BEFORE THE JUDICIAL COUNCIL
OF THE UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

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IN RE COMPLAINT NO. 23-90015

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DEPOSITION OF AARON G. FILLER

DATE: Friday, June 20, 2025
TIME: 9:34 a.m.
LOCATION: New Civil Liberties Alliance
4250 North Fairfax Drive, Suite 300
Arlington, VA 22203
REPORTED BY: Sydney Browning
JOB NO.: 7411738

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A P P E A R A N C E S (Cont'd)

ALSO PRESENT:

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Helen Boone, NCLA Summer Associate

I N D E X

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D O C U M E N T S R E Q U E S T E D

P R O C E E D I N G S

THE REPORTER: Good morning. My name is Sydney Browning; I am the reporter assigned by Veritext to take the record of this proceeding. We are now on the record at 9:34 a.m.

This is the deposition of Aaron G. Filler taken in the matter of In Re Complaint No. 23-90015 on June 20, 2025, at 4250 North Fairfax Drive, Suite 300, Arlington, Virginia 22203.

I am a notary authorized to take acknowledgments and administer oaths in the state of Virginia.

Additionally, absent an objection on the record before the witness is sworn, all parties and the witness understand and agree that any certified transcript produced from the recording of this proceeding:

- is intended for all uses permitted under applicable procedural and evidentiary rules and laws in the same manner as a deposition recorded by stenographic means; and

- shall constitute written stipulation of such.

At this time will everybody in attendance please identify yourself for the record, beginning with our witness.

MR. FILLER: Aaron G. Filler.

MR. MORRIS: Andrew Morris with New Civil Liberties Alliance.

MR. DOLIN: Gregory Dolin, New Civil Liberties Alliance.

MS. NEVILLE: Maeve Neville, New Civil Liberties Alliance.

MS. BOONE: Helen Boone, New Civil Liberties Alliance.

MR. HARRINGTON: Chase Harrington for The Judicial Council Federal Circuit.

MR. PHILBIN: Patrick Philbin also counsel for The Judicial Council Federal Circuit.

THE REPORTER: Okay. Thank you. Perfect. Hearing no objection, I will now swear in the witness.

Please raise your right hand.

WHEREUPON,

AARON G. FILLER,

called as a witness and having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

THE REPORTER: Okay. Then you are all set to begin.

EXAMINATION

BY MR. PHILBIN:

Q Good morning. Could you please state your full name for the record?

A Aaron G. Filler.

Q Dr. Filler, my name is Pat Philbin. I'm an attorney for The Judicial Council of the Federal Circuit, and I'll be taking your deposition today. Have you been deposed before?

A Yes.

Q About how many times?

A Probably about 500.

Q About 500 times?

A Yes.

Q Okay. That's a lot, but I'm going to run

over some ground rules just to refresh your memory just in case. So I'll be asking you questions, and the court reporter will transcribe the answers. So it's important that you verbally respond to my questions, not with a head nod or an "mm-hmm," but verbally respond. Do you understand that?

A Yes.

Q Your answers will be given under oath, subject to penalty of perjury, the same as if you were testifying in court. Do you understand that?

A Yes.

Q And your testimony may later be used as evidence in this proceeding. Do you understand?

A Yes.

Q Okay. If at any time today you don't understand one of my questions, in whole or in part, please let me know. If you do, I'll rephrase or clarify the question. If you go ahead and answer, I'm going to assume that you understood the question. Is that fair?

A Yes.

Q Okay. There will be times today also where

in the middle of my question you might think you know what I'm asking, but I'd ask you to please wait until I finish my question before you answer, because if there's crosstalk, the court reporter can't get it down. Do you understand that?

A Yes.

Q Okay. Similarly, if any time today I start to ask you a question and you weren't finished with your answer, please let me know, and then I'll stop and let you finish your answer. Okay?

A Yes.

Q From time to time, your attorney may raise an objection. Unless he instructs you not to answer after he objects, you can go ahead and answer the question. Do you understand?

A Yes.

Q Okay. If you need to take a break at any time during the day, we can take a break. If there's a question pending -- like to get the answer to that question first, and then we can take a break whenever you want. Is that okay?

A Yes.

Q Okay. Is there any reason, mental or physical or otherwise, that you would not be able to give truthful and accurate answers to questions today?

A No reason.

Q Okay. All right. Dr. Filler, I'd like to start with your professional background. Where did you go to college and medical school?

A University of Chicago.

Q And what year did you graduate from medical school?

A Graduated from medical school in 1986.

Q Okay. Did you do a postdoctoral residency?

A Yes.

Q And where was that?

A Based at University of Washington in Seattle, about -- but about three and a half years in total were spent in England.

Q Okay. And was that a neurosurgical residency?

A Yes.

Q Okay. Did you do a fellowship?

A I did -- what was it like? Three

fellowships. One is complex peripheral nerve surgery. One is neuroimaging. One is complex spine surgery.

Q Okay. And where do you practice primarily today?

A So I'm primarily in Santa Monica, California, but I also have an office in Houston, Texas, and I was just there for a few days.

Q And do you do surgeries in Texas as well?

A No. The surgeries are all done in Santa Monica.

Q Okay. So is the Houston office to see patients for purposes of scheduling surgeries in California?

A Well, I'm seeing and examining and imaging, so -- oh, and I'm -- and we also do transcranial magnetic stim, which is brain repair, which is non-surgical. It's done by neurosurgeons, so we're doing that both in Texas and in Santa Monica. And I also do MRI-guided procedures, so I'm working inside a person who's awake while I watch on the scanner, and we do that in Dallas and in Santa Monica.

Q Okay. Have you ever been suspended from

membership in a professional organization?

A No.

Q Have you ever been suspended from the practice of medicine?

A No.

Q Ever had your privileges at a hospital suspended or revoked?

A No.

Q Have you ever been under disciplinary investigation by any professional body, like a licensing board?

A No.

Q Have you ever been a plaintiff in a civil action?

A Yes.

Q Okay. What were those circumstances?

A One was a, you know, neighbor dispute about building -- you know, we got approved building permit. The opposite neighbor was architect, and they raised opposition to this, so that was what that was about.

Q Okay. Any other cases?

A There have been some, like, landlord

disputes. Sometimes, under -- under my practice identity, there would be some payment disputes.

Q That went to litigation?

A Well, there -- there would typically be. Sometimes it would be small claims actions. I had a manager that liked to do small claims action many years ago, so we -- that -- we haven't done any of that for more than 20 years.

Q Okay. I think you've been involved in some patent infringement cases. Is that right?

A Yes. We have extensive, extensive patent litigation done, you know, across the country over more than ten years with the defendants being Siemens, GE Philips, Hitachi [ph], Toshiba, Medtronic, and numbers of universities and other specialty centers with regard to this principal patent 5560360.

Q And is that litigation ongoing?

A There's no more patent infringement litigation, 'cause the patent was, you know, filed 1992, 1993 for the file -- formal filing, so that -- that was granted in '96, so expired in 2013, six years past that would be 2019, and you can't assert a new

claim past that point. There's no ongoing dispute about -- based on the claims of the patent.

Q Okay. Have you ever been a defendant in a civil action?

A I would say a couple of real estate actions that were early settled.

Q Real estate actions that were settled. Okay. Have you ever had a lawsuit against the IRS?

A I have, yes.

Q And what were those circumstances?

A Well, it's really part of the patent dispute, so basically the United States government extensively infringed the patent and did not do unusual in that I had no grant support from the United States. So there are litigations around that, some of which so come into, for instance, if the -- if you have a loss from a failure to pay patent infringement fees, is that a loss? Who is it recognized?

Q So you claimed a loss on your taxes?

A There was a loss with regard to nonpayment of the infringement while the litigation was going on, yes.

Q Okay. And was there ever a tax lien on your house?

A I don't -- I think there have been some liens filed, but nothing that's ever been, you know, active, meaning that they weren't very well founded. So once, you know, so I don't know if they're on the books or not, but it didn't really affect us.

Q But my question is just was there a tax lien placed on your house?

A Not necessarily on the house, but -- but there's basically -- there could be a lien for payment, yeah.

Q All right. Let me put it this way. Has a tax lien been placed on your property?

A No -- it's on a sum, so there's a -- there's a lien for a sum, which is a sum in dispute.

Q Okay. Do you understand what a lien is?

A It's a priority request for payment should funds be available.

Q Okay.

A If it were -- if it were active. So they're not enforceable because the only one that's there, you

know, the reason why it's in litigation is the -- the -- they're not -- yeah, they're not actively enforceable. I should add for the patent litigations, it's mostly one of my entities, Neurographics [ph]. I wasn't generally a personal litigant in that.

Q And were any liens placed on Neurographics [ph]?

A No.

MR. PHILBIN: Okay. Could we have this marked as Exhibit 1? And we'll need a copy.

(Exhibit 1 was marked for identification.)

THE REPORTER: Okay.

MR. PHILBIN: Thank you.

BY MR. PHILBIN:

Q Okay. I've handed you what's been marked as Exhibit 1, which is listings of tax liens from public records. And I'd asks you to go to page 4 of this. At the top, it says page 13 of 170. And you see down on the bottom half of the page, it has debtor information, and it has the name Filler, Aaron G. Do you see that?

A It's on page 4?

Q Yeah. At the top right, it says "Page 13 of 170." And it gives an address of 1356 Sunset Avenue, Santa Monica, California.

A Mm-hmm.

Q Is that --

MR. MORRIS: I'm sorry. Take your time and look at it and make sure you --

THE REPORTER: And also if you could remember to answer verbally --

THE WITNESS: Okay.

BY MR. PHILBIN:

Q Do you see the address there, 1356 Sunset Avenue?

A Yes.

Q Is that an address related to one of your properties or professional properties?

A That's my home in Santa Monica.

Q Okay. And then the filing information down below says that a lien for $766,394 was filed?

A Yes.

Q Okay. Does this refresh your memory about

any liens?

A Well, I said that -- so what's happened with that is it was, you know, we assert it was an error. We sued in tax court, and that went up through the Ninth Circuit. And it should have -- it should have been resolved, but the key agreement that resolved it disappeared from the record. The attorney from the IRS admitted under questioning in front of the Ninth Circuit they appeared to have destroyed the record to mislead the judge, and that is under current litigation. The attorney would face criminal charges and imprisonment.

Q Okay.

A So that -- and the only thing that's -- and that's -- that's what's not resolved.

Q Okay. I understand you have an explanation for your litigation with the IRS, but my question is just is this a lien placed on your house? Does this refresh your memory?

A Well, I don't -- I don't think it's -- that's the address. That's our address. I think it's a lien for an amount of money.

Q Okay.

A So there's not like -- so I -- I guess that's a -- a detail is there's amount that they want to collect, and it's in dispute. And they place a lien for the amount of money, meaning in the event of a -- it's not that they're seizing the house, it's that if you were to sell the house and there were money, that they would have a prior right claim of to the funds to that amount.

Q Okay. So we've talked about some of the patent litigation. We've talked about the tax litigation. Have you ever been a defendant in any other sort of civil action?

A As I said, there's different real estate disputes which are minor but have come and gone.

Q Okay. Have you ever been a defendant in a malpractice case?

A I've been a defendant in about 12 or 13 malpractice cases.

Q Okay. And did any of those cases resolve with a payment to the plaintiff?

A No. We won every one of those, but they

were all dismissed.

Q When you say that you "won every one of those," what -- do you mean that it was litigated to a judgment?

A No. So basically, I would say eight of the thirteen were just grossly fraud on the part of the plaintiff, and once their fraud is exposed, they drop the case or the attorney dropped the client. And all the others, again, there was no real basis for the claim and they didn't go very far.

Q Okay.

A We could go through them one by one, but --

Q But your testimony was that in all of the malpractice cases, the plaintiff dismissed the case without receiving any payment either from you or your insurer?

A Absolutely. Nothing was paid him, anything.

Q Okay. I'd like to turn to your involvement in this case, Dr. Filler. You submitted a declaration or an expert report in this matter, both dated September 17, 2024. Is that right?

A Declaration and report, yes.

Q Okay. And you also submitted a reply report in March of 2025. Is that right?

A Yes.

Q Did you review the report and the reply report to prepare for your deposition today?

A Just cursorily, yes.

Q Okay. What else did you do to prepare for the deposition?

A Well, I looked for recent -- recent literature relevant to the use of Perfusion CT and to questions raised about the use of neuropsychology.

Q So were you looking at articles that are not cited in your report?

A Any updates. Yeah, I'm looking for, you know, because there may have been 1,000 publications since that report was written.

MR. PHILBIN: Okay. Well, we may come back to wanting a copy of anything that he looked at that's not in the report.

MR. MORRIS: Sure, we can discuss it.

BY MR. PHILBIN:

Q Did you review any of the other expert

reports that have been submitted in this matter?

A Yes, briefly.

Q Which ones?

A Well, we have one from the neuroradiology side and one from the neuropsychology neurology, and neurology. So those three.

Q Okay. Other than looking at some articles, did you review any other documents?

A No, just articles, searches. Nothing else was really reviewed.

Q Did you speak to anyone other than the counsel here to prepare for your deposition?

A No.

Q Okay. Did you talk to Judge Newman?

A No.

Q Okay. Have you reviewed any of the transcripts of the depositions that have been taken in this case?

A No.

Q Okay. In reviewing either your own reports or other reports, did you make any annotations or notes in preparing for the deposition?

A No. I did prepare a short PowerPoint to summarize the updated literature review.

Q You created a PowerPoint to summarize the recent articles that you looked at?

A Yes.

Q Okay. And when did you create that?

A This morning.

Q And about how long did it take you to create that?

A Well, I'd say the review of literature was three or four hours, and then the report was about an hour.

Q Okay. I've had marked -- handed you what's been marked as Exhibit 2. Is that the declaration that you submitted in this case?

(Exhibit 2 was marked for identification.)

A Yes.

Q Did anyone assist you in preparing that declaration?

A I think it was probably reviewed by Mr. Dolin. Usually I prepare all these things myself,

but I think he had a look through this one.

MR. PHILBIN: Okay. Can I have that marked?

(Exhibit 3 was marked for identification.)

BY MR. PHILBIN:

Q Okay. I've handed you what's been marked as Exhibit 3. Is that the initial report that you submitted in this matter?

A Yes. It appears to be the original report.

Q And did anyone assist you in preparing that report?

A No.

Q Did you make any notes when you were preparing that report?

A Everything written. There may have been some progressive versions of it, but I just progressed those versions, so I don't think there's any additional -- there's no other notes.

Q You don't have a separate document that was, like, an initial outline or something like that?

A No. I just kind of get my thoughts

together, and then I just produce stuff like that.

Q Okay. And then we're just going to get these all in the record now. Okay, I've handed you what's been marked as Exhibit 4. Is that the reply report you submitted in this case?

(Exhibit 4 was marked for identification.)

A Yes.

Q And a similar question: Did anyone assist you in preparing that reply?

A No.

Q Did you make any notes or other documents on the side when you were preparing that reply?

A No.

Q Okay. So, Dr. Filler, now I'd like to ask you some questions about your current practice, your current work. You have a clinical practice in which you are seeing and treating patients as a neurosurgeon. Is that correct?

A Yes.

Q Okay. And what sort of operations or treatments does that involve?

A So I mentioned earlier MRI-guided procedures, so I have a patient in an MRI scanner. I've identified a pathology based on MR neurography, one of my inventions, that allows us to see nerves inside the human body and to see locations -- identify locations that are entrapped or irritated.

And generally our first round of interventional treatment, generally successful, will be to go in with these titanium or MRI-guided needles, doing serial MRI scans where I advance the needle up to the point of entrapment and introduce a scar-dissolving agent around the nerve to accomplish a nerve release percutaneously.

In patients where that's not sufficient, I will do a surgery, a minimal access surgery, and all of these surgeries were my own design, so I really reinvented this whole field. I'm the editor of one of the major textbooks in neurosurgery, and I write the textbook chapters, and my surgical methods are now generally the ones widely used by my colleagues --

Q And I'm sorry. Is that what you're describing, would that be called "peripheral

neurosurgery"? Is that surgery on peripheral nerves?

A Those are peripheral nerve surgeries. I still do some spine surgery, so I was a fellowship-trained complex spine surgeon. So for many years I did large complex, I would say revision surgeries, so someone who had multiple level fusion with pedicle screws and all of that, but it all fell apart and the implants spit out and the screws broke from some other surgeon.

And most of the docs just like to do fresh cases, but I would go in and take all that apart, put everything back together again, that kind of thing. Those are 18-hour surgeries. And I haven't done any of those for, I'd say, six or eight years. And then -- but I do do some complex spine that other surgeons aren't familiar with, such as releasing an autonomic ganglion from the sacrococcygeal joint.

It's another surgery I've described and discovered the utility for. And then additionally, I mentioned earlier our practice in transcranial magnetic stimulation, which is a process of brain repair. By example, we had a client who was a CNN

correspondent who'd been attacked and had her head pounded on the ground and developed slurring and stuttering of words. So she lost her career and we were able to repair this -- locate the brain injury by my advanced imaging methods and then repair and restore her speech via transcranial magnetic stimulation. So we used to do this type of work to locate the problems with an open brain.

We can now map and locate with TMS, transcranial magnetic stimulation, and now we can also do repair of a variety of injury problems. And so I have a fairly active practice in that as well.

Q And about what percentage of your practice focuses on that latter category of things you said that involve the brain as opposed to the peripheral nerve surgery?

A Right now it's about 80 percent brain-focused practice.

Q Okay. And we've noticed from websites, Doctor, there are several legal entities that seem to be associated with your practice. The Institute for Nerve Medicine is one. Is that right?

A Yes.

Q Okay. And the Neurography Institute, is that another?

A Yes.

Q And the Neurological Injury Specialist, is that a third?

A Yes.

Q And could you describe just briefly what each of those entities does?

A So the Institute for Nerve Medicine is a d/b/a for Aaron G. Filler, MD, PhD, APC. So it's a personal, professional corporation in California, which is my neurosurgical practice. The Neurography Institute Medical Associates is what we call a electronically distributed subspecialty neuroimaging practice.

So we will have maintained and operated on a lease basis imaging centers around the United States, and in some cases overseas. We had a practice in the UK some -- for many years, maintained licensure in the United Kingdom as well. So we had a image facility in London for many years.

And in these, basically, we're leasing time on a scanner. For many years, that corporation was under a neuroradiologist named Grant Heishima, who passed during the pandemic. And we still have some activities under that. The Neurological Injury Specialist is just a newer designation that pulls the entities together.

Q It's like an umbrella entity for those?

A It's -- yeah. Well, it's a newer -- it's a newer -- it's just a new entity that we set up with a different name that -- that includes all those activities and some of the new activities, like the transcranial magnetic stimulation repair. So it's just a -- it has just different parties involved in it.

Q Okay. And you're also the managing partner of Tensor Law PC. Is that right?

A Yes.

Q And what work do you do there? Is that for your work as an expert witness?

A So anything that we feel should be billed under a legal entity. So this is something like

the -- in different states, the Bar. So, for instance, they have concerns about companies that have both accountants and attorneys in them, that if attorney work is done, it should be billed by an attorney entity rather than having an accountant -- so to be absolutely careful about this, we -- I maintain the Tensor Law PC. And when we feel -- we feel something is attorney skill-based, we'll collect through the law corporation.

Q But that would not be all of your work as an expert witness?

A Most of it, yeah. Most of it we end up billing through that entity, just to be cautious about the California bar rules.

Q Okay. And is it correct that your work, your clinical work, where you're treating and seeing patients, that's sort of one set of patients, and is that distinct from your work where you're serving as an expert witness, that that's different people who have come to you for your expert witness capacity? Is that accurate?

