question.

Question three, that Thelen failed to file suit

within four years after he discovered or in the exercise of reasonable diligence should have discovered the existence of the injury or damage. Answer yes or no.

If your answer is yes, this ends your deliberations, and your foreperson should sign and date the last page of this verdict form. If your answer is no, go to the next question regarding damages.

Then it says -- it's broken up with damages, and it says, four, what is the amount of Thelen's damages for future medical care, if any. And there's a line to fill that in.

Five, what is the amount of Thelen's loss of income, if any. There's an amount to fill that in.

Six, what is the amount of Thelen's damages for physical pain, mental suffering, inconvenience, humiliation, injury to reputation, and loss of society and companionship, if any. There's a number for that.

There's a spot for the date and the foreperson's signature, and I ask whoever the foreperson is to print their name, because most signatures are difficult to read, so we'll know who the foreperson is.

So those are the jury instructions. The next step in the trial is for the attorneys to present their closing arguments. I've made the decision at this point to do that tomorrow morning for this reason. The -- it's been a long case. It's involved technical testimony. The attorneys need

some time to explain that to you. And if we did that today, you would be deliberating way past what we need to do. So it's going to go quicker if we put that off until the morning.

There's a famous saying, which I've repeated to the lawyers, if only I had more time, I could write a shorter speech. So they have a lot of time now to work on their closing arguments, which I expect will be better and more helpful to you presented in the morning with some time to reflect than doing it now and then trying to keep you here late at night.

We're going to report back tomorrow at 8:30. At 8:30, you'll hear from the attorneys on their closing arguments, and you will certainly be deliberating on the case before lunch. I don't know how long you'll want to deliberate. That's up to you. Once I turn it over to you, I almost lose control of the scheduling because you're kind of driving the train at that point in terms of your deliberations.

All right. So just plan on that for tomorrow. Leave your tablets here. Do not discuss the case amongst each other or anyone else, as I've said all along. And the -- we are here at the end of the tunnel, but the train is stopping right before it's exiting the tunnel. That will happen tomorrow. And I thank you for your time today and look forward to the conclusion of this case tomorrow morning at 8:30. Thank you.

THE COURT SECURITY OFFICER: All rise for the jury.

CERTIFICATE OF REPORTER

STATE OF FLORIDA

COUNTY OF HILLSBOROUGH

I, Rebekah M. Lockwood, RDR, CRR, do hereby certify that I was authorized to and did stenographically report the foregoing proceedings; and that the foregoing pages constitute a true and complete computer-aided transcription of my original stenographic notes to the best of my knowledge, skill, and ability.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand at Tampa, Hillsborough County, Florida, this 15th day of June 2023.

REBEKAH M. LOCKWOOD, RDR, CRR
Official Court Reporter
United States District Court
Middle District of Florida