A No.

Q Okay. Why not?

A I would say the vast, vast majority of my patients that are -- where I'm testifying, and are -- they're all coming in through the -- the medical practice. So in Texas, it's a little different from in California. So in Texas, they rarely have an expert, even on the plaintiff's side, also see the patient.

So they like to separate medical relationships from testimony relationships, which is more typical in defense where they will have only a legal relationship. It's extremely rare for me to serve as an expert in a case where I have not seen -- examined -- seen and examined the patient. I do not consider the patient as my patient, the person as my patient.

That is the kind of expert work where you just send some documents to review and you generate a report and testify. So every now and then, once every year or two, something like that comes up, which I do. The vast majority of it, I'm seeing and treating patients, and generally, I don't know in advance, but

I may, depending on the details of the case, I may be designated as an expert at some point later in time.

And I rarely prepare -- though I do them from some frequency, I very rarely prepare, like, a freestanding expert report. So generally, I just prepare a very detailed clinical report. So for instance, my brain DTI imaging reports tend to be 40 pages. That's a routine diagnostic image. But if there's a admissibility challenge to the DTI, for instance, then I will write a -- a report defending the admissibility of DTI, for instance.

Q Okay. So in most cases where you end up being an expert, you are providing clinical care and treatment to the patient as well. Is that what you're saying?

A Yeah, 98 percent.

Q Okay. About how many hours a week do you spend on your medical work?

A The practice is all pretty much a single process, and it runs into, you know, 18 to 20 hours per day, 7 days a week.

Q Eighteen to twenty, seven days a week on a

sustained basis?

A Yes.

Q Okay. I had some questions to drill down a little bit more and make sure I understand about the sort of patients you see. So I'd like to distinguish a couple categories. One would be patients who have suffered some sort of brain injury, which I would refer to as having a traumatic brain injury or TBI. Is that fair for a category?

A Yes.

Q Okay. Do you see patients who have had stroke? Is that something that is part of your practice?

A Occasional, so that's rare.

Q Okay. So let's put TBI and stroke to one side. And I'm curious, in your regular practice, do you see patients who come to you because they want to find out, they want to determine whether they have a cognitive impairment related to aging?

A We do some of that, yes. So it's -- it's a small but growing area of practice for us.

Q Okay. What sort of percentage would you

say?

A I would say at present it's 2 or 3 percent, but we expect it to be 10 to 20 percent over the -- so we're -- we're in the active. We have a process of -- of growing that.

Q So you're in the process of growing a practice to attract patients, to diagnose them as to whether or not they have an age-related cognitive impairment?

A No, I think we're just trying to respond to requests to do these image evaluations. So one thing that I do, which is a little unique, is to see and examine patients in detail and image and read the images. So, you know, I think -- so we just have -- yeah, so that's -- it's -- it's been something we've always done. It's just there's a little more of that going on.

Q Okay. And when you see people in that category who are coming to you to find out if they have an age-related cognitive impairment, what is the workup that you do?

A Well, I -- I developed, with -- particularly

with regard to head injury, my own assessment system for symptoms, that is the way you break down or understand human thought and brain function. So, you know, there's been understandings of way the brain works and how we think that go back in written form to Socrates; right? and beyond.

But now, through my imaging and my work, and many others working in these fields, we can understand the brain from the point of view of actual circuits that have become known through neuroscience over the past 200 years, that we can now visualize. So you have to -- so we -- so the idea is to be able to break down function and look at the different underlying biology.

So I used to get referrals from head injury neurologists that would describe a patient as having a "concussion," whereas to me that's 250 different possible symptoms, each of which has a particular location in the brain. So -- and that method of analysis has proved to be fruitful, both to understand people's symptoms and to plan treatments now that we have methods like TMS available to do repair.

Q Okay. So when someone comes to you asking if they have an age-related cognitive impairment, do you do what -- are you familiar -- strike that and let me withdraw that question.

Are you familiar with the term "cognitive screening test"?

A Yes.

Q And are you familiar with, for example, the MOCA or the MMSE, or those tests that are familiar to you?

A Yes.

Q Okay. And those are cognitive screening tests, aren't they?

A They are.

Q Okay. So when someone comes to you wondering if they have an age-related cognitive impairment, do you do anything that would be called, like, a cognitive screening test?

A My own -- of my own design. So I'm an inventor and developer. I --I developed, like, an image method that now has a million publications and is life-saving around the world. I don't -- so I'm

always looking to see how do we advance or improve our technology, not how can I do what's been done for 50 years. So in this realm, there is vast criticism of MOCA or dementia, but no one knows what to do, how to break away from using them, because most doctors aren't in a position to have anything instead to put in place.

But now we have all this advanced imaging and information about patients that I'm deploying and that I'm in that position to develop it, publish about it, put it in our textbooks, put it in our board certification exams, and advance the field of knowledge in the area.

Q Okay. I'd like to distinguish between imaging studies, which I understand you use imaging studies and have placed a lot of reliance on those. But let's put imaging studies to one side and focus on other things that would be in the realm of a cognitive screening test that involves asking questions or asking the patient to do something. Is that a fair distinction? So that we have categories to talk about.

A Yes, imaging versus questions, sure.

Q So when you have someone who comes to you asking about whether they have a cognitive impairment related to aging, putting aside the imaging, do you do -- I take it you don't do a MOCA --

A No, as I already just testified, I designed an image-based set of questions so that I'm looking at a structure called the fornix, and I know when it's impaired in one place, it'll cause a particular type of memory problem. So I'm asking the person, "Do you have this memory problem?"

Because I know if they state they have that, I can look at their image of that spot and see, one, the veracity of the statement, the severity, or whether it's part of a global, because that's one of the big questions, is it a global deterioration of the brain, or is there a -- a specific injury, or is it the normal course of aging?

So these are the type of questions. And my redesign of it, it's not something that we sell or market, it's just the way I do assess people for scientific reporting purposes, and then we have the

advanced imaging to investigate the pattern or what's the underlying nature of the problem. So this is what -- what my sort of duty or mission is.

Q So, Doctor, do you -- you have a set of questions, I take it, that you have created to perform this evaluation of the patient. Is that correct?

A Yes.

Q Okay. And do you ask these questions before looking at the imaging, or do you direct the questions based on the imaging?

A No, I -- we -- I will talk to the patient or obtain those answers to those questions as an initial evaluation.

Q Okay. And do you have a particular form, like, you know that the MOCA has a sheet, a very standard sheet with questions on it; correct?

A Yes.

Q For the one that you've developed, do you have something similar that's like a template or a sheet that you go through?

A Yes.

Q Okay. And has that been introduced into the

record in this case?

A No, because in this case I did question Judge Newman on all -- went through this verbally and then made my assessment of abnormalities. There's not a completed form.

Q Okay. So in your ordinary clinical practice you have this form that you use. Yes?

A Yes.

Q Okay. But we don't have one of those in this case?

A Right.

Q Okay.

A And I always go through the patients, all those questions. We use the form for -- partly to efficiently handle a volume of patients so that we have -- it's faster if someone's already filled out the form to quickly go to their abnormal claim statements or normals as I interview them. So it's a matter of efficiency. But I don't have a written form completed by Dr. Newman, as she did not complete. I mean, Judge Newman, as she did not complete.

Q Everyone's been doing the titles wrong in

every deposition. So I think you just said -- is it a form that usually the patient fills out?

A They first fill it out, right, and then I do an interview through the form and make notes.

Q Okay. And does it have questions, like, I think you mentioned earlier, "Are you having this sort of memory loss?" Is that --

A Right. So it has, like, 23 different types of memory question.

Q Okay. And the patient -- you then self-reports what issues they're having?

A Yes.

Q Okay. And for this form and this approach that you have developed, have any studies been done to establish that it accurately determines whether or not a person has a cognitive impairment?

A Well, it's something that the study has done in the sense that we have, I guess, about 1,200 of those and 1,200 people that have had one or multiple imaging exams and one or -- and multiple follow-ups so that that data's there, but I haven't published it yet.

Q Okay. So I take it that means no, there is no article in a peer-reviewed journal that discusses this. Is that correct?

A That's correct.

Q Okay. If we could look at page 14 of what I think is Exhibit 3, your report, the main report.

MR. MORRIS: Two is -- three is the main report, yeah.

MR. PHILBIN: Three is the main report.

MR. MORRIS: Because 2 is the declaration -- sorry.

MR. PHILBIN: Okay.

THE WITNESS: That threw me off. Which -- which page did you say?

MR. PHILBIN: Page 14. And this is in the paragraph just before the heading for part 4.

MR. DOLIN: In this report --

MR. MORRIS: In the original.

MR. PHILBIN: Fourteen --

BY MR. PHILBIN:

Q Okay. And there's a line -- I think it's the second sentence in that paragraph that says "I

carry out 10 to 12 similar evaluations per week on a wide variety of individuals with wide range of occupations and educational backgrounds." Do you see that?

A Yes.

Q Okay. And I just want to understand what that means. Does that mean ten to twelve evaluations a week on patients who present to you asking whether they have age-related cognitive impairment?

A Just cognitive impairment in general, yeah. So there's different reasons -- people will want to know, is it age-related? Is it injury-related? When I see -- I mean, a classic case is a 70-year-old who was in an accident and the defense wants to claim that it's all age-related losses and I'm trying to determine are they traumatic versus age-related, so this is a common issue.

Q Okay. But so I think you said earlier that the age-related people come to you that are just wanting to know if they've got the cognitive impairment that's age-related, about 2 percent to 3 percent --

A That's correct.

Q So the rest would be people who have had some sort of brain injury or suspected brain injury. Is that right?

A That's correct.

Q Okay.

A And it's also -- I think one thing I would like to add is just that although the -- many of the -- the assemblage of the whole form of my questions is more extensive and unique, it's similar to -- similar in some ways to various other standard questions that are questionnaires that are in use, not necessarily to MOCA or MMSE.

Q But to other neuropsychological tests?

A Or not -- they don't belong to neuropsychology. Neuropsychology is not done by doctors. It's generally done by psychologists or not physicians, so I tend to be looking at physician-based materials.

Q Okay. But we don't have a copy in this case of that form showing the kind of questions you use?

A That's correct.

Q Okay. And then on page 14, it's in that same paragraph. The last sentence in that paragraph says "From this practice, which includes at least 1,500 individuals evaluated by DTI imaging exam combined with a personal medical examination in a large clinical report under preparation, I have acquired a focus special expertise, which I'm relying on to address the question of Judge Newman's neurologic and cognitive capabilities." Do you see that?

A Yes.

Q Okay. So is that the 1,500 patients in a clinical report, is that what you were referring to a minute ago, that you have something under preparation that's not been published?

A Yes.

Q But those 1,500 patients include -- the vast majority of them are patients with some sort of brain injury rather than just wondering about age-related cognitive impairment. Is that correct?

A I would say the majority, yes.

Q Because only 2 to 3 percent of your practice

is the people who have just age-related cognitive impairment.

A That's correct.

Q Okay. And in your reply report, I'm just curious, at page 3, paragraph 4, I think there in paragraph 4, it says -- sorry -- page 3, paragraph 3, page 3, paragraph 3 "Currently I'm completing data analysis on a 3-year study of 1,200 brain injury patients."

A Right. And then the 1,500 versus 1,200 is because I think I spent the first -- some years, developing a fixed set of questions and methodology of analysis, and then that -- then use that over about 1,200 patients. So the overall process is about 1,500 patients on this project, but the number that would be in that paper is about 1,200.

Q Okay. And this is 1,200 brain injury patients. So is it -- really, it's almost entirely brain injury patients that are the subject of that?

A I think that the -- the publication would distinguish or publications would distinguish a brain injury assessment versus the use of the data in

general cognitive impairment. So there would be a separate publication about the purely cognitive papers -- patients, but it's a smaller number.

Q So there would be a separate publication about patients that do just have questions about whether they've got an age-related cognitive impairment?

A Yes.

Q Okay. But that's also just in preparation that this is published?

A Yes.

Q Okay. If we go back to the main report, to page 9, under the heading Structure of the Report, there are three numbered paragraphs there. Do you see that?

A Yes.

Q Okay. In the first paragraph, the second sentence says that you are a neurosurgeon with subspecialty in this field and that you're fully qualified to conduct and have conducted thousands of such examinations. When you say "subspecialty in this field," what does that mean?

A So within neurosurgery, in a sense, we don't have any subspecialties. That is, you get certified for the whole thing. Nonetheless, you may have a -- a particular area of interest. So, for instance, some neurosurgeons only do aneurysm surgery. Some only do tumor surgery. So I have a subspecialty interest in the use of imaging to diagnose and TMS to repair cognitive functions.

So that means that I have a higher level of knowledge in it. I develop the technology and inform colleagues about it. So I, for instance, will have papers at meetings of radiologists or neurosurgeons where I explain the findings and how it will -- should affect their practices.

Q Okay. But is this subspecialty recognized by any board or organization that certifies physicians?

A No. I mean, for instance, there's no subspecialty for neuroradiology. They only have radiology, but they call themselves neuroradiologists. So in neurosurgery, we're very loathe to define subspecialties because we expect all neurosurgeons to

be capable of doing all aspects of neurosurgery, even though someone may hold themselves out as a subspecialist is -- is okay to indicate they have particular expertise, but it's not like there's a separate board or something like that.

Q Okay. I'm just curious. You had a fellowship in peripheral neurosurgery. Is that right?

A Peripheral nerve neurosurgery was one of my fellowships. And then I did one on neuroimaging, one in complex spine. And I would say that because of the -- my role in developing this -- the leading form of brain imaging now, which was a plan, you know, that I worked on for 20 years and now have employed for 30 years, that I'm always in a position to lead in that, plus I'm fortunate to be recognized to teach and educate in my -- in neurosurgery generally.

Q Okay. When you have a patient who comes to ask you if they've got a cognitive impairment related to age, you have your form and your set of questions that you do; correct?

A Yes.

Q And then you also then use brain imaging.

Is that correct?

A Well, you skipped the part where I spend two hours meeting with them and discussing their symptoms and then do a neurologic examination, and then we also have imaging, yes.

Q Okay. And are those all of the parts of what you do, or is there something else that we haven't covered?

A Well, we talked about -- we didn't talk too much about brain repair, the TMS, which is important.

Q Sure, but that goes to treatment. I'm just wondering about the diagnosis in the first instance.

A Yeah, I mean, it's -- yeah, the forms, physical exam, so as you take that together. So, for instance, if somebody claims severe balance problems but my test doesn't reveal it, that's important information for me. If someone claims there's nothing wrong with them but they seem to have numerous problems, that's also informative.

Q Okay. So when you're diagnosing someone, what role does the imaging play? If, say, someone's questionnaire in their interview with you seems fine,

but you see something on the image.

A Well, you're -- we're interested in identifying symptoms. So if -- if they're complaining of abnormalities but the images are normal, this could -- like in a litigation, this could be someone who's overstating their injuries, and that's helpful to know.

On the flip side, I'm thinking -- thinking of this particular 70-year-old gentleman recently who had had a pretty severe head injury, and he would say, "Well, my wife claims my memory's bad, but I don't think so," and then you'd see an injury in the part of the brain that was consistent with the accident and would cause a memory formation problem. So I'm always trying to decide, "Okay, now" -- but if someone doesn't have a symptom, you know, we don't go around treating images if there's no symptom.

Now, up to a point, so let's say someone claims there's nothing wrong with them, but it looks like they have a leg deformity. They have a lot of pain if I touch it, and they can't walk. And my image shows a broken femur. I mean, sure, that's it --

well, this is a psychiatric issue, but I'm going to recommend treatment of his broken femur.

Q Okay. What --

A Yeah. So -- but -- but generally, if someone says their leg is fine and the imaging shows, let's say, some torn ligaments, I would take from that that, "Wow, maybe those ligaments aren't as important as we thought."

Q Okay. And what if the form and the interview suggest there's a problem, there are deficits, but you don't see anything on the imaging?

A Well, that's -- that means it's sort of a tick against them on a validity test. So basically the way the -- the neuropsychologists try to do validity tests by asking complex, trick, or repetitive questions, my validity is to see do they have the impairment that goes with a specific complaint that they claim.

And then we might see, well, they have 30 complaints. And ten of which they really have the matching injury for. And I can actually generally tell, looking at these forms, "Okay. That's going to

be over-claiming because of the way I structure the form." And some questions like, do you experience total blindness?

And they've -- in this list, then just checked off yes on everything, and I can see they're obviously not blind. So these are, on the one hand, they're my own -- own validity test questions, and it helps if it does seem like a good, valid statement. We'll say -- you might say, "Well, this image finding is highly correlated with patient response, and this question seems to be only very lightly correlated with physical findings.

So maybe that physical image finding is not as important as we thought, or the brain has a workaround for this imageable injury."

Q So does that mean that there are circumstances in which you might see something on a brain image, but you would decide that actually the person seems to be functioning fine?

A Yeah, you would report, you'd say, you know, there is a fracture in the crus of the fornix. However, the patient states normal -- you know, normal

memory formation. You just would -- would note that.

Q Okay.

A And so then later, if you were reporting it, you might say that a fracture in the crus of the fornix appears to be related to a complaint of new memory formation in approximately 70 percent of individuals, as opposed to some severed optic nerve results in a complaint of one eye being blind in 100 percent of patients -- this kind of thing.

Q Right. In your practice, do you ever conduct fitness for duty evaluations for people?

A Not formally in that -- on that basis. There's a -- I generally would -- am not asked to do that.

Q Okay. And I think we discussed earlier you've been an expert witness in many cases. If we go to page 4 of your report, actually let me make that a question. You have been an expert witness in many cases, haven't you?

A Yes.

Q And if we look at page 4 of your report, the paragraph at the top, right about the middle of the

paragraph, there's a sentence that starts towards the right-hand margin that says "I have been admitted as an expert in more than 100 cases in various state and federal courts, and my testimony has never been excluded." Do you see that?

A Yes.

Q Is that accurate?

A Yes.

Q Okay.

A There's one case that was a late file that they declared me an expert after a deadline. I was restricted to participant rather than expert testimony because of late filing of a designation, but I don't think there's been a limitation of testimony -- of expert testimony.

MR. PHILBIN: Okay. Could we mark that? Did you --

THE WITNESS: So in this Norwalk case, I wasn't --

MR. MORRIS: Wait for a question.

THE WITNESS: Okay.

//

BY MR. PHILBIN:

Q So, Dr. Filler, I've handed you what's been marked as Exhibit 5. Sorry. 5? Yeah. Okay. And this is an opinion that came out in the Klein vs. Norwalk Hospital case. Do you see that?

(Exhibit 5 was marked for identification.)

A Yes.

Q Okay. And it has some highlighting in it just so that we can easily get to particular spots. Could you read the highlighting that's on the first page there?

A Yeah. It says that the plaintiff was -- had engaged me as an expert. However, I don't have any record of being engaged. That it was basically -- it was a patient that we had imaged. They never contacted me about the case. I never knew there was a challenge. I was never designated. I was never paid. So that's an inaccurate statement.

Q Okay. So you're saying that you were not engaged as an expert in this case?

A That's correct.

Q Do you remember the case?

A I looked it up when I heard about it once, and I thought, "Well, I imaged this person, but I never was contacted to testify about it." If they had asked me, they wouldn't have got themselves -- you know, I would have written a report or something for them. But no, I mean, I was never engaged in this. There's no report.

Other than I did a, you know, a one-page image report. The patient -- the guy had had a needle stuck into a nerve in his arm and was sent for imaging. He was imaged in Connecticut, I think, and did a report saying he had a nerve injury. But I was not aware they had designated me as an expert. They never contacted me. They never paid. I was not aware of the litigation. I only knew that I had done an image reading.

Q Okay. But just so the record's complete, if you could look at page 2, and there's highlighting there that says "The defendant argued that the MR Neurography is not a scientifically valid tool for admission as testing and diagnosing a traumatic nerve

injury because the testing procedure itself is not generally accepted in the medical community and has not been approved as reliable." Is that right?

A It's a false statement. I mean, the radiologist --

Q Doctor, my question is, is that what this says?

MR. MORRIS: [Unintelligible response.]

THE WITNESS: That's what it says, yeah.

BY MR. PHILBIN:

Q Okay. And then if we go to page 6 at the bottom, the highlighted portion there says, "Therefore, the court finds that the plaintiff has failed to demonstrate an adequate peer review study that supports the admission of the scientific evidence of the MR Neurography performed at the Neurography Institute by Dr. Filler or his associates."

A And this --

Q Is that correct?

MR. MORRIS: Wait for the question.

//

BY MR. PHILBIN:

Q Is that what it says? Do you see that?

A That's what it says, but it's completely false.

Q Okay. Is there any other case in which your testimony or a report has been excluded?

A Not that I'm aware of other than, as I said, there's a case where that was late designated and it was limited to not -- you know, to percipient rather than expert testimony on the basis of late designation.

Q Okay.

A San Diego case.

MR. PHILBIN: Could we have that marked?

(Exhibit 6 was marked for identification.)

BY MR. PHILBIN:

Q Okay. I've handed you what's been marked as Exhibit 6, which is an opinion in the case of Orlando vs. Nelson. Do you see that?

A Yes.

Q Okay. And again, the highlighted language in the right-hand column, it says "Appellant opposed respondents' motion and provided the declaration of Dr. Aaron Filler, a neurosurgeon." Do you see that?

A Yes.

Q Okay. And then the next highlighted portion says: "Before the hearing on respondents' motion for summary judgment, the trial court issued a tentative ruling sustaining some of respondents' objections to Dr. Filler's declaration and granting their motion. Both in the tentative ruling and in the subsequent hearing, the court identified what it considered to be major substantive flaws in Dr. Filler's declaration. The court found his opinions too conclusory." Do you see that?

A Yes.

Q Okay. Then on the next page, the opinion says that Appellant then filed a second declaration by Dr. Filler. Do you see that?

A Yes.

Q And on the right-hand column, it says "The trial court stated that Dr. Filler's second

declaration did not address many of the problems the court had identified, and in some respects, it was "almost like he ignored me." Do you see that?

A Yes.

Q Okay. On the next page, which is page 3 down at the bottom, under the heading Analysis, the court says "The trial court did not abuse its discretion in striking portions of Dr. Filler's second declaration." And at the end of the paragraph, it says "Dr. Filler's opinions about each of these alleged injuries were conclusory and not properly supported." Is that correct, that that's what this says?

A Yes.

Q Okay. Does this refresh your memory?

A Yeah, I don't -- I don't really recall this one.

Q Okay.

A I have to look it up and see. But it sounds like they limited some parts of the report. I don't -- I was not aware of being excluded in that case, but I don't remember the details of it.

MR. PHILBIN: Okay.

Did you give them --

UNIDENTIFIED SPEAKER: Yeah.

MR. PHILBIN: Okay.

BY MR. PHILBIN:

Q Okay. I've handed you what's been marked as Exhibit 7, which is a report in the case of Belfiore-Braman vs. Rotenberg. Do you see that?

(Exhibit 7 was marked for identification.)

A Yes.

Q Okay. Do you remember this case?

A That one I do, and I discussed this one earlier.

Q Okay. On the first page there in the right-hand column, the highlighted language says "The issues on appeal center around the trial court's ruling in limine after a hearing under Evidence Code section 402, that excluded certain medical opinion testimony Plaintiff offered on issues of causation and damage, from her recently designated nonretained expert witness, Dr. Aaron G. Filler." Is that right,

that's what it says?

A Yes.

Q Okay. And if we could go to page 8 down in the right-hand corner. The highlighted language there on that page says "Using either formulation of Dr. Filler's opinions, the trial court had a reasonable basis to conclude that his views on causation were too speculative to present to the jury." Isn't that what it says?

A Yes.

Q Okay. Are there any other cases in which your opinions were excluded in whole or in part by the court?

A So this is one where I said it was limited, and the problem was that it was a late designation. And then I was aware of the Norwalk one, but then again, I say it -- as far as I can determine, we did a report, but I never -- never was designated as an expert, so it's difficult for me to understand that. And I don't recall this. It sounds like this Orlando is one where they limited certain parts of the report, but I don't think I was excluded in that case.

Q But you understand that portions of your testimony were excluded?

A Well, apparently, yeah. I mean, I don't think the -- sometimes you don't even hear from the attorneys about it, so they're using some part of it. I don't think it's one that I testified in. I remember doing a report, but sometimes they don't even -- like something like this, it's very possible they -- they didn't let me know about the outcome of it or it didn't affect their -- their case.

Q Okay. All right. Okay. If we go to page 13 of your report, and if you look on page 13, the last sentence on that page, could you read that as a sentence starting with "My most recent" --

A "federal court testimony was Haysbert vs. Bloomin' Brands," Rebecca Beach Smith is the judge. That was just on the date at which I wrote that report.

Q Okay. And then there's a footnote there, footnote 7. Could you read what it says in footnote 7?

A "As in other cases, the Court rejected

defendant's motion to exclude my testimony."

Q Okay. I handed you what's been marked as Exhibit 8, which is an opinion in that Haysbert vs. Bloomin' Brands case. Do you see that?

(Exhibit 8 was marked for identification.)

A Yes.

Q Okay. Now, on the very first page, there's a footnote, footnote 1, and it says "Also pending was Defendants' Motion to Strike Dr. Filler's testimony on the basis of admissibility, and Plaintiff's Motion to Admit Work Orders as Subsequent Remedial Measures over Defendants' objections." Do you see that?

A Yes.

Q Okay. And then it says "Although these matters were briefed, the court did not make any rulings on these issues, and, consequently, these matters are not resolved further herein." Isn't that what it says?

A Yes. I mean, what's happening there is unusual.

MR. MORRIS: Wait for a question.

THE WITNESS: Okay.

BY MR. PHILBIN:

Q So what it says here is that the court did not rule on the merits of the motion to strike your testimony. Isn't that correct?

A Right. They went ahead and testified, yeah.

Q Well, no, Dr. Filler, what the court says is that it doesn't need to make a ruling on those because it's disposing of the case in another way.

A Right, but then they refiled it. So the background is that in that particular one, I had been hired by a doctor named Dr. Huma Haider just to read the report. And normally I give the history exam and the impression, but she liked me just to read the report and she would do the exam and the impression.

She failed to appear for court, and the attorney was severely sanctioned, and she was in trouble, so I appeared, and the -- the allegation was, "Well, I" -- "since I didn't give the whole history and the impression myself, that there wasn't a basis to consider just my findings." But the court decided then to let me go ahead and do the findings, but they

terminated the case because of the failure of Dr. Haider to appear.

That case subsequently was reinstated and then settled before trial, if you follow that case through.

Q Okay.

A So that's really what happened. But -- so I -- from my perspective, in fact, I argued that successfully that a physician is allowed to rely upon the opinions of other experts that are -- other physicians that are treating the patient. So I was allowed, even though my report didn't include the -- my initial evaluation, because it was supposed to be Dr. Haider's, I was allowed to rely on other physicians whose reports were in evidence.

She struck Dr. Haider because she failed to appear, the doctor -- the judge did. So it's a little more complicated, but I would not say this resulted in exclusion of my --

Q Understood, Doctor. I'm not suggesting it resulted in exclusion. But what the court says here is it doesn't need to rule on the motion to strike

your testimony because it's resolving the case on other grounds; correct?

A Right. She allowed me to -- she decided she allowed me to testify, and then ended up deciding to -- I think, was it a mistrial or something, because of the failure of Dr. Haider to appear. But she had not -- she just, I guess, first made an initial decision to let me go ahead and then subsequently decided that she was just going to stop the case.

Q Okay.

A So I did -- I did -- I testified for many hours.

Q Doctor, you're serving as an expert witness in this matter on a pro bono basis. Is that correct?

A Yes.

Q And about how many times do you think you have done that, been an expert on a pro bono basis?

A It's -- it's rare, but I mean, you know, as an attorney you're supposed to do some pro bono work, and this seemed like inappropriate case as far as I knew.

Q So do you view your work in this case as an

attorney?

A Well, the -- some of it is, because I'm testifying as to -- I appeared before her and I'm stating -- so it's not sufficient to say that she is not demented. We want to know, can she practice as a Federal Circuit Court of Appeals judge? That's a very high level, other than just "I'm not demented"; right? So therefore, I knew that I was going to be looking at my testimony and interactions with her in court.

And then remember, I then give her -- I -- I tell her some technologies, have her explain the technologies back to me. I pose what I believe would be a complex patent law question, an admissibility of a particular claim to her, and had her spontaneously, with no clerk and no time to write it up, to then opine as if from the bench on a complex legal question about -- about allowance of a particular type of claim.

And so I believe -- this is -- my analysis usually is, does the test and the -- and potential billing rely in a way on my legal skills? Because if it does, then the California bar says that's the

practice of law. So, and I'm just -- so yeah, I would say it falls under that.

And I -- and I've been saying repeatedly, I'm just trying -- I'm a member of the bar of the court, and I know that -- and not -- I'm trying to just provide information to assure the court can make the best possible decision here. I have great respect for Judge Moore as well as for Judge Newman and -- and Judge Taranto, who I've been before. So --

MR. PHILBIN: Okay. I think we've been going about an hour and a half, and this is a good spot for a break.

MR. MORRIS: All right. Sounds good.

MR. DOLIN: Ten minutes?

MR. PHILBIN: Sure. Ten's good.

THE REPORTER: Okay. It is currently 10:55 a.m., and we're going off the record.

(Off the record.)

THE REPORTER: We are back on the record, and the time is currently 11:10 a.m.

You're good to proceed.

//

BY MR. PHILBIN:

Q Dr. Filler, I'd like to discuss now your involvement in this case. If you look at page 3 of your report, in the middle paragraph there, it says "I volunteered to evaluate her, using modern and objective technology." Do you see that?

A Yes.

Q So how did that come about? How did you volunteer to become involved in the case?

A Well, you know, I see information about this in the Legal News and Law 360, so -- and I think I also get some of the patent organizations that send out newsletters. So I was aware of it, and, you know, I had appeared before Judge Newman a couple of times. So I just thought that I could be helpful, you know?

I thought, "Well, that's interesting, because I'd appeared before her, so obviously a very high-functioning individual, and I feel I have good objective tools to assess her, as well as experience at a high level." So I sent an email. I saw Mr. Dolin being, I think, quoted in something, and identified as counsel to him, so I think I sent an

email to him -- to him saying, "You know, I'm a member of the Bar of the Court, and I've been before this judge, so I could testify from experience about her function by comparison to my prior appearance, plus I could do an assessment. Let me know."

And so, I didn't hear back, I think, for quite a long time, as much as a year, and then he did say that they -- they were interested to take me up on that.

Q Okay. So you reached out first to Mr. Dolin by email?

A That's what I think, yeah.

Q Okay. Do you still have a copy of that email?

A Probably.

Q Okay. I think we'd like a copy.

MR. MORRIS: I'll look and see if we have it.

BY MR. PHILBIN:

Q And then, by what time frame do you think that was?

A So I would -- it was early on in this

process, because this -- yeah, I mean, I remember it being approximately a year from when I sent that to when I ended up filing this report.

Q Okay. So about a year elapsed from that first email to September of 2024?

A Yeah -- yeah, because this whole thing -- yeah, it became public, yeah, May of 2023; right? Or May, yeah.

Q Okay. And then, so you sent the email, a while went by, and then what happened next?

A At some point, I think I got -- it was an email or a phone call. I can't say; I'd have to look back and see, from Mr. Dolin saying that was I still interested to do this, 'cause, you know, they were -- they thought it might be helpful.

Q Okay. And at some point, did you execute a retention or engagement letter?

A Yes, I prepared a retention letter stating that I would, you know, carry out this medical evaluation and be prepared to compare her current function to my personal experience of her as an attorney, and that it would be on a pro bono basis.

Q Okay. And before you were retained, before you did that letter, what were your discussions with Mr. Dolin?

A Very limited. Just, as I said, I had written an email. I think there was definitely a call where I explained a little bit about myself and what I do, and, you know, just said, "If it would be helpful, I'd be interested to do that."

Q And did Mr. Dolin tell you anything about the case? Why he hadn't contacted you for a year?

A Just very vaguely, you know, "This is what's going on, you know." And that he thought -- you know, he told me there had been a couple of evaluations, I think was what he was saying, I think it was at that time point. And that it -- you know, that additional -- it seemed to him that additional evaluation would be helpful.

Q Did he tell you anything else about what he would like you to do? What would be useful for the case?

A No.

Q Did you speak to Judge Newman before you

were retained?

A No.

Q Okay. When did you first speak to Judge Newman in connection with this matter?

A I think it was only just on the morning that I did the evaluation, so I totally -- I communicated with Mr. Dolin; arranged to do the evaluation in the D.C. area. I went through a process, 'cause I would -- I was a licensed physician in Virginia, which is, you know, what you have is it's an adjacent state regulation. You can see a patient in D.C. if you were a Virginia-licensed physician as long as you did not have an office in D.C. But I went through the process of establishing a District of Columbia license, also just to be on the safe side with this medical license.

Q Okay. But so the first time you spoke with Judge Newman was the morning of the evaluation?

A Yes.

Q Which was August 24, 2024?

A Yes.

Q Okay. So in preparing your report, did Judge Newman or her counsel provide you, other than

the medical records, what I'll refer to as the medical records, did Judge Newman or her counsel provide you with any other documents?

A I was able to look through the different affidavits and --

Q Okay. Anything else?

A And the opinions of the other doctors that evaluated her. That's just-- you had the neurology assessment and the neuropsychology assessment.

Q Are you referring to Dr. Rothstein and Dr. Carney?

A The ones on their own that were essentially supportive of her, the two that I had. I think I had all of them. I had both -- I had both -- I had all of them -- everything had been done, yeah.

Q Well, let's distinguish between the time that you prepared the initial report, then later there's the reply report. At the time you did the initial report in August of 2024, you had the reports of Dr. Rothstein and Dr. Carney. Is that correct?

A Yes.

Q Okay. All right. So the first time you

spoke with Judge Newman was the morning of August 24th; correct?

A Yes.

Q Okay. But she had the CT perfusion scan performed at GW on August 22nd. Is that correct?

A Yes.

Q And I think you say in page 8 of your report that the CT scan was obtained at your direction. Is that correct?

A Right. So what happened is that my first original thought had been that we could do a DTI scan. And -- but then we were told that she had this pacemaker and it was an issue. So we said, "Well, maybe, maybe not." So let's get the -- so you have to get the manufacturer and the implantation information.

And then you contact the manufacturer to see if it's MR safe. And if it is, you get the documentation. And then when the patient goes to get their scan, you present the documentation to the scan site as to safety. But it turned out in this case that although historically it was a safe implant for MRI that the company had been purchased, St. Jude was

purchased by a competitor, and the competitor didn't renew the -- the MR approvals.

So therefore there were no usable MR approvals. And it may have been a commercial decision they made to make people get their pacemaker replaced if they wanted an MRI. But the bottom line was we couldn't do the MRI. And we have occasionally used perfusion CT. Like, a good example is a young woman where the airbag had exploded improperly and there was metal in her eye, so we could not get an MRI without risk of ripping up her retina.

So we used -- and -- the -- one of the groups I work with in Texas had actually purchased a system to do perfusion CT scanning for that purpose of either imaging patients that could not have an MR, or we also -- there's a big interest in using perfusion CT early after injury as - a -- it's a quick -- less expensive method to -- because it's -- it is useful for identifying patients likely to have persistent post-concussive syndrome.

So there are a couple of reasons why in our head injury practice it would be of use. And in the

course of deciding to advise on the purchase of that system, I educated myself about other uses.

MR. MORRIS: Just answer his question and then stop.

BY MR. PHILBIN:

Q I'd like to focus just on this case, just on the interactions with Judge Newman and the decisions that you made there. So how did you get the information about her pacemaker and evaluate that if you didn't speak to Judge Newman?

A Yeah, I think that these were mostly communications between my clinical staff and the clerk and one of the clerks in her office.

Q Okay. Do you know which clerk?

A I -- you know, I'd have to look back through those emails to see who they were communicating with.

Q Okay. And then you mentioned that you went through a procedure because you're licensed in Virginia to be able to do things in D.C. How did it work with getting GW to do the scan? Do you just write a prescription for a scan and Judge Newman takes it there and they do it, or how does that work?

A Yes, you don't -- I don't need to be licensed in -- I don't need to be licensed in District of Columbia to order a test there, to be done there, as long as I'm writing the order while I'm in California, for instance. But once you get to examining -- even examining a -- a patient, the rules vary from state to state.

And technically it looked like I would have been okay as an adjacent state physician, but in an abundance of caution I went through the D.C. licensing procedure 'cause they have a reciprocal relationship that accelerates the process.

Q Okay.

A Reciprocal with Virginia.

Q Did you have any other medical records of Judge Newman's before you ordered the CT perfusion?

A No.

Q Okay. And you didn't talk to Judge Newman about getting the CT perfusion scan?

A No. We just -- I think I -- I probably, whether it was verbal, I have to look back and see if I sent an e-mail, but said we provide the information

through the clerk that, in fact, we were not able to get her cleared for an MRI and that we had a recommendation for a -- my recommendation is that we would perform a perfusion CT, that it could be done in D.C., a convenient location, though we had some -- identified two or three options 'cause not every center does them.

And noticing that, so -- yeah, so -- and I -- I provided, again, maybe -- it was the clerk or in the e-mail. I have to look and see the explanation of what -- what it was and that it would help provide objective data, which had, in my opinion, significant recognition in the literature relevant to the question at issue.

Q Okay.

A Which would -- which would be of age-related dementia, present or not, that there was a literature. Had shown that it was being used for this purpose and was considered to be better than useful and -- useful for that purpose and better than older methods in some regards.

Q Okay. So these e-mails with the clerk, the

clerk was providing you with facts and information so that you could decide what to do. Is that correct?

A No, we -- we're just saying I was going to recommend this advanced MRI, but based on our findings, the judge can't have an MRI. We're recommending a perfusion CT, which does have a contrast injection, but if she's agreeable to that, I think it would be helpful. And I think word came back that she said yes, she would -- the judge had decided yes, she would be agreeable to that, particularly if it could be done at GWU, which was convenient to her.

Q Okay. But to make the decision to do the CT perfusion instead of the MRI, you had to get information about the fact that Judge Newman had a pacemaker; correct?

A Right, we -- so we asked that.

Q Just -- so the information about the pacemaker came to you, I believe you said, through e-mail from one of Judge Newman's clerks. Is that correct?

A That's my recollection.

Q Okay. And you didn't have other medical

records?

A That's correct. We just asked for the document that they contact her. If they did not have it, they should contact the cardiologist. It's a routine thing. And my office does this all the time. And because we're imaging patients with MRI, we've been doing that for more than 30 years. And so we have a question, do you have a pacemaker? You have to ask people.

You don't want to just find out by accident later. And so they're trained to ask that question. And if the answer is yes, they ask for the documentation. And then we have -- there are a couple of people in the office who would -- were sophisticated to contact and -- and track down the approval or not from the manufacturer.

Q Okay. Did you know at the time that you ordered the CT perfusion scan that Judge Newman had kidney disease?

A Well, I knew that there would be an issue. You know, I think what usually happens --

MR. MORRIS: The question was, did you

know?

THE WITNESS: Yeah, I -- I'm not sure if I knew about it.

BY MR. PHILBIN:

Q Okay. But the contrast agent used for the CT perfusion can present risk to a patient with kidney disease, can't it?

A Right. You need that full -- you need the full -- that's another question. Once you come to giving contrast, the image center would have to know about that as well. Yeah.

Q Okay. But you didn't know about her kidney disease?

A I'd have to look back and see the sequence. I'm not sure.

Q Okay. So right now, as you are here today, you don't remember whether or not --

MR. MORRIS: That's what he answered, yeah.

MR. PHILBIN: He can testify, Counsel.

MR. MORRIS: Well, he had answered that.

BY MR. PHILBIN:

Q Are you saying that right now, as you sit here today, you can't remember whether or not you knew about the chronic kidney disease?

MR. MORRIS: Objection. Asked and answered.

Go ahead, you can answer again.

THE WITNESS: Yeah, so usually we have a -- we have questionnaire process that -- which addresses contrast agents. So I'd have to look back and see. It should -- the questionnaire should turn that up. But I just -- it's not that my -- not the main question I was speaking of. It's a pre-imaging questionnaire that asks those questions. I'll have to go back and see. I just can't recall. But that would have turned up.

BY MR. PHILBIN:

Q Okay. And in your ordinary clinical practice, when patients come to you, is it your ordinary practice to order some sort of imaging before you've seen the patient?

A Occasionally, yeah, 'cause neurosurgeons do

that all the time. Many of my colleagues refuse to see a patient unless they've already been imaged.

MR. MORRIS: Again, he just asked if that was the practice. That was your practice.

BY MR. PHILBIN:

Q Let's back up and focus on it. Is it your practice, in your clinical practice, to order imaging for a patient without seeing the patient?

A It occurs occasionally for logistical reasons. But it's not my -- it's not my preferred practice, but occasionally we do that.

Q Okay. All right. Dr. Filler, I've handed you what's been marked as Exhibit 9. Do you recognize this?

(Exhibit 9 was marked for identification.)

A Yes.

Q And this is the report from the George Washington University Hospital Radiology Department on the CT perfusion scan, isn't it?

A Yes.

Q Okay. Who signed the report?

A Well, there's a note of signature under Dr. Reza Taheri, and it's also -- say it's dictated by Samuel Beloin and approved by Reza Taheri.

Q Okay. Have you ever spoken to Dr. Taheri?

A Yes.

Q Okay. When?

A When I got this report.

Q And what was the substance of that conversation?

A I said, "Well, this is a pretty simple, limited report. I gather that it has the key information, but you guys don't usually do a more extensive report?"

Q And what was the response?

A He said, "Well, you ordered the CT perfusion, but if you had ordered a CT and a CT perfusion, then I would have given a more extensive report. But because of the way you wrote it, we don't bill, so I don't do a big report."

Q Okay. Any other substance to your conversation?

A And he said, "You know, would you like to

order that?" And I said, "No, that's fine. I usually read these myself anyhow."

Q Okay. But you were concerned enough to ask him first about, "Hey, isn't there more to this report?"

A Well, I just wanted to make sure we had everything that he -- that he said.

Q Okay.

A I thought, this, "Is this it?" And -- because we wanted to get the raw data and analysis, which was also only provided 'cause there's -- there's more. You know, we have the -- the full i-RAPID analysis and you know --

Q Okay. Let's go to page 32 of your report. In your report, page 32. And right in the very top line on page 32, it refers to Dr. Taheri's report. And it says -- it starts at the bottom of the previous page. "This study was interpreted by a staff neuroradiologist, Dr. M. Reza Taheri, MD, PhD, as being completely normal." Do you see that?

A Yes. That's what -- yeah, I asked him, is that what that means? And he said, "Yes, it's normal

as to the test that you ordered, Dr. Filler."

Q Okay. So in the telephone conversation you had with Dr. Taheri, you asked him if this report meant that it was completely normal?

A Well, it says it's normal. I would just ask them, "Is there anything else you're planning to comment on, on this CT?"

Q Okay. Can you just point out to us, point out to me on the report where it says "completely normal"?

A So it says that the diagnostic value of the parameters provided can decrease as a result of artifacts. And the volume of tissue at CBF less than 30 percent is zero. So basically, the -- that -- in the literature, volume of CBS being below -- 30 percent below the contralateral would be an -- would be an abnormality. So it's saying --

Q So if I could just -- so we'll go through in order. If I could just stop you there. What that's saying, what you're reading, where it says "A equals volume of tissue with CBF less than 30 percent relative to contralateral side." CBF refers to

cerebral blood flow. Is that right?

A Yes.

Q And what that's saying is the volume of tissue that had cerebral blood flow less than 30 percent relative to the contralateral side. That means relative to the other half of the brain. Is that right?

A Yes.

Q So it's reporting that there's not a mismatch in the flow between the two sides of the brain. Is that correct?

A That's correct. Let's say if it -- if one side were normal and one side were abnormal, then you would see that difference.

Q But if, for example, both sides had a low blood flow but they were the same, this would report here that there's not a difference relative to the contralateral side; correct?

A Right, yeah. I mean, it could be they were -- had a similar pathology on both sides, and so that that answer on A would only rule out an asymmetry.

Q Okay. And so when you said that this is completely normal, I guess my question is, that's your interpretation of the fact that on these reports of A and B, it was saying there was no difference from one side to the other?

A Well, that's A, but see B is also saying -- it's giving you a -- an absolute value of a T-max greater than six seconds. So this is the transit time, which means there's no abnormality of transit times, no slowing. So basically if you have a typical -- one of the -- many of the typical conditions in dementia will impair blood flow, and the measure you get is an increase of T-max. I think that in this case that would be an absolute abnormality, even though it says relative to contralateral side.

Q So you're saying that even though the report says that it's reporting something as relative to the contralateral side, do you think it's not actually just reporting relative T-max from one side to the other?

A Yeah, I think it's also putting it into a normal -- a generally normal range.

Q And why do you think that, since it says relative to contralateral side?

A I didn't write the format of their report, but that's just what it says.

Q Okay. So you think the report is wrong?

A No, I don't think it's wrong.

Q You think it's not accurate in what it's reporting?

A It may be -- it may be accurate and otherwise significant.

Q Because we do agree, though, that what the report says is that it's reporting volume of tissue with T-max less than six seconds relative to the contralateral side.

A Yeah, so I did ask him. You know, I said -- I said, "Well, I mean, I" -- I said, "I can go back to i-RAPID, and I go through the data, which I did. I can go to the company, but what I'd like to know, Dr. Taheri, is am I correct in reading this as saying that there's normal" -- "you found no flow abnormalities?" And he said "That's what it means." He was very not -- he didn't really want to talk very

much about it, but he was very clear, and I was very clear.

Q Okay. So now --

A And I report --

Q You had a more detailed discussion.

A That one call. It was one call. I would say, I mean, I wasn't irritated. I wasn't -- I thought that there would be more here, that he would be more -- and he just said, "Yeah, it's normal. You can look at the numbers yourself, but it's normal." As if I -- as if there was me asking a question comparable to yours, I was being crazy, you know?

So that was my impression of the call with him. But, I mean, maybe I misunderstood, but -- and then, I -- so I went through, and I looked at the values and the measurements and literature on it, and it did seem to be normal. And I agree that, you know, they use mismatch to -- so because if you were -- I think the reason it's written that way is that if you were looking at stroke, okay, the chances of having two strokes in the exact same place on two sides of the brain is very low at the same time.

So you're going to have one stroke, and therefore, putting it in this language of contralateral, and he basically said that's just how -- he doesn't, like, dictate or type this. It's just, I think, how radiologists like to do it is they just hit a button, and the report gets generated.

Q Okay.

A So --

Q And do you know the way, this report was prepared using i-RAPID CT perfusion software --

A Yes, and I talked to the i-RAPID company. I looked through their software. I examined their outputs. I went through the literature about what they measured and how they measured it, and some of which I cite and describe in the body of my report.

And I reached the conclusion, based on the image findings and the literature and the area assessed in determining these volumes and rates, that indeed this had come out normal. So I -- I was satisfied with it because we have our own software for doing perfusion analysis, although we possibly would have had to reimage her.

So I was trying to decide, is their analysis sufficient to answer the question, or do we need to reimage using my Nordic Neuro Lab perfusion software? And this i-RAPID software is very well accepted, and even for this use. So it was my impression, after talking to Dr. Taheri, reviewing the data, reviewing the literature, speaking with the manufacturer, that this was sufficient to demonstrate normality.

Q Okay. When you say that this i-RAPID software is very well accepted, even for this use, what does that mean, "this use"? What are you referring to?

A Well, you could use i-RAPID to look at perfusion for stroke, or it could be used in a dementia screen.

Q Okay. So just to be more clear, your testimony is that it's very well accepted to use the i-RAPID software on CT perfusion to screen people for dementia?

A Yes, I mean, I looked to see -- I asked them about it, the company -- I mean, I don't think it's -- I'm not sure if they have a label indication, and the

way I like to explain that is, if you're going to release a medication that works for 15 different things, and most of them it's 80 percent effective, and one of them is 95 percent effective, you only put in -- and it's a -- and the 95 percent one is hugely common, you only put in for the one indication, 'cause that'll get it out in the market, and adding other indications doesn't help you.

And once it's out there, doctors could use it for whatever indicated. So I looked into this question, and I'm saying there that to Taheri it's -- it's normal, nothing needs to be done.

Q Okay.

A And that his report sufficiently communicated that.

Q Okay. Then just one last question to make sure that I understand this. On that line where it says "B, volume of tissue with T-max," and it's reporting that, were you saying that when you contacted the i-RAPID company, you looked at the software, and that your understanding is that this line where it says "volume of tissue with T-max, less

than six point seconds relative to contralateral side," that it is not simply reporting whether there's a difference from one side to the other, and instead is reporting absolute values. Is that correct?

A Right, it says "T-max greater than," so if the -- if it's -- if the T-max is greater than six seconds.

Q Greater relative to what?

A Just greater than.

Q But it has to be greater than something, greater relative to what?

A Greater than six seconds.

Q Okay. Greater than six seconds.

A Then it would be going slow.

Q And so I guess my question is, you understand this to be saying that it's not measuring simply a difference from one side to the other, it's just giving you an absolute time measurement? Is that correct?

A Yeah, so it -- it's giving an absolute time measurement, and then you can take the -- the two side measurements. I -- I didn't write this format, and

i-RAPID didn't write this report either. They simply are providing the measurements.

Q Okay. Let's move on to your in-person examination of Judge Newman. So where did you do that examination?

A In judge's chambers.

Q Okay. And that was on August 24th?

A Yes.

Q Which was a Saturday?

A Yes.

Q So why do it in the judge's chambers?

A It was her choice. I mean, I had arranged to -- I had a couple of options to arrange for space either in -- so originally in -- in Arlington. And so you run into the issue of, would that conflict with the rule that you can use a adjacent state license as long as you don't have an office in this state?

Because what they're trying to prevent is, I have a big office in D.C., but I only have a Virginia license, and I have a whole business. But as soon as I have an office, rather than following my Virginia patient into D.C. So at the time, I think my license

came through around that time anyhow, we contemplated having her go to an office.

But then they said, "Well, can you just do it in her chambers?" And I said, "Yeah, we can do that. I think that would be okay to do it."

Q Okay. And why not do it at her home?

A I also thought I might be going over to the location of her home. But it turned out she had suggested it be done in chambers.

Q Okay. Let's look at page 28 of your report. And if you look under the heading General Physical Examination at the second paragraph, the second sentence there says "She is observed entering and exiting the vehicle by which we arrived at the Courthouse of the Court of Appeals of the Federal Circuit, and then observed walking to the elevator in the parking garage and from the elevator to her chambers." Is that correct?

A Yes, and I stated the --

MR. MORRIS: Wait for the question.

THE WITNESS: Okay. Go ahead. Yes.

//

BY MR. PHILBIN:

Q Okay. That's what it says?

A Yeah.

Q So I'd just like to unpack that a little bit. So how did that work? Where did -- how did you get in the vehicle with her? And where was that? And where did you see her get in the vehicle? And how did you get to the court?

A So I stayed at The Hay-Adams; right? Which is where I usually will stay if I'm testifying in the Federal Circuit, Court of Appeals of the Federal Circuit, or the other court that's adjacent to that. The -- so the -- I think when I talked to the clerk that morning, or her clerk that morning, she said that the judge would prefer to do this in chambers.

I said, "Oh, I'll just walk over there." And she said, "Well, we can" -- "we're on our way. Why don't we just pick you up and take you over to the court? Because it's locked up on the weekend. You won't be able to get in."

Q And was that -- do you know the name of that clerk?

A I'm not recalling right offhand, but I -- I have -- I have that in my records.

Q Was it [redacted]?

A I think so, yeah.

Q Okay. So [redacted] and the judge picked you up at The Hay-Adams, and you drove over to the court building. Is that right?

A Yes.

Q Okay. And then did [redacted] drive the vehicle down underneath into the parking garage below the court building?

A Yes, because it's -- that's all -- that's their point was it was locked up on the weekend, so the one -- but she could get entrance, and so they drove down in there.

Q Okay. And did she stop and talk to the marshal or the guard to get entry into the garage?

A I think so, yes.

Q Okay. And because it was locked up and it's a federal building, did they have to identify who you were to get access to the garage?

A I don't recall. I think it was sufficient

that the judge was there and indicated that -- and with [redacted], they should be admitted.

Q Okay. Did you hear any conversation that [redacted] had with the marshal there at the garage entrance?

A I don't recall.

Q You don't recall any conversation?

A There may have been, but I just can't recall what was -- some words were said, a few words, that was -- seemed to me very basic along the lines of --

MR. MORRIS: If you don't --

THE WITNESS: Yeah.

MR. MORRIS: Go ahead.

BY MR. PHILBIN:

Q So did -- you don't recall [redacted] identifying you for anyone?

A I think she may have identified, but I just can't be sure.

Q Okay. So did [redacted] mention anything to you about having to sign into the building in a visitor log?

A I don't recall that.

Q Okay. Did you have to show anyone an ID to get into the building?

A I don't think so.

Q Okay. I'm handing you what's been marked as Exhibit 10. Dr. Filler, this is a declaration signed by [redacted], who's the Security and Emergency Management Administrator at the U.S. Court of Appeals for the Federal Circuit. And can you see in paragraph 3, he says that "The attached document is a true, accurate, and complete copy of records generated by the Passage Point Visitor Management Software." Do you see that?

(Exhibit 10 was marked for identification.)

A Yes.

Q And on the next page, it's a visitor log. And on the top line there, you can see there's a time in and time out column. And on the top line there, it gives a time in on August 24, 2024, at 1:03 p.m. Do you see that?

A Yes.

Q Okay. And the person there on that top line

is given as Ralph Fischer, and the person below that is [redacted]. [redacted] is the clerk, isn't she?

A Yes.

Q Okay. Was Ralph Fischer in the car with you, with [redacted], when you arrived?

A No, I was just -- I was the only passenger.

Q Okay. So and further down the last line on this page of the visit log shows Judge Newman. Do you see that?

A Yes.

Q And the times for all three, August 24, 2024, at 1:03 p.m., for Ralph Fischer, for [redacted], and for Judge Newman, they all arrived at 1:03 p.m.; correct?

A Yes.

Q Okay. But the three people in the car that you arrived in were Judge Newman, [redacted], and you. Is that correct?

A Yes.

Q Okay. But [redacted] never talked to you about having to sign you into the building?

A No. I don't recall any -- I don't recall

anything -- it being sort of raised an issue -- as an issue.

Q Okay. All right. Then when you went up to Judge Newman's chambers to do the examination, was anyone else present?

A No.

Q [redacted] wasn't there?

A Well, she went up with me, and then she said she would be going out to, I think, work out or something like that, or run.

Q Okay. But during the examination, it was -- you and Judge Newman were alone. Is that correct?

A That's correct.

Q Okay. All right. I'm going to hand you what's been marked as Exhibit 11. Do you recognize this?

(Exhibit 11 was marked for identification.)

A Yes.

Q And is this a copy of your notes from the examination of Judge Newman?

A Yes.

Q Okay. And I just want to make sure that I understand some things on here. You see on the first page there's a heading that says "Review of DTIQ"?

A Yes.

Q What does DTIQ stand for?

A That's that questionnaire with a couple hundred questions on it. So I'm, like, looking at this form, and I'm asking her questions off the form.

Q So when you say that form with a couple hundred questions, that's the questionnaire that you have created for doing a screening of your patients?

A Yes.

Q And -- but Judge Newman had not filled that out; correct?

A Correct.

Q Did she have it in front of her?

A No. So I'm -- so if -- if a patient showed up at my office, it happens all the time, and they didn't fill out their form, they have to sit out there and try to fill out the form. I have the choice always of just going through with the patient myself and just go through the whole questionnaire. But

often it's time-consuming, and I don't. But I think, you know, certainly in deference to the judge, I thought, "Well, I'll just ask her the questions."

Q Okay. So when you were talking with Judge Newman, you had in front of you your questionnaire of 200 questions?

A Right, on a computer screen. So I'm going through, and I'm asking her.

Q And you asked her all of those questions?

A Yeah. And I do that pretty much in all my exams. I go through. I mentioned -- testified earlier, that I then go -- they fill it out, and then I go through, and I ask them, you know, the same questions.

Q Okay. But this time she had not filled it out?

A That's correct.

Q So you were basically administering the questions to her?

A Yes.

Q Is that accurate?

A Yes.

Q Okay. Could you tell us -- just because I'm not good at handwriting sometimes or reading, what does it say on your notes, on your memory?

A So firstly, we -- so the way that -- the form goes through, but I'll -- I'll just read out what it says, to answer your question. "So long-term memory, auditory tact, denies decrease in name recollection, denies decrease in recalling words to songs. Consistent scope of recall for oral argument cases.

Long-term memory visual, denies decrease in face recognition, denies decrease in recall of landmarks. Long-term memory, time sequence of events, states as normal." And, you know, I'm just reading this rather than telling you what the questionnaire says.

Q Yes, that's all I wanted.

A Okay.

Q That's perfect.

A All right. So "new memory formation, recalls substance of phone conversation, recalls instructions." I think that last line is "recalls

intention." So it's "intention of travel." That is -- why did I -- why did I go to that other room?

Q Okay.

A Then it's "immediate memory, not repeating herself, not losing track of her train of thought as she speaks. Speech, word finding stated normal. Normal flow" --

Q I'm sorry. Doctor, but when stated normal, does that mean that Judge Newman stated that her word finding was normal?

A Yes. The question is, do you sometimes have trouble thinking of the word you want to say?

Q Okay.

A And she states, "Nope, word finding is normal, don't encounter that." Then I go through normal flow of speech, "denies any stuttering or slurring of words." And then "no impression of no impairment of understanding of speech responding to questions. Reading, no difficulty recognizing words, able to maintain attention during reading. Good recall of read texts."

Q If I could just stop you there, Doctor, did

you give her a text to read and then ask her questions about it?

A Well, the test I did, no. What I -- the only test I did, which I described subsequently, is to describe a technology in a patent question. And then she had to explain back the technology, which is very complex. Two or three of them I gave. And then -- and then to spontaneously comment on her impression of the -- what I believe to be a at least worthwhile question in patent law, where there might be difference of opinion among judges.

Q Okay. But at this point in your evaluation or examination, when you noted "able to maintain fluency of reading and good recall of texts," was that based on just asking her?

A Yes.

Q Okay. She just self-reported this?

A Yes. This is all -- just like -- that's how these questionnaires work. Just -- so writing states "good maintenance of" -- "good, you know, it's advanced technical legal writing."

Q That's, again, her self-report?

A Yes.

Q Okay.

A And I had reviewed several of her opinions recently. I had a stack of her recent last few opinions, you know, that I had read through. And you can see a problem, but I understand that clerks could have contributed to -- you know, to those. Okay. So cognitive. Okay. You know, on multi-step planning and multitasking. Navigation states no impairment. Simple math, normal, e.g., calculating tips, et cetera. Attention and -- and concentration, denies any impairment.

Q And these are all, again, self-report?

A Yes.

Q Okay, great. I think that was very helpful. That's good for that form. In your interview or evaluation with her, did Judge Newman deny having any history of syncope?

A I think I discussed that with her.

MR. MORRIS: You take your time and look.

//

BY MR. PHILBIN:

Q Well, it'll probably expedite things. Let's go to page 4 of your report.

MR. DOLIN: -- on the report or still on --

MR. PHILBIN: Of the report.

BY MR. PHILBIN:

Q So on page 4 of the report, the paragraph that's about two-thirds of the way down the page, starting with the word "Prior to," there's a sentence in the middle of that paragraph that says "While the records" -- and this is referring to medical records -- "are described more fully below, nothing in the records shows that Judge Newman has ever suffered a heart attack," and then there's a parenthetical, "or had a fainting episode."

And then it goes on to say "The records reviewed by me do not shed light on Judge Newman's current condition." Do you see that?

A Yes.

Q Okay. And then on page 18 of the report, in the top paragraph under the heading Past Medical

History, the last sentence of that first paragraph says "Judge Newman denied having had a heart attack at any point in her life or any fainting episodes, and records do not reveal any such episodes." Do you see that?

A Yes.

Q So that's saying she denied having any syncope, and your review of the records did not reveal any fainting episodes?

A By which I mean the medical records, and I understand there's a report, an affidavit, I'm saying the medical records do not reveal.

Q The medical records don't reveal?

A Yeah.

Q Right. Okay. So let's take a look -- okay. I've handed you what's been marked as Exhibit 12. And this is a medical record that was among the set of medical records that you reviewed and were given to us by Judge Newman's counsel. And you can take a minute to look at that.

(Exhibit 12 was marked for identification.)

MR. MORRIS: Do we look at any particular part?

BY MR. PHILBIN:

Q Well, let's go to page -- there are Bates numbers in the bottom right-hand corner. Let's go to page 1676. And do you see there in sort of a -- there's a gray bar near the top with text in it?

A Yes.

Q Near the top of the page there's a gray bar that says "04/19/2023 - ED to Hosp-Admission (Discharged) in [redacted] Hospital." Do you see that?

A Yes.

Q Okay. And actually, if you look at the Assessment section, there's a line there that says "Judge Newman is a 95-year-old female with a history of hypothyroidism, pacemaker placement by Dr. [redacted], presenting after a brief syncopal episode lasting a "split second." Admitted with syncope and AKI." Do you see that?

A Yes.

Q Okay. So she was admitted to [redacted]

Hospital, according to this record, on April 19, 2023, after an episode of syncope. Isn't that right?

A Yes.

Q Okay. And if you go to the Bates number, page 1681, and it's sort of in the bottom half of the page. There's a note there. Do you see where the author is Theresa Osuji?

A Yes.

Q And this was a note at 04/20/2023 at 6:39 a.m. Do you see that?

A Yes.

Q And it says "Received patient from emergency department." And then towards the end "patient had a good night sleep." So do you see that?

A Yes.

Q So this shows that Judge Newman was in the hospital overnight. She was admitted overnight as a result of that syncope episode?

A Yes.

Q Okay. And then on page 1683, down in the bottom third of the page, there's a heading that says Prior to Treatment.

A Yes.

Q And then there's a line that says "Referral Diagnosis."

A Yes.

Q And it says "admitted for syncope episode, found to have AKI." Do you see that?

A Yes.

Q Okay. So is it fair to say this is -- I mean, it's a document that starts at page 1667 and goes through page 1685. This is a multi-page document about admission -- her admission to the hospital for an episode of syncope; correct?

A Well, I think they're concerned about her cardiac rhythm. Yeah, that's -- that's the issue. So it's not that they're all examining her for the whole syncope workup or something. They're specifically -- whoever -- whoever was the source of saying "a split second," enough to raise concern.

Q But she had an episode of syncope, according to the records?

A Yeah, but the records -- the most detail you get is "a split second." So I'm not sure why they --

does that mean she didn't fall to the ground or just, you know, it's hard to know.

Q Okay.

A And -- and, you know, it's not as if you -- you don't have -- so you don't have an observed syncope, but absolutely it says what it says.

Q Is there a reason you didn't mention this in your report?

A I think I'm just indicating a -- the statement that they -- that she did not -- her statement that she did not have a blackout.

Q Well, let's go back to page 18 of your report. So under that first paragraph, under Past Medical History, again, the last sentence says "Judge Newman denied having had a heart attack at any point in her life or any fainting episodes, and records did not reveal any such episodes."

A Right. So, I mean, it's the difference between an actual faint where you're out unconscious somewhere being observed versus saying that you felt faint for a split second.

Q Yeah.

A So -- and I think -- I think they're both fair descriptions, but, you know, I take your point. The record says -- has the word syncope in it.

Q Well, at the time you prepared your report, did you not include a mention of these medical records we just went through because you didn't think they met the threshold for syncope?

A No, I -- I mean, I reviewed the records, and at that point in the report I'm talking about her statement.

Q Well, Doctor, you're also saying "and records do not reveal any such episodes."

A Fainting episodes, yeah. I mean, a faint is -- is going to be more than a split second.

Q Okay. So I just want to understand what you thought when you wrote this down. You knew about these medical records referring to the hospital admission for syncope?

A Yes.

Q But you decided they didn't count as a medical record showing a fainting episode --

A Well, it's a diagnosis code that they're

trying to support to get a certain reimbursement. So sure, I mean, I guess the -- there might be a difference between saying someone fainted, like the period of blackouts comes up all the time in head injury where there was -- was there a moment of breach of memory? What is the description of this, you know?

And a split second might have been a sense of feeling, a moment of loss of sensorium. I -- you know, I don't know. But I think that a faint -- being fainted means that you should be seen unconscious, which I don't think that is what this is, which I don't think this -- but I -- I agree that you could use the word in many situations, syncope, to overlie a -- a faint, but there's -- they're not exactly the same thing.

Q I'm just trying to find out what you meant when you wrote down "The records did not reveal any such episodes."

A They did not reveal -- they did not reveal what I just -- I already testified on this. I'm not going to keep saying the same answer again.

Q Okay. I just want to understand. You were

aware of this particular medical record when you wrote that sentence. Is that correct?

A We can have the court reporter read back. If you already asked me that question, I already answered it.

Q Doctor, I just want to know, were you aware of this medical record when you wrote that sentence?

MR. MORRIS: Cumulative testimony.

THE WITNESS: I'm waiting for her to read it back.

MR. PHILBIN: Sure.

THE REPORTER: Just one moment.

(The reporter repeated the record as requested.)

BY MR. PHILBIN:

Q So you were aware of the records, and now I just want to understand. The reason you didn't mention them here is you thought they didn't count as a fainting episode. Is that your testimony?

MR. MORRIS: Object to the form.

THE WITNESS: Yeah, no, I just --

MR. MORRIS: I'm sorry. That was not

his testimony.

MR. PHILBIN: Okay. I'll withdraw the question.

BY MR. PHILBIN:

Q Doctor, you've testified that you were aware of the medical records showing that she was admitted to the hospital for an episode of syncope. My question is, why did you say here that the records do not reveal any episodes of fainting?

A Yeah, I -- I just said and this is why I don't like to testify --

MR. MORRIS: Same objection.

THE WITNESS: That, again and again is that any little word difference, you can put the two of them -- "Well, here you said A, and here you said B," so I don't like to answer the same question twice. I feel I answered it, which was to say, and I'm going to repeat it, but it's an advanced objector. You're doing this is a way to get two different statements of the same thing.

But that a faint would be something like someone being witnessed to have been blacked out

and fallen, for instance. The description of a "split second" indicates maybe a brief moment of feeling a decrease in sensorium. I'm saying there not that she didn't have a brief moment of syncope. I'm saying she didn't have a faint.

BY MR. PHILBIN:

Q Okay. So --

A I did not read the past records into the note, I -- but I cited to the past records.

Q Okay. So are you saying that syncope is something different from fainting?

A Well, a full syncopal episode would be similar. That is, someone's witnessed to be unconscious, but they're not saying that's what happened.

Q Okay. I've handed to you what's been marked as Exhibit 13, and this is another medical record. Could you go to the page that's Bates marked 1436 in the lower right-hand corner?

(Exhibit 13 was marked for identification.)

A Okay.

Q And can you see up towards the top where it says "BEGIN - Office Visit"?

MR. MORRIS: I'm sorry to jump in. Can you give him a -- on the date too?

MR. PHILBIN: Sure.

BY MR. PHILBIN:

Q Just below where it says "BEGIN - Office Visit," it says "Date of Service Tue Apr 25 2023."

A Yes.

Q And it says "Chief Complaint Hospital f/u," which is follow-up, I believe, "for syncope"?

A Yes.

Q Okay. So this is April 25th. It's a few days -- it's six days after the April 19th event when she was admitted to the hospital for syncope. Correct?

A Yes.

Q Okay. And under Subjective, can you read just the first four lines there?

A It says: "She was working at home. She stood up from her chair and passed out and fell to the floor" -- or "feel to the floor. It did not have any

symptoms leading up to the syncope."

Q Okay.

A And -- below that --

Q And then a couple of lines below that, do you see where it says "Had similar episode prior to getting pacemaker"?

A Yes.

Q Okay. So where it reports that she passed out and fell to the floor, does that count as fainting?

A Yes.

Q Okay. So same question as before, why did you not mention this record in your report?

A I might have missed that line. I -- I think I saw the brief -- the thing that's saying it was a split second, but I don't think I saw that.

Q Okay. So -- and you see also it says that on that same page "Had similar episode prior to getting pacemaker"?

A Yes.

Q And then if you go to the page that's Bates marked 1441, in this same set of records, in this same

exhibit, if you see sort of in the middle of the page, it says "BEGIN - Office Visit"?

A Yes.

Q So this is a separate office visit, and it gives the date of service as Friday, March 17, 2023?

A Yes.

Q And if you look down under Subjective, the last sort of hashtag, the last section there, it says "Lung nodules on CT done when she was in the hospital for syncope."

A On 1441?

Q Yes.

A Yes.

Q So this is referring to an earlier episode when she was in the hospital for syncope?

A It's saying lung nodules were noted on the CT scan when she had the hospital admission for syncope.

Q So she was admitted to the hospital another time for syncope?

A I -- that doesn't say that. It just said -- says "Lung nodules on CT scan when she was in the

hospital for syncope."

Q Okay. If we could look at page 23 of your report.

A Okay.

Q In the middle of the page there, there's a Problem List as of August 22, 2024. Do you see that?

A Yes.

Q So you included in your report the things that showed up on the problem list. Is that right?

A As far as I recall, yes.

Q Okay. Now, if memory impairment had showed up on her problem list, would that be relevant?

A It would be -- would be relevant. I'm not sure if this was a -- a problem list that I did or if it was -- if I'm reporting somebody else's problem list here.

Q I think you're reporting a problem list that showed up in the medical records. Does that seem familiar to you?

A Yes.

Q Okay. So let's -- okay. I've handed you what's been marked as Exhibit 14. And this is also

from the medical records. If you could turn to the page, it's the second page. It's got Bates number 1359. And do you see that on this page there's a problem list?

(Exhibit 14 was marked for identification.)

A Yes.

Q If you go down -- I think it's in alphabetical order, if you go down to the M's, do you see that it says "memory impairment"?

A Yes.

Q Can you tell when that was noted on the problem list?

A Well, it says April 27, 2022.

Q Okay. And then-- I've handed you what's been marked as Exhibit 15, which is another medical record. Could you look to the page that's Bates number 1133?

(Exhibit 15 was marked for identification.)

MR. MORRIS: Can you let him get oriented about what it is?

MR. PHILBIN: Sure.

MR. MORRIS: And look at the date. And take your time and get whatever you need.

THE WITNESS: Okay.

BY MR. PHILBIN:

Q So if you look at Bates number page 1133, up in the top in the box, there's a list of Reviewed Problems. And this is -- you can see in the Date line that this is April 17, 2024. Do you see that?

A Yes.

Q And in the list of problems -- this one's not alphabetical entirely, but sort of the fourth from the bottom. Does that list memory impairment?

A Yes -- no, it doesn't say if that lasted for a day or an hour or if it was a permanent total memory deficit of -- no, and I think that the context of it seems to be a list of concerns, and then there's no detail, there's no examination. So I would take from that the impression it was taken by the clinician as minor rather than knowing who she was -- who writing -- the person writing this report. So --

Q Okay. Going back to the exhibit we had a

second ago, the other memory impairment, do you have that in front of you, page 1359?

A Yes.

Q And you said that you could tell the memory impairment there was noted on April 27, 2022?

A Yes.

Q Okay. But do you know who noted it?

A I didn't write this record.

Q I understand that.

A So it comes from the Virginia Hospital Center [redacted]. And the person -- so this -- you know, someone has entered in the medical record. So the problem list -- you know, anytime you mention a problem, even years later, something that lasted for an hour may pop up in your problem list.

They don't curate them, but they do attend to the ones they're concerned about. So I agree that it's -- appears in the list and we just don't know if it was just the day she had the -- a single episode or it happens continuously and she doesn't know where she is. I don't think that's accurate. So it's hard -- there's no -- I don't know if there's any additional

qualitative information or any testing they did or --

Q Would it be relevant to know those things?

A Well, it would be helpful, but she states that she doesn't have a memory impairment, which, you know, I asked the person, at least in person directly as a physician. And didn't just ask memory impairment. I asked her a whole series of separate, different questions and situations and aspects that we all lump as memory. So I see it's there, but by my exam she denies memory impairment.

Q Okay.

A And I didn't find any during my exam.

Q You did put a problem list from the records in your report; correct?

A Yes.

Q Okay.

A Absolutely.

Q Why did you not mention the memory impairment on the problem list?

A Well, I'm looking at some problem list and whatever one I was looking at must not have had that on it. 'Cause I don't list -- I didn't copy all these

in, and the records, as far as I knew, would be occluded or attached.

Q So were you aware of the records putting memory impairment on the problem list when you prepared your report?

A No, I didn't -- I don't -- didn't do a line-by-line typed-up summary of this. So basically, I'm being her neurosurgeon, not her internist. So -- and I did look through her records. She didn't have a prominent complaint. I don't know why that's in there. I agree that it would have been relevant to ask her about that, why it was there. I may have asked her, and she said she didn't know why it was there. I just don't know.

Q But you don't know if you asked her that?

A I presume I did, but I don't have a specific recollection of discussing that entry.

Q Okay. Because you could only have asked her about that when you saw her on August 24th if you had the medical records before you saw her that day?

A Right. I did the review on most -- I had -- I had some records, but I did the full review

subsequently.

Q So you did have some medical records before you saw her on the 24th?

A I didn't have time to -- they were given, I think, at the -- I think on the same day, so I didn't really have time to do the full review at the time of the visit.

Q Okay. How were they given to you?

A My recollection is they were on a thumb drive.

Q Okay. So you think that on the morning of the exam you were given a thumb drive with the medical records?

A Yes.

Q Okay. Are you sure about that?

A Yes. It's possible it was sent to me before. I guess I'll have to go back and see if I have any notes about it if there were -- but I -- that's my recollection of it, but I'll have to go back and see if I have any further notes about it. Somehow, I was given this set of records, which I then summarized, you know, for my report.

Q Okay. Just -- okay. I'm going to hand you what's been marked as Exhibit 16. And, Doctor, these are UPS Second-Day Error mailing labels that are addressed to you. Do you see that on the first one?

(Exhibit 16 was marked for identification.)

A Yes.

Q Okay. And I will represent to you that [redacted], Judge Newman's clerk, submitted a declaration in this case stating that she sent the medical records to you on a thumb drive by UPS.

A Yes.

Q And that these are the mailing labels showing that.

A Yes.

Q And if you look on page 2 of the exhibit of the mailing labels -- okay, on that second page there, do you see sort of right in the middle top it says "Hello, your package has been delivered"?

A Yes.

Q And what's the delivery date?

A September 4th.

Q Okay. So does that refresh your memory about when and how you got the medical records?

A Yes. They obviously were sent to my office at that time.

Q So you didn't have them on August 24th when you talked to Judge Newman?

A I probably brought them with me.

Q Okay. So, Doctor, we just looked at the label saying it was delivered on September 4th --

A All right. I'm sorry. So the -- the visit -- the visit was August 24th. So this is after the visit.

Q Correct. So does this refresh your memory that you did not have the medical records before talking to Judge Newman?

A Well, it's possible that I was given something at the time, and this is an additional record. I don't know what she said about it. So -- but I know I didn't review records on the date of the visit 'cause it's a lot to look through. But I -- I reviewed it. So the date of the report is not -- this is -- is the date of the visit, but it isn't

necessarily fully prepared, like, in ten seconds while I stand there at the end of the visit or something.

Q Understood. The date of your report is September 17th; correct?

A Yes.

Q Okay.

A That's -- that's what I was looking at. So we -- I have them by the time I'm writing the report. I reviewed them to do a summary. This set, at least, I didn't have. I have some recollection about there being some thumb drives, and they may have said, "Oh, what? You know what? We'll just send them to your office," or something. I -- I -- you know what? I -- I don't know. But I didn't have time that day to review records. And I think it was a good choice to send them with a documented e-mail just for this very purpose. When did they arrive? How were they delivered? Et cetera.

Q So on the day you spoke to Judge Newman on August 24th, you had not reviewed the medical record; correct?

A As I think about it, there were some

records, and I said, "You know, there's no time to do this today. Let's go through with this, and please send them to my office."

Q Okay. But --

A It seems to be what it was. So there were records there. I remember something about that, but saying, "There's not going to be time to go through all this. I don't know what all's there, and let's just address the present situation, and then I will look at the records."

Q So you had not reviewed them before your --

A No, absolutely not. No, I didn't have an extensive review of records. And I -- I will typically scan records, if available, immediately prior to seeing a patient. I will allot five to ten minutes to get the major gist of it. And then in doing a report, I will just -- I'll go through it. But I'm not being the internist, but I do want to know the major contours.

Q So just -- I'm just trying to focus back on this specific record about memory impairment, because a minute ago you said that you thought you might have

asked her about that in the interview. And I just want to see if now, if your recollection is refreshed, that you couldn't have asked her about that in the interview because you hadn't reviewed the records.

A I hadn't done a detailed review. I think I'd had a -- a quick look at it. And -- but I did not do a review of records. I never do a review of records with a patient during a visit because it's a separate issue. So I have my interview, and I have my examination. And in the course of a report -- and patients should declare their prior medical conditions, so that I can be aware of them in examining and discussing with them. So my impression here is I did not -- I -- I had some quick look at it, but I said, "Well, I'm not going to review these now. Please send them."

Q Okay. So now having seen these documents, having had a chance to refresh your recollection on some of these things, I just want to make sure, why did you not mention the memory impairment medical records?

A Well, I -- 'cause I did a -- I don't know.

I did a detailed evaluation of it. I don't -- I don't remember specifically excluding it, but I talked -- I went through -- it's such a very general term. I don't know, was it her memory formation? Was it her auditory tag long-term memory for songs, you know? So I've really covered that ground in detail in terms of her present status. But I don't -- but I don't think that I did a page-by-page, line-by-line summary of her medical record.

Q I understand you didn't do a page-by-page summary. I'm just trying to find out, when you prepared the report, were you conscious and aware of the medical records listing memory impairment, and did you decide not to mention them for some reason?

A No, I think somehow, I may have missed that line in there.

MR. PHILBIN: Okay. Should we break for lunch?

MR. MORRIS: Any time is fine. That's fine with us.

MR. PHILBIN: Okay.

MR. MORRIS: This is a good stopping

point.

MR. PHILBIN: Yep.

THE REPORTER: The time is currently 12:39 p.m., and we're going off the record.

(Off the record.)

THE REPORTER: We are back on the record, and the time is currently 1:39 p.m.

And you are good to go ahead.

MR. PHILBIN: Thank you.

BY MR. PHILBIN:

Q Dr. Filler, I just want to go back briefly to a couple of the hospital records we discussed concerning the event of syncope in April of 2023. And do you remember if there was -- the second one we looked at, I'm pretty sure it's Exhibit 13, which has --

MR. MORRIS: Hold on. Let me get the exhibit. Thirteen?

MR. PHILBIN: Mm-hmm.

MR. MORRIS: Oh, one came up right here. That's 14 --

MR. PHILBIN: It might be under what he

has there.

MR. MORRIS: We'll get there -- 13. Organize these.

BY MR. PHILBIN:

Q And does that have down in the bottom right-hand corner Bates number 1434?

A Okay, I see the one with 1434, yes.

Q Okay. So if you go to page 1436, this is the one we discussed. We're under subjective. It says "Syncope was working at home, stood up from her chair and passed out and fell to the floor." Do you remember that?

A Yes.

Q Okay. And I think you said that you missed this one in going through the records?

A Yes.

Q Okay. So then the other one, which I think was Exhibit 12, I was asking you about why didn't you note that in your report?

MR. MORRIS: Okay. Hang on, and let's get the exhibit. Which page, please?

MR. PHILBIN: Well, it's Exhibit 12. I

just want to get the exhibit in front of him. The Bates number at the bottom right is 1667.

MR. MORRIS: Okay, 1667, okay. And look at whatever else you need to look at. 1667.

BY MR. PHILBIN:

Q Do you have the exhibit, Doctor?

A I have the Exhibit 12 here, yeah.

MR. PHILBIN: Okay. So if we could play back the earlier testimony.

THE REPORTER: Okay. If you'll give me one moment here.

(The reporter repeated the record as requested.)

Okay. Go ahead.

BY MR. PHILBIN:

Q All right. Doctor, I'd like to direct your attention now on Exhibit 12 to the page Bates-numbered 1670. Do you have that page?

A Yes.

Q Okay. And up at the top, do you see where it says "Reason for Visit"?

A Yes.

Q And then Chief Complaint?
A Yes.
Q And then could you read what it says there?
A It says: "Loss of Consciousness (Patient ambulatory to ED, 1 hour post witness, syncopal episode after standing up out of a chair. Denies head injury."
Q Okay. So that says this was a witness syncopal episode; correct?
A Yes.
Q Okay. If you could go to page 1672. And in the middle of the page, there's an area that says "History of Present Illness." Do you see that?
A Yes.
Q Okay. And in the large paragraph there, right sort of in the middle of that paragraph, there's a sentence that starts "She experienced no lightheadedness," do you see that?
A Yes.
Q Okay. And then it says: "She experienced no lightheadedness or dizziness prior to her syncopal episode, which lasted a "split second." She was told

that she had her eyes open prior to falling to the floor without hitting her head." Do you see that?

A Yes.

Q Okay. So that also describes that she fell to the floor, doesn't it?

A Yes.

Q And that someone else told her about that?

A Yes.

Q So someone else saw it.

A Well, she would have been aware of it because she was on the floor.

Q Okay. And then if you go to page 1680, in the middle of the page under ED Case Management Social Work Consult, there's a line towards the end of the second line there. It says "Patient reports that her fall was an isolated incident and the last fall she had was ten years ago." Do you see that?

A Yes.

Q Okay. So in light of those aspects of the record, do you want to modify, say anything else about why you didn't mention this in your report?

A No, I think I've acknowledged that I

obviously missed the -- detail -- some of the details of that so -- issue, I -- I think, is that she needed the pacemaker, which was the correct thing to do.

Q Okay. Doctor, in your clinical practice, when you are seeing a patient to determine if someone has an age-related cognitive impairment, which I think you said earlier, that's a small part of your practice; correct?

A Yes.

Q Do you seek -- are you familiar with the term "collateral source information"?

A All right. So the --

MR. MORRIS: [Unintelligible response.]

THE WITNESS: I'm not sure how that applies in medicine. Yeah, I mean, I think in law maybe, but collateral source information, I'm not sure how that'd apply in this.

BY MR. PHILBIN:

Q Okay. So in terms of trying to determine whether someone has a cognitive disorder, you're not familiar with the term "collateral source information"?

A I guess I just -- 'cause you're trying to get every and any type of information you can, but, I mean, in the course of our neurosurgical practice, which is not assessing people for, like, a contested will or something like that, it just -- we see -- I see patients. I have about two hours to fully examine them and review their records.

MR. MORRIS: I'm sorry. But the question was just if you're familiar with the term. Is that right?

MR. PHILBIN: That was the question.

THE WITNESS: No, I -- I am not familiar with the term.

MR. MORRIS: Okay.

BY MR. PHILBIN:

Q Okay. So when you're trying to determine if someone has an age-related cognitive impairment, is it part of your regular workup to try to get information directly from, say, family members about that person's behavior?

A No, I'm -- my focus is going to be the scan.

Q Okay.

A So I want to know, do you need a scan? And if there's a concern about loss of consciousness and there's no cardiac cause. So that's -- so I'm not a general doctor and I'm not a neurologist. So I'm oriented to saying, is there something here that's focal that we can fix? That's really how -- what the neurosurgical thinking.

So and I'm -- I'm interested in the ability of the imaging test, because they help convert a generalized impression from 1,000 sources into a specific lesion that's maybe treatable, and also in distinguishing specific treatable causes from generalized dementia. So I'm really -- I'm looking for an indication to evaluate, and I think it was a good indication to do the evaluation of Judge Newman.

And that we did the best image evaluation, which was reasonable to the information, and that was indicated by the situation.

Q Okay. So I understand you focus on the images, because the image can potentially show you something that as a surgeon you can fix.

A That's how surgeons do.

Q Correct? Yes?

A Yeah.

Q Okay. But say someone comes to you just because they have a general concern, "I'm getting on in years. I think I might have a cognitive impairment," it's a general concern just about cognitive impairment, is that someone that you see and then evaluate whether they have a cognitive impairment?

A No. I'm asking -- so the -- the cognitive impairment is a symptom. That -- so what you're trying to do is reach a diagnosis of a disorder that allows us to either prognosticate, "Oh, I can see from what you have here, you are involved in a relentless progressive deterioration. It's not a bad idea to think about winding up your affairs," versus, "Oh, but you got here. Did you have a fall?"

"Oh, yeah, I just bumped my head the other day in the car." "Well, look, you have damage in the crus of the fornix, which is causing you to have this memory impairment, and the rest of your brain is in very good shape. I can give you a medication that

fixes that. If you want to start a new business, yeah, you're probably going to be okay. I don't see a progressive decline."

So my purpose in this is to say, is there sufficient indication to proceed with this image evaluation? And does the image evaluation identify a treatable syndrome, or does it identify a -- an untreatable progressive problem? So I'm looking for sufficient information to, one, indicate whether I should image, and two, the most -- whatever information is available to help me reach the diagnosis.

But typically the neuropsychologists will proceed to a diagnosis without imaging, which I think is the flaw of and -- and I guess -- and you try to reach the correct diagnosis by intensive detail and multiple specialties and other family members and work-relate, but this goes beyond the scope of the underlying question of, is the person in a progressive state of decline, which I think the image answer is better, should has a -- have a major effect on one's diagnosis, than talking to neighbors and family

members, which are helpful, you know for -- but it's not something that I would do in my practice.

Q Okay. So talking to those other people, family members, neighbors, is not something you would do?

A Yeah, if they've come in with the patient, fine, but I can't go out and do investigations and call people in. I just am not able to do that. But --

Q But if they come in with the patient, you would ask them?

A Yeah, I mean, sure. Usually the -- the family members that come in the exam room will comment on issues, and yeah, we'll talk with them.

Q Okay. So you met [redacted] in the morning --

A Well, she didn't participate at all in the evaluation, yeah, and I did not question her at all.

Q Okay. You didn't think it would be relevant to find out something from her about Judge Newman?

A Well, she's not a family member, so it might not have been proper as a physician, so I wouldn't

normally go to someone's work associates. I'm not doing an investigation for -- I mean, I can see why it has the effect of being an investigation for the court, but from my perspective, although there's lawyer skills involved, I'm trying to make a medical diagnosis from the patient. I would have been -- if they had a statement from [redacted] for me to look at, I would have looked at it, but it -- I did not question her.

Q Do you think it would have been useful to have a statement from [redacted]?

A It would be useful, but it would be very unusual in medicine for somebody to comment on another person's health condition. Maybe in this situation it would be reasonable, but no, I didn't do it.

Q Okay. And this might save some time, are you aware that [redacted] is listed as the point of contact for Judge Newman in multiple of her medical records?

A Right. And she acted in this case to help -- help be a communication point between my office and the judge.

Q Okay. So if we could get -- and I'll hand you what's been marked as Exhibit 17.

(Exhibit 17 was marked for identification.)

MR. MORRIS: Thank you.

BY MR. PHILBIN:

Q Do you recognize that document?

A Yes.

Q And what is it?

A So this is the patient -- one of the -- one of the forms. We have eight -- eight forms that we give out, and this is a form that asks for past medical history and various other administrative issues.

Q And this is the form that was filled out for Judge Newman; correct?

A One of the forms, yes.

Q Okay. And if you look at the email address box there, can you see whose email is given? It's on the first page.

A [redacted].

Q Okay. And then the phone number provided on

the form, do you see that? That's (708) 848-4756?

A Yes.

Q Okay. And are you aware that that -- are you aware of whose phone number that is?

A I'll have to look it up and see.

MR. MORRIS: Well, you don't -- don't look it up. I mean, just ask --

THE WITNESS: Not offhand, but could -- it could be [redacted].

MR. MORRIS: -- might have it.

MR. PHILBIN: Right.

MR. MORRIS: He'll let you know.

BY MR. PHILBIN:

Q Let's look at the bottom of the page at the emergency contact. Who's listed there as the name of nearest relative or friend?

A That's [redacted] with the same number.

Q Okay. So it's the same phone number as the contact number for Judge Newman up above; correct?

A Yes.

MR. PHILBIN: Okay.

MR. MORRIS: Oh, thank you.

BY MR. PHILBIN:

Q I'm handing you what has been marked as Exhibit 18. And you can see that this is a medical record that lists up in the left-hand corner the team member, the medical team member is Elizabeth Gannon?

(Exhibit 18 was marked for identification.)

A Yes.

Q Okay. And for patient contacts, can you see there that the second patient contact listed is [redacted]?

A Yes.

Q And it shows the same phone number again, that 708 phone number.

A Yes.

Q And under Relationship to Patient, what does it say?

A Legal Guardian, Emergency Contact.

Q Okay. So -- but in light of the records showing, you know, [redacted] is the emergency contact, on other records, on your intake, she gave her email and her phone number as the contact for the

judge. She's listed on other records as a legal guardian in some instances. You did not decide that it would be useful to talk to [redacted] about her experience with Judge Newman?

A Yeah, usually, unless the person's really incompetent or unable to speak, I will just deal with the patient directly. If the patient asks me to talk to someone else -- but in the medical record, you don't -- if you've ever seen any medical reports, they don't -- a general medical report doesn't have a discussion with another person and family the members.

Now, some of them would be if it's a -- if the person's not competent to speak, but I don't think there was an allegation that Judge Newman had an impairment that severe. But I saw her, you know, and I felt like she was able to describe her condition. But in the normal course of the practice, it is rare that I have information from family members unless the person's unable to communicate something --

Q Okay.

A If it's severe, then absolutely, all the information comes from the family members and

guardians if that person can't communicate.

Q Okay. Let's look at page 24 of your report, Exhibit 3.

A Not Exhibit 3 of the report, just page --

Q Yeah, just page 24 of the report.

MR. MORRIS: Particular place? He looks like he's got the page.

BY MR. PHILBIN:

Q It's right in the middle of the page. There's a text that's in bold and italics. Could you just read that?

A "The overall current assessment of her One Medical Group providers as of 7/31/2024 is: 'Able to carry on normal activity; minor signs or symptoms of disease.'"

Q Okay. And is there a reason that you put that in bold and italics?

A I think it was a general assessment from coming out of the records.

Q Did this have particular significance for you?

A I think it was a good, useful general

assessment coming from the records 'cause I'm moving -- I'm transitioning from the record review to my summary.

Q Okay. And this was -- I think you said this is an overall assessment of Judge Newman's health. Is that how you understood it?

A Yeah, it was an overall assessment of July 31, 2024.

Q Okay. I've handed you what's been marked as Exhibit 19. And do you recognize this?

(Exhibit 19 was marked for identification.)

A I don't have a specific recollection, but it looks like a report to do with Pauline Newman.

Q And the date on it up in the upper right-hand corner is 07/31/2024. Is that right?

A Yes.

Q And that is the date of the overall assessment that we just looked at on page 24. Is that right?

A Yes.

Q Okay. And this is a document -- you said

that assessment was the One Medical Group providers, and this is a One Medical document; correct?

A Yes.

Q And so under performance status there, can you read that line?

A "Karnofsky: 90 percent Able to carry on normal activity; minor signs or symptoms of disease."

Q Okay. So is that the language starting with the word "able" that you quoted on page 24 of your report?

A Yes.

Q Okay. And the first two words in that line, "Karnofsky 90 percent," you didn't quote in the report. And why is that?

A I don't know. Well, because it -- the -- I was trying to quote the statement, the conclusion. I think if you say Karnofsky 90 percent, then I imagine people want to know what is Karnofsky, what's 90 percent. So I think that the statement, which is supposed to be a summary statement of their condition, is what I wanted to put in a narrative report.

Q Okay. What is the Karnofsky?

A Well, it's a rating scale used for different degrees of ability to carry on normal life activities, you know? So say someone has a brain tumor and they're gradually deteriorating, you have a Karnofsky rating. That would describe whether they're not able to feed themselves, you know? Not able to take themselves to the bathroom, this kind of thing, and there'd be a -- they'd put a -- a percentage score like this.

Q Okay. And does the Karnofsky score of 90 percent serve as a measure of decision-making capacity?

A Well, I think that that's incorporated in it, but I didn't rely on this. I'm just stating that's the -- that's a summary here.

Q Okay.

A So it's not my decision-making that's informed by this, and it's not the only summary, and it doesn't substitute for all of this and the imaging, but it's a statement that I'm quoting.

Q Okay. I understand that, but it's a statement you quoted in bold and italics. I'm just

trying to understand what significance you put on it. Do you think that the 90 percent Karnofsky is giving an indication that Judge Newman has perfectly fine decision-making capacity? Does it bear on that in your understanding or not?

A Well, I did not rely on this. That is not -- I actually have a large report. I actually examined the patient, did extended numerous questions, discussed in detail what she can -- what she does. And carried out an advanced imaging evaluation to try to address the question. It isn't -- the whole examination and the answer are not confined to the one line, but I think it's fair to quote that line from here. And I didn't --

Q Doctor, I --

A And it would not be a good -- I mean, we could -- I don't think if I just said Karnofsky 90 percent and left off the words, it would mean anything to a court, for instance, or an attorney.

Q I understand that you did a large report. You had a lot of other things you relied on. My very specific question is, what is your understanding of

what the Karnofsky 90 percent means? Does it convey anything as to decision-making capacity?

A Well, I think it's a - it's a contributory statement -- you know, it's just a -- there are numerous factors that go into it. Obviously, you could be 100 percent, which might be better than being 90 percent.

Q Okay. I'm handing you what's been marked as Exhibit 20. Okay. And, Doctor, this is a record from Virginia [redacted]. Can you see that?

(Exhibit 20 was marked for identification.)

A Yes.

Q And the date on it is August 19, 2024?

A Yes.

Q Okay. Then if you go to the Bates-numbered page in 1936, you see down in the lower part of the page it says "PERFORMANCE STATUS"?

A Yes.

Q And then can you read what it says there?

A It says "Karnofsky: 80 percent Normal activity with effort; some signs or symptoms of

disease."

Q Okay. So from July 31st to August 19th, this indicates that Judge Newman's Karnofsky rating went down from 90 percent to 80 percent. Is that correct?

A That's what that -- at least that person's assessment is different. Yeah, I don't know if I had this record. But it looks like it's from right around the time the record set was transmitted; right?

Q Well, this was in the set of records that was provided to us as the set of records that was given to you. That's why it has the Bates stamp on the bottom there. So to our understanding, based on representations from counsel, this was among the records that you had. Okay. Dr. Filler, in your practice, when you're seeing someone to determine whether they have a cognitive impairment, I think we went over earlier, you've developed a questionnaire that you use to go over with the patient. Is that correct?

A Yes.

Q So is it fair to say then that you do not

administer any of the, what we discussed earlier, as cognitive screening tests, things like the MOCA, the mini-MOCA, the MMSE, things like that. You use your own bespoke questionnaire instead?

A Well, I'm going to be relying on the imaging, and if those tests were done, I -- I usually will look at them if they're available.

Q So if --

A But I wouldn't administer those because neurosurgeons basically don't administer MOCAs and MMSEs, you know? So, you know, there's probably, from practice neurosurgeons, 99 percent of their patients, they could administer them, but we don't. So we're often looking for the treatable or identifiable pathology.

And I think that a lot of different pathologies get lumped together, and the imaging is underused, and it would be helpful, but all this is helpful as well. But I wouldn't be administering those tests, no.

Q Okay. So before you diagnose someone as having a cognitive impairment, do you ever refer them

to someone else to get some kind of a cognitive screening test?

A No, I'm looking for specific symptoms. I don't want to use what was used 50 years ago. I want to look at specific symptoms that doctors have generally failed to identify, and look for brain parts that demonstrate damage that correlates with those symptoms. So it's a different process, which I think proves to be a valuable process, 'cause there's vast criticisms of MOCA and MMSE and their unreliability and their subjectivity.

And in my practice, with head injury, as I say in here, on 99 percent of the cases, there's a defense neuropsychologist and a plaintiff neuropsychologist. They disagree on every single point and on their conclusions, as if there's no basis at all of reliability, and I don't find that attractive about those tests, such as the Karnofsky.

You could see if there was a plaintiff specialist giving a Karnofsky and a defense, they would probably be different, because you don't have any -- for a lot of these things, you just don't have

a good objective anchor on the significance or the range of questions to ask.

Q Okay. So, Doctor, I just want to make sure that I understand the steps you take, the things you do before diagnosing someone with cognitive impairment. And I think that the steps are, you have this bespoke questionnaire that you have developed. You use that in an interview with the patient. You have imaging. Those are two major steps. Is there another part to it?

A Well, I examine -- I examine the patient. Like, they may not check for balance. All those tests, they don't check for smooth pursuit motion. They --

Q So a neurological, a standard neurological exam?

A Yes.

Q And is that it, those three parts?

A Well, there's a neurological exam. There's the interview that I do. And then there's an imaging test, yeah. And then review of records for information such as this that's available.

Q Okay. But you don't do what would be called a "cognitive screening test"? I think we covered that. Correct?

A Right. I mean, there are -- as in this case, they're done -- they were done previously. And so I'm trying to add something more definitive or objective.

Q In what percentage of cases would you diagnose someone as having a cognitive impairment without anyone, without there being in the record a cognitive screening test?

A But I'm not going to --

MR. MORRIS: Go ahead and answer. That's a confusing question. What's the universe you're asking -- the all those diagnosed with it or those you evaluate?

BY MR. PHILBIN:

Q We're talking about patients who come to you, Doctor, who want you to tell them whether they have an age-related cognitive impairment.

MR. MORRIS: Okay.

//

BY MR. PHILBIN:

Q So that's the universe of people I'm going to ask you a question about.

A Yeah, so I'm not --

Q I'm going to ask you a question in just a minute about those people.

A You had a pending question I was in the middle of answering.

Q Well, that -- withdrawn.

MR. MORRIS: -- he's breaking it down because I was -- it was too hard me to understand.

BY MR. PHILBIN:

Q Okay. So we're talking about the universe of people who come to you who say, "Doc, I'm concerned. I'm losing a step. I'm getting old. I want to know if I have a cognitive impairment." That's the question presented by the patient.

A Yes.

Q And so my question is, how often will it happen that a patient comes to you with that question? There's no cognitive screening tests like a MOCA or an MMSE or anything in the file. No one has done that on

the patient. And then you do the steps that we talked about. You do your bespoke interview questions, you do a neurological examination, you review the medical records, you order a scan, and you make a diagnosis of cognitive impairment.

A I'm never going to do that because I'm not going to make a general diagnosis like that. I'm going to say, "You have a problem with short-term memory that's caused this specific lesion here and it will respond to this medicine. I recommend this treatment."

Because that global statement reflects the inability of these doctors to be able to say specifically what's wrong with the person. You could assess cognitive impairment from somebody who's going to be just fine tomorrow. They're going to get over their viral syndrome and be unimpaired tomorrow. Or it could be somebody with a -- with a just diffuse deterioration of their whole brain who from -- and I could say, "Oh, you have this condition. This is your diagnosis. You have, you know, Lewy body," L-E-W-Y, body -- "disseminated, type 4, whatever. And

therefore this is your treatment."

So I'm trying to -- rather than a global statement that a psychologist might make, that you're impaired. They know they're impaired. That's why they're coming to see me, you know? So -- so, no, I would not be -- they would be fine to go to those other doctors. If -- I'm more concerned with advancing the whole field by reducing this to subcomponents, many of which are treatable and don't get treated.

So that's really my objective with it. So I feel that the term "cognitive impairment" sweeps up multiple different diagnoses that should not be confounded and that cannot be distinguished with the methods that are in current use.

Q And so are you familiar with the term "mild cognitive impairment" or MCI?

A Sure.

Q Okay. And is that -- that is used as a diagnosis by others?

A Sure. I'm not saying that they don't use it or that they can't. I'm just saying that it's not --

those are not the perfect -- everyone agrees this is 100 percent perfect. Everybody loves it. We don't want to do any better because this is the ultimate fantastic way to describe people, no.

There's enormous frustration in all of those fields that they can't get past that. They can't really -- that doesn't prognosticate for a person. Yeah. Suppose they're saying, "You have mild cognitive impairment." "Does this mean I'm going to get Alzheimer's and die and need to sell everything?"

Or does that mean that "Yeah, I'm having a little trouble with new memory formation, but you can see it's due to the fact that I hit my head in the -- the other day, you know?" And that can -- that will get better or you can treat it and therefore it's not the end of -- the end of my life.

So that kind of breakdown is not the way it's been done for 100 years. And there are lots of doctors happy to do things the way it's been done for 100 years. And as lawyers, you want to enforce that because it fits into historical cases. But it doesn't mean it's wrong for us to advance medicine all the

time. Medicine advances all the time.

If it was your heart, you wouldn't want to say, "You've got heart disease, therefore you're going to die and nothing can be done." You want us to say, "Well, wait a second. Is there an electrophysiology study you can do? How about a high-resolution digital injection cardiogram with an MRI with DTI of your heart and therefore X?" So this is really -- the issue is how do we see?

And -- and I think this is an excellent case, and I'm going to make that point, because if we find, for instance, that Judge Newman did get upset and yelled at somebody, does that mean that, "Oh, this is Alzheimer's and she's wrecked? Or does it mean she got frustrated one day like all of us do, you know?" And what is the overall picture?

Q So, Doctor, are those the only alternatives, like it's either Alzheimer's or she's not cognitively impaired?

A Well, we all know there's gradations, but the gradations aren't fine enough.

Q Are the alternatives she's got Alzheimer's

or she's fine? Are those the only alternatives?

A No, I mean, I didn't say that.

Q Okay. But let's go to then -- you mentioned you know, did she get angry at someone, some of the affidavits that were collected by the special committee. And I'll see if I can just ask you so that we don't have to introduce a bunch of affidavits into the record if you remember some of the things in those. Do you remember there were affidavits from people who worked in the IT, the Information Technology department?

A Yes.

Q And they described situations in which Judge Newman said that she was going to have one of her clerks named [redacted] arrested and removed from the building. Do you remember that?

A Yes.

Q Okay. And she said that she was going to make a big fuss and go to the Supreme Court. And it'll be on the front page of the Washington Post.

MR. MORRIS: I'm going to object. If you're going to ask him about the [redacted] affidavit,

for example, I think you should put it in front of him.

MR. PHILBIN: Okay.

MR. MORRIS: Let him see the other content of the affidavit.

BY MR. PHILBIN:

Q All right. We'll do all of them. Let's start with -- okay. I've handed you what's been marked as Exhibit 21. Do you recognize this?

(Exhibit 21 was marked for identification.)

A Yes.

Q Okay. And this is the affidavit of [redacted], isn't it?

A Yes.

Q Who works in the IT department at the Federal Circuit.

A Is he a neurologist also?

Q No, he works in the IT --

A I know.

Q -- okay. Department at the Federal Circuit

A Okay.

Q Okay. If you look at paragraph 6, at the top of page 2 in paragraph 6, do you see it says "At that point, Judge Newman began to discuss her relationship with [redacted]"? Do you see that?

A Yes.

Q Okay. And "She said that [redacted] no longer wanted to work for her and that she was not taking it well." Do you see that?

A Yes.

Q Can you read the next sentence?

A "Judge Newman then said that she was going to make a big fuss and planning to go to the Supreme Court and that she'll hear more about this because it was going to be on the front page of the Washington Post."

Q That is a sentence there, but if you could skip two sentences earlier. The sentence starts "Judge Newman then said."

A "Judge Newman then said that she was going to have [redacted] 'removed from the court' or 'arrested.'"

Q Okay. I'm handing you what's been marked as Exhibit 22. And do you recognize this?

(Exhibit 22 was marked for identification.)

A Yes.

Q This is another affidavit of [redacted], isn't it?

A Yes.

Q Okay. If you look in paragraph 3, the second sentence, this is [redacted] explaining that he went to Judge Newman's chambers and he says "I told Judge Newman that I was there to help retrieve some of her files and I asked what she was looking for"?

A Yes.

Q Do you see that?

A Yes.

Q And then can you read the next sentence?

A "Judge Newman looked angry that I was there and said she needed her financial disclosure files."

Q Okay. And then could you read the last sentence in that paragraph?

A "I started to walk toward Judge Newman's computer so that I could show her where the files were located, but Judge Newman angrily said no."

Q And then if we go to paragraph 5, could you read the last sentence on page 1 and it carries over onto page 2?

A "She was clearly upset and frustrated and was walking back and forth mumbling about how her computer and phone had been taken away from her when that was not the case."

Q And then can you read the first sentence of paragraph 7?

A "At that point, I got worried that Judge Newman was getting so angry that she might collapse or have a heart attack if the conversation continued. I told Judge Newman that we would get back to her and told [redacted] that we should go."

Q Okay. Handing you what's been marked as Exhibit 23. Do you recognize this?

(Exhibit 23 was marked for identification.)

A Yes.

Q And this is an affidavit from [redacted], isn't it?

A Yes.

Q And in the first paragraph, he says he's been employed in the Information Technology Office of the Federal Circuit since February 28, 2022. Do you see that?

A Yes.

Q Okay. Can you read paragraph 4?

A "When I asked Judge Newman about the problem that she was having, Judge Newman said that she believed that her computer was being monitored, hacked, and reviewed. She also mentioned her phone in that same conversation. However, she did not specify if she meant her personal landline or court-issued iPhone or any specific issues or events regarding her phone. She sounded annoyed, agitated, paranoid, and upset."

Q Okay. Then in paragraph 8, can you see that it says "She told me she would not elaborate on things disappearing"? It refers to paragraph 7 -- things disappearing -- "she was under the impression that the court may have been responsible for messing with her computer." Do you see that?

A Yes.

Q "She also suggested at one point that the court was interfering with her mail at her residence." Do you see that?

A Yes.

Q And then can you read the next sentence?

A "I would describe Judge Newman's response as nonsensical because there was no reason to believe any of that was happening. She seemed to be in attack mode and mentioned litigation."

Q Okay. And then if we go to paragraph 19, about four lines down. In paragraph 19, in the middle of the line there's a sentence that says "After briefly discussing the situation regarding the phones, Judge Newman started to talk about [redacted]." Do you see that?

A Yes.

Q And then if we skip a couple sentences, it says "Judge Newman stated that she would have [redacted] removed from the court or arrested." Do you see that?

A Yes.

Q Okay. And can you read the last sentence of that paragraph 19?

A "I would describe the call as bizarre and unnecessarily hostile toward [redacted]."

Q Okay. Handing you what's been marked as Exhibit 24? Do you recognize this?

(Exhibit 24 was marked for identification.)

A Yes.

Q And this -- [redacted] was -- he worked in Judge Newman's chambers. Remember that?

A Yes.

Q Okay. You see -- let's go to paragraph 31. And you see in the first sentence it says "On April 13, 2023, I brought my concerns that Judge Newman was being abusive and retaliating against me to the Director of Workplace Relations and filed a request for assisted resolution"?

A Yes.

Q Okay. All right. And in paragraph 33, Mr. [redacted], he starts off saying on April 18, 2023, he called Judge Newman for a routine 9:30 a.m. call. Do you see this?

A Yes.

Q And then he explains that she made comments along the lines of: "You deserted chambers. When are you returning to chambers? This isn't going to work. When are you going to be back? You're not doing anything for chambers. None of the staff can get any of their work done because you're not in chambers." Do you see that?

A Yes.

Q And then down at the bottom, could you read the last two sentences on this page starting with "I would"?

A "I would describe Judge Newman's behavior on the call as aggressive, angry, combative, and intimidating. The call made me feel very uncomfortable, anxious, and insecure because I had no idea what Judge Newman was going to do or what her response was going to be. And I felt that if I responded, she would get angrier and more upset."

Q Okay. And then on paragraph 37 at the bottom of that page, could you read the first sentence of paragraph 37?

A "I would like to say that I love, revere,

and admire Judge Newman personally and professionally for all her accomplishments and who she is as a person, which makes the last few months so much more difficult."

Q Okay. All right. I hand you what's been marked as Exhibit 25. And do you recognize this?

(Exhibit 25 was marked for identification.)

A Yes.

Q And this is an affidavit of [redacted], isn't it?

A Yes.

Q And in the first line, he says that he works as a law clerk for Judge Newman?

A Yes.

Q Let's go to paragraph 14. Sorry. First, let's look at 13. In the first sentence there, it says that Judge Newman, at a meeting with her clerk, said that she was not happy that [redacted] had asked the chief to place him outside of chambers. Do you see that?

A Paragraph number 13?

Q Thirteen.
A Yeah.
Q First sentence.
A Mm-hmm.
Q See, it says that Judge Newman said she was not happy that [redacted] had asked the Chief to place him outside of chambers?
A Yes.
Q Okay. And then paragraph 14. Can you please read the first sentence?
A "At that point in the meeting, I informed Judge Newman that working in her chambers was hurting my ability to complete my work and taking a toll on my mental health and harming my relationships at the court."
Q Okay. In the next sentence, he says "I then reiterated that I would like to be loaned out to another judge." Is that right?
A Yes.
Q Okay. And then, could you please read paragraph 17?
A "The next day, April 19, 2023, I brought my

concerns to the Chief and indicated that I could no longer work in this environment and requested to be moved to another chambers."

Q Okay. I've handed you what's been marked as Exhibit 26. Do you recognize this?

(Exhibit 26 was marked for identification.)

A Yes.

Q And this is the affidavit of [redacted], isn't it?

A Yes.

Q And he says in the first paragraph that he's worked in the Information Technology Office at the Federal Circuit for 17 years. Do you see that?

A Yes.

Q Let's look at paragraph 2. Do you see the second sentence there says "When I first started, I was amazed that someone in her 80s, like Judge Newman was at the time, could pick things up so quickly and easily"? Do you see that?

A Yes.

Q Can you read the next sentence?

A "However, particularly over the last few years, I have noticed a significant increase in Judge Newman forgetting how to perform basic tasks that used to be routine for her."

Q Okay. And then could you read the first sentence in paragraph 3?

A "Judge Newman routinely blamed her inability to find a file or email on someone hacking her computer."

Q And then the next sentence?

A "I would describe her on these calls as sounding paranoid."

Q All right. And then in paragraph 5, Mr. [redacted] says that "Judge Newman was unable to complete an annual security awareness training two years ago." Do you see that?

A Yes.

Q And he says "The training required a user to watch a short 10-20-minute video presentation and answer a series of questions based on the information provided in the video." Do you see that?

A Yes.

Q Okay. And then skip over one sentence. There's a sentence that begins "I believe," could you read that?

A "I believe Judge Newman tried and failed multiple times to answer enough questions to pass the training because she was unable to retain the information from the video she had just watched."

Q And then he says "I had to sit with her and help feed her answers to the questions in order for her to pass the training." Is that right?

A Yes.

Q Okay. Let's go back to Exhibit 21, which was the first affidavit of [redacted]. Do you have that exhibit?

A Yes.

Q If you go to page 2 to paragraph 8, could you just read paragraph 8, please?

A "Over the last year, I've noticed my interactions with Judge Newman that seems to be significant mental deterioration. Judge Newman routinely states that her computer is being "hacked" even though her concerns seem to be easily explained

by Judge Newman forgetting what she was doing or not realizing that the network disconnected her based on inactivity."

Q And then the last sentence says "She seems agitated and paranoid and we frequently have to calm her down in order to be able to help her with her problem." Do you see that?

A Yes.

Q Okay. If we look now at paragraph 9, he's describing that Judge Newman frequently requests help. And in the third sentence, he says "Many of these requests are a result of Judge Newman not being able to remember where she saved a file or email or Judge Newman forgetting the steps to remotely access into the court's computer network." Do you see that?

A Yes.

Q And then there's a sentence starting "These are things," can you read that sentence and the following sentence?

A "These are things that Judge Newman has done for years and these processes have not changed. She never used to have a problem with these routine tasks

but now seems to repeatedly forget how to do them."

Q And then the next sentence says "We have to walk her through the same steps over and over and she does not seem to remember them from day to day." Is that right?

A Yes.

Q Okay. And if we go back to Exhibit 24, which was the affidavit of [redacted], and look at paragraph 14, can you read the first sentence of paragraph 14?

A "Over the last year, Judge Newman would make statements to me that her phone and computer were being "bugged" and "hacked" and that bloggers at the media were out to get her and bring her down" -- "and media. These would seem to occur at least once a week and most frequently on our Monday calls."

Q Okay. Now, on page 27 of your report, if we could take a look at that. If you look under DEMEANOR at the second full paragraph there, it says that you've reviewed the affidavits of various court staff. And then the second sentence, Could you read the second sentence there?

A "While I understand that Judge Newman recollects several episodes differently than the affiants, I do not endeavor to resolve which recollection is more accurate, and, for the purpose of my evaluation, take affiants' statements at face value."

Q Okay.

A "I do note that most of the reports of Judge Newman's outbursts concerns events that occurred following the launch of the present investigation and thus may be explained by the stress occasioned by this process. At the same time, if there was any inappropriate behavior towards colleagues or subordinates by Judge Newman, I do not seek to justify or excuse it."

Q Okay. So you note there that Judge Newman recollects several episodes differently. What did Judge Newman tell you about these episodes?

A She just minimized the degree of agitation. She said she might have been irritated or she might have had a moment of forgetfulness, but that it had been magnified in these reports. And I would say,

"You know, working, having employees, I've seen this kind of thing with people of all ages.

I've seen it between Harvard faculty members. I've seen it." So one, those happen, and two, I think another -- one of the -- so the three things they're complaining of are impairment of new memory formation, excess anger and irritability, and some paranoia. So -- and the one that's -- one of the ones that's most concerning, say, about work would be impairment of new memory formation.

And maybe that syncopal fall, she did have an impact and the crus of the fornix was injured 'cause we don't have the MRI, and Aricept would fix that if she took -- because that is a very focal problem that responds well to a medication. But it's not -- those -- now, it is true that people with Alzheimer's deterioration could have those symptoms, among other things, but those symptoms by themselves in an older senior employee with a lot of authority don't add up to --

Q I asked a specific question.

A -- degenerative dementia.

MR. MORRIS: [Unintelligible response.]
BY MR. PHILBIN:
Q Okay. Please try to just answer the question that I ask you.
MR. MORRIS: Understood. But he -- fair enough, he's entitled to finish his answers.
MR. PHILBIN: We'll be here a long time.
MR. MORRIS: Well, he's entitled to finish his answers.
MR. PHILBIN: [Unintelligible response.]
BY MR. PHILBIN:
Q Did Judge Newman deny to you that she had complained about her computer being hacked?
A I didn't discuss it in detail, but my understanding of it was she felt that her comments were exaggerated in an unfavorable light.
Q Okay. And when you say that for purposes of your evaluation you "take the affiants' statements at face value," what does that mean? You say you're not trying to resolve the dispute; you take them at face

value. Does that mean you're not disputing that these things happen?

A So I have to get involved in HR 'cause I have employees. If an employee comes in and says, "This is what I experienced from that other person." Now, I may accept that is true, that person did behave badly and these episodes happen from time to time.

And then you have to try to, you know, try to balance, was there a particular episodic reason? Do you need to terminate the person? What's the level of the misbehavior? What's the frequency? Is she doing this constantly? Is she unable to do her work? So it has -- it -- it has context. So I'm not in a position to determine the accuracy of the -- the statements.

I understand their affidavits and I state that. But they don't -- so let's say if a Harvard professor was doing that, okay? Who's producing important academic work and books that are widely read, but he's paranoid, he's nasty, and he forgets stuff all the time. Do we need to remove him from his faculty position? Do we need just to counsel his

graduate students?

So these are -- you know, this is -- these are the questions. Is it dementia? Well, based on his work, how is somebody demented and still doing the work that we see? Or you might find another person who's very nice, but no longer is able to produce anything as a professor. And then, you know, so they're not doing their job of producing, of teaching and producing research, and that's -- you know, that is what you look at.

So these are behavior concerns for sure, and they're very common problems for HR departments, I can assure you. Whether they prove dementia, warranting removal of a judge, again, is beyond my scope. That is -- I don't know what the rules are on that. But they are each describing specific isolated types of behavior, which I just characterized: memory impairment, paranoia, and excess aggression, which -- which they do say is episodic.

It's not all the time, but, you know, that -- those could be going on absent, let's say Alzheimer's or, you know? So -- so those are --

and -- and they may be actionable. So it may be that if you yell at one clerk once, you have to be terminated from the court. I -- I don't know.

Q Okay. But just in terms of do these statements provide evidence? I think you said it was behavioral issues. Do they provide evidence, some evidence, some evidence of potential cognitive impairment?

A Not cognitive impairment. Those are specific. I can tell exactly where in the brain each of those is occurring, and it doesn't -- this idea of a global cognitive, like the whole brain gets better or worse. There -- the brain is not like a computer that has thousands of identical transistors, each of which can do whatever is assigned to them at any moment.

Different parts of the brain do different things. And there are conditions where the whole brain is deteriorating, a virus or certain types of Alzheimer's that are just dramatic global deterioration of the brain. And there are other things where the brain looks fine, but there's a

particular circuit that's impaired and that's fixable.

So right now what I'm getting from these is they're not saying that she's mentally incompetent. No one's addressing how these opinions are -- court opinions are being produced. The types of behavior being addressed here, as I said, are very, very common in HR, as I've seen it again and again.

Q Do these statements provide some evidence of memory impairment?

A Well, some of it are -- they're stating they believe it's memory impairment. So maybe when she fell, she hit her head, and she's got that memory formation problem.

Q I have a specific question. Do these statements provide some evidence of memory impairment? Do you think they provide some evidence of memory impairment or not?

A I already answered that. I just answered it again.

Q Well, I don't think you did, Doctor, so please just answer the -- is there some evidence?

A It's new -- it's -- new memory formation is

different from recall, and the types of recall implicate different parts of the brain. So they seem to be saying, for instance, that she takes a course, she looks at it, and then is not able to report back what the course said.

So she has an impairment of new memory formation, which I asked her about. She denies. They're stating they've seen signs of it. It's hard to know if it's episodic, that is, she comes in and out, or she continually is unable to form new memories. If that's the case and she had a head impact, I would suspect that it's a focal problem in that memory formation circuit, and it would respond to, say, Aricept. Not -- it doesn't fix dementia. It just fixed new memory formation.

Q Is that something, since you raised that she did have a falling episode, and it could be something that's treatable, is that something that should be explored?

A Yes. I mean, I think that's -- you know, pointing that out. But she denies it. You know, she had denied she had -- I thought she would acknowledge

problems in new memory formation because that's very common, and she's very firm that she was not having that problem. And I did test her, which is I gave her, you know, I described to her a complex technology, one in matter-antimatter physics, another in complex genetics, and another to do in patent history about the printing press, and asked her to repeat back to me the technology that I just described to her, and she did that accurately.

So while she may have demonstrated poor memory formation at some episodes, I directly examined that in an intensive way that many people could not pass, and she was able to describe back what I verbally described to her. And I don't think they're saying -- everyone's globally saying, she doesn't remember anything anymore. But they do cite some episodes where she appears to have had a problem with memory formation, and if she did hit her head when she fell, that may be the explanation.

Q Okay. So you acknowledge there is a possibility that she does have a problem with new memory formation?

A She denies it. I didn't find it. But these people are making affidavits saying that she has such a problem, not that she's caught -- so you want to take that and say, obviously this is a severely cognitive impairment, but they're really very specific to three individual functional issues, and -- which, for whatever reason, she doesn't exhibit continuously because she certainly was not acting paranoid or hyperaggressive. Or even I gave her opportunities to open up and criticize her colleagues, and she did not do so.

Q Okay. But, Doctor, I just want to understand your opinion in this case, have you ruled out that she has any problem with new memory formation?

A Well, she says she didn't. She didn't have it when I tested her. And this is different from usual medicine where you have somebody who maybe has a conflict with her under outside pressures. They don't want to get the judge more angry at them, are making the statements confidently as affiants. And they may be describing a failure to remember something that

occurred under the stress of the investigation, or it may be going on all the time.

I'm just saying I did examine her for this issue. I'm not able to do an MRI to see that particular mechanically sensitive structure involved in new memory formation. If a patient denies a symptom, they're not going to take the medicine. But that -- there are several of these that can be specifically treated, but they don't add up to global cognitive failure.

Q Okay. I understand, Doctor, you just went through sort of all the pieces of evidence that are available to you. But what I want to understand clearly is your conclusion. Are you ruling out that she has an impairment with new memory formation, or are you holding open the possibility that given these affidavits that might very well be a problem?

A Yes, and it's one of those that's fortunately easy to fix.

Q Yes, you're holding open that that might be a problem?

A Based on these affidavits, but as I said at

the time, she denies that these are accurate. And so you really can't get a person to take a medicine for a problem that they claim they don't have. That's -- you know --

Q Okay.

A So -- or if I tested them and found --you know, you -- rather than say, "Can you, you know, count backwards and forwards, or remember a story I just told you," I gave her a complex judge, you know, patent judge level, detailed presentation of new technology she could not have known about, and she was able to describe back the substance and also to appreciate the legal issue.

And I don't think these clerks are saying she couldn't do that 'cause they're not addressing that kind of issue. So that we have conflicting information, and as you know as an attorney, one always has conflicting attorneys, that's why we have trials and that's why we have these litigation processes. And we have to try to adjudicate fairly and equal -- evenly how do these different competing sets of informations lead us to a correct assessment

and action.

Q Okay. Is it always the case that some impairment in new memory formation could be treated? You mentioned Aricept. Is the cause of that problem always treatable?

A That particular feature is usually treatable, yes.

Q The particular feature, if she had an injury to a particular part of her brain that --

A Well, they -- they use that medication to treat people who have Alzheimer's and develop that impairment as part of a global brain -- brain functional loss. Okay? However, we also have found it far more effective in patients, even young patients, who suffer that as a -- as a specific loss that comes from some head impacts or accelerations because it's extremely mechanically sensitive and it has that striking feature of impaired new memory formation even when global recall of the past seems to be intact.

Q So is it your testimony that anyone who has a problem with new memory formation, that's treatable?

A Well, most people, yeah. I mean, it's -- when I can get a -- if I get an image of their fornix, it shows they have a fracture there, and there are implants that are done now to treat this.

Q I don't want to limit it to people who have a fracture in their fornix. I want to say anybody who's got a problem with new memory formation, which could include people with Alzheimer's, could include people with other kinds of dementia. All right. Could involve people I know you don't like the diagnosis, but MCI that's been diagnosed by a neurologist, are you saying that all of them get treated and it can be fixed with this Aricept?

A Well, they're all worth a trial in the medicine.

Q Okay.

A So in most -- many -- I would say that the majority of people will improve on new memory formation with Aricept or Donepezil as a generic. So it's worth a try. Now, if she has that and acknowledges a problem and takes the medicine and finds out, "Wow, my memory's better, therefore I'm not

angry and paranoid because information isn't missing." So it could be something as simple as that.

It doesn't mean that their brain is gone. Mild cognitive impairment is a broad term. It would include someone who is grossly -- you know, relatively generally demented globally. It could include somebody who just has a little memory -- clear memory formation problem. You can call them mildly cognitive impaired. It covers many, many, many things, just calling like somebody somewhat disabled. What's wrong with them? Well, a lot of things could be wrong with them.

Q Okay. I had a couple questions about Dr. Rothstein's report and your references to it. On page 41 of your report -- if you could go to page 41 of your report.

A Yes.

Q In the paragraph sort of in the middle, maybe the lower half of the page that begins with the word "Ultimately."

A Yes.

Q It says "Ultimately, the central point at

issue here is the need for testing." Do you see that?

A Yes.

Q And then it says "Judge Newman already has the opinion of her senior respected neurologist, Dr. Ted Rothstein." Do you see that?

A Yes.

Q So is it fair to say that here you are relying in part on Dr. Rothstein's report to support your conclusion that no further testing is needed?

A Yeah. I mean, I'm saying that they found she's fine and then my analysis did. So, yeah, it seems like there's sufficient findings --

Q Okay. And similarly on page 40, the previous page, if you look at -- there are numbered paragraphs there at numbered paragraph 4, it says "I'm confident in stating" -- and there's an open parenthetical -- "(consistent with the opinions rendered by Dr. Ted L. Rothstein and Dr. Regina Carney) that there is no material concern that requires further medical testing." Do you see that?

A Yes.

Q And so, again, are you pointing in part to

Dr. Rothstein's report to support your conclusion that no further testing is required?

A Yes. I mean, normally if I send someone to a neurologist or a neuropsychologist and they both say the person seems fine, I do the evaluation imaging, they seem fine. I mean, if you have an investigation and you're determined -- to get a certain result, you will ignore opinions inconsistent and just keep testing until you find a result that's consistent with your -- with your predisposition. Courts shouldn't do that. That's not how medicine is practiced.

Q Okay. I think you just said if you send someone to a neurologist or a neuropsychologist. In what circumstances do you send a patient to a neurologist?

A If I believe they have a condition that neurologists treat as opposed to a neurosurgeon. So there are a number of conditions they'll treat, like management of non-surgical epilepsy. So if they have epilepsy, we'll look and see if there's a lesion that we can treat and repair. If it's not, then they're going to be on medications and need a lot of

follow-ups. Migraine typically is handled by -- by neurologists.

Q Alzheimer's?

A A number of degenerative disorder -- disorders that have medical treatment are handled by neurologists.

Q Would Alzheimer's be one?

A Well, if they don't have any treatment, then they don't -- you know, they just check on them, you know, just check for stroke and seizure. But they, you know -- there's not -- there isn't a cure or treatment or even an excellent, really super excellent diagnosis for Alzheimer's. There's a lot going on in that field.

Q If you had a patient who came to you wanting to find out if I've got some kind of age-related cognitive impairment, and you did your workup and you thought they had Alzheimer's, is that a patient you would send to a neurologist, or what do you do?

A Well, they may be -- they might go back to their general practitioner. They could go to a neurologist, who neurologists may not treat or take

care of Alzheimer's. They may get another opinion, you know, based on their test, it seems like Alzheimer's.

But if you have an image diagnosis and a biological diagnosis from a blood test, then, you know, the person may want to wind up their affairs, look at what's the best care situation, whatever medical people they need to help them. I mean, a neurosurgeon at that point can't really do very much to fix up the Alzheimer's, if that's what it is.

That's a particular degenerative disorder that's only just so well understood, but it's certainly a common cause of progressive dementia. But we should -- I don't think that's what we're seeing here.

MR. PHILBIN: Okay. You know, it might make sense to take a ten-minute break now, if you want a break.

MR. MORRIS: All right.

THE REPORTER: Okay. Then the time is currently 3:01 p.m., and we're going off the record.

(Off the record.)

THE REPORTER: Okay. We are back on the record, and it is currently 3:13 p.m.

You're good to begin.

BY MR. PHILBIN:

Q Dr. Filler, before the break, we were talking about some of the affidavits that court employees have submitted in this case. Do you remember that?

A Yes.

Q And when did you receive those affidavits?

A My general -- general recollection was around the date of the visit. I can't remember specifically, because I got the prior reports and the affidavits, I think, in a packet.

Q When you say the "prior reports" --

A I mean the evaluation by the neuropsych and the neurology, Rothstein.

Q So you received the report from Dr. Rothstein and the report from Dr. Carney and the affidavits together in one set?

A Yeah. I can't be extremely specific, but I feel like they came together and I had to look through

them.

Q And you think that was before the day that you saw Judge Newman?

A It might have been on that day.

Q It might have been on --

A And sometimes they -- something might have come in my office, and the thing is I'm so busy taking care of so many people that I tend to wait until I'm focused on a particular person to start going through their -- their things.

Q Okay. So you think you might have reviewed those when the morning of the day that you saw Judge Newman?

A If they were in my position, that was when I would have looked at them.

Q Okay.

A Otherwise then, or if I hadn't had a chance to look thoroughly, I would have looked at them, as I note here, at the time of preparing the report.

Q But you're not sure which it was?

A Or it might have been both.

Q Okay. But do you recall specifically

discussing those affidavits with Judge Newman?

A Yeah. I remember having some trepidation about it, but I -- you know, I wanted to bring that up, you know, and say, "I understand there are some employee issues that have been raised. What's your impression about this?"

Q Okay. Then I'd like to turn to your report.

A And I don't know if any of them are under litigation as of their workplace complaints against the court or --

Q Yeah. If there is, it's something separate from this proceeding. So if we could look in your report at page 16.

A Yes.

Q In the full paragraph towards the top of that page, the last sentence of that paragraph says "There is substantial medical literature that convincingly supports the proposition that high-speed perfusion brain imaging supplants the inevitably subjective practice of neuropsychology in the fundamentals of cognitive assessment." Is that right?

A Yes.

Q That's what it says. Okay. And then on page 3 of your report, in the paragraph in the middle of the page, there's a sentence in sort of the middle of the paragraph that says "As a result of these stunning advances in spatial and temporal resolution, there is now a widespread medical understanding that Perfusion CT can be used to identify or rule out the presence of dementia or cognitive impairment on a reliable, objective basis." Is that what it says?

A Yes.

Q Okay. And I just want to level set some terms and understand what you're saying. This sentence seems to distinguish or to acknowledge that there is a distinction between dementia and potentially other forms of cognitive impairment. Is that right?

A Well, I mean, dementia is a broad term. So, you know, it kind of says something's wrong with your brain and we don't know what it is. Because if you talk just like I listened to those reports and didn't say dementia, I said, "Oh, well, we have new memory formation. We have excess anger. We have some

paranoia."

So these are specific symptoms with specific locations in the brain. So you might say "It's the approach to the patient who is a generalist or non-physician thinks may have dementia. So what do we do? We should interview and examine the patient, try to sort out the symptoms, and do, when available, appropriate imaging to identify a diagnosis we can treat and/or medications we should use. So as opposed to classifying them as normal or demented and not knowing what to do to treat."

Q Okay. Doctor, what I'm trying to get at is basically this. You made claims about imaging and perfusion CT being able to identify or rule out, sort of rule in or rule out some things. Sometimes it's phrased as they can identify or rule out dementias. Other times it's phrased as they can identify or rule out dementias or all forms of cognitive impairment. I just want to understand what is the claim you're making. Are you distinguishing between dementias and cognitive impairment or not?

A Okay. So -- and I -- I had put together a

PowerPoint with a bunch of, you know, literature searches and all that, which I was just advised not to -- I wanted to have it sent to you, but -- this moment would come. But there are very substantial literature, so you're looking into hundreds and even thousands of publications. Okay?

So -- and some, you're shaking your head, but all right -- so there are certain named dementias, so Alzheimer's, dementia. There are, and several of those have unique image characteristics, and you can run the image and say, "That person has Alzheimer's dementia. Or, no, no, that person has this other type of dementia."

So a number of them turn out to have extremely specific image findings. So you can run the image and say, "Yeah, they have that disease, and this is what we can expect their course to be to the extent we know, once we have somebody with that diagnosis." Sometimes a diagnosis can be made by a blood test. Sometimes it's made on purely clinical grounds.

So one is -- is the -- and -- and then similarly with cognitive impairments, as long as it's

a black box and we don't know what's inside the brain, and we do a bunch of tests and come up with a score, that says, "Oh, cognitive impairment," as opposed to saying, "Oh, well, this is new memory formation. This is a failure to recall faces in a person who remembers other types of visual information. We should look at what part of that image recall process has got some little, you know, stroke in it or something."

So it's that process. And the fact is, when you see 1,000 publications, okay, if we don't add them up, I agree, but it does mean that there is substantial -- when a number of them and reviews of them state that they are -- and compare to older methods and show that they are reliable in identifying correct and effective treatments.

Q Doctor, I'm just trying to understand so we're using the same terms the same way. I'm just trying to understand. You're saying that the imaging can rule in or rule out, at least let's just start with, dementias; correct? And there could be Alzheimer's dementia, could be Lewy body dementia, frontal temporal dementia. There are several types of

dementias. And your claim is that the imaging can rule in or rule out each of those types of dementias. Is that much true?

A Yes.

Q Okay.

A Yes. And they're actually showing they can show people, looking at people with the genetics of the disorder, that you can identify when it starts earlier than the tests can. So it's -- it's very helpful.

Q Okay.

MR. MORRIS: His question for now is rule in or rule out.

THE WITNESS: Yeah, in some cases, yes.

MR. MORRIS: Terminological, I think.

BY MR. PHILBIN:

Q In some cases or in all cases?

A Well, I didn't say every known condition known to man is now immediately identified by imaging. But I did say that several of the major dementias can be identified by specific image abnormalities and that account for the vast majority of dementias. So it's

well, well worth doing before you start turning back on tests that go back centuries. If you have nothing else you can do.

Q Okay. So I think you just said you are not saying that the imaging can rule in or out all forms of dementia. Is that correct?

A Yeah, I would say it's the major ones that have been studied, yes.

Q Okay. Then putting dementias aside, I think you were acknowledging that there can be somebody who has, in a general way, some kind of cognitive impairment that is not qualified or classified as one of those dementias. Is that fair?

A Yes.

Q Okay. So then my question is, are you claiming, is it part of your claim here, that the imaging can also rule out any of those types of non-dementia cognitive impairment?

A I would say, let's not say all, but let's say many or most of the major types of cognitive impairment now have identifiable image characteristics.

Q Okay. But not all?

A Right. There's maybe one person who has something that no one else has, so "all" would be a broad term.

Q Okay. So if you could look at your reply report, which I think was Exhibit 4, on page 15, paragraph 29.

A Yes.

Q At the end of that paragraph 29, it says "Perfusion CT is newer, but it does work to effectively, objectively, and conclusively, rule out the known forms of dementia." Do you see that?

A Yes.

Q So should that be more qualified, that it's most dementias, not necessarily all?

A By known forms, I'm talking about they -- there are studies in, I think, virtual, I can't say 100 percent, but all the different named subcategories that have identified genetics or identified behavior patterns. So the -- let's just say the major known forms of dementia would be better. But I say rule out the known forms of dementia. There may be those that

are not known because we don't -- you know, we know they're demented, but we don't know -- we can't figure out how to describe it or something. So I would say that, yeah, you could qualify it a little bit. The better-known forms of dementia. How about that?

Q Okay. Then I'd like to ask you a couple of questions about a couple of the academic articles, the studies cited in your report. Okay. So this is 27, Exhibit 27. And do you recognize this?

(Exhibit 27 was marked for identification.)

A Yes.

Q This is an article or a study prepared by Dash et al.? Is that right?

A Yes.

Q Okay. And if you look under methods there under the abstract, it says this was a study enrolling 25 dementia patients. Is that right?

A Yes.

Q So this study involved, and then in the parenthetical there, 15 cases of -- lost where the definition of that is. It's vascular dementia.

Fifteen of vascular dementia and ten of Alzheimer's dementia. Is that right?

A Yes.

Q Okay. And I think that in your report on page 17, you describe this report as saying that "perfusion CT is a reliable imaging modality for early diagnosis of dementia and differentiating vascular dementia from Alzheimer's dementia." Is that right?

A Yes.

Q Okay. But it didn't examine any subjects with any other form of dementia --

A Not this study.

Q Okay.

A But remember, there's hundreds of studies like this.

Q So if we could look at page 324 in the last paragraph before the conclusion, it begins with the word "certain."

A Right. And they -- they always put that, you know, reservation in public -- published articles. All the things that they haven't looked at yet and -- because if you're reviewing an article, they'll say,

"Oh, well, you guys should acknowledge it doesn't do this, it doesn't do that." But it doesn't mean that this study is worthless or something.

Q My question, Doctor, is just that this says there are certain limitations that they must acknowledge; correct?

A Of this particular study, yes.

Q Right. And they say that their sample size was small because it was only 25 people; right?

A Yes.

Q And second, we only evaluated the two most common forms of dementia, that is Alzheimer's dementia and vascular dementia. Correct?

A Yes.

Q Okay. So this study didn't involve forms of cognitive impairment that were non-dementia; correct?

A Right. No, it's just about those two.

Q Okay.

A There's no contention about that.

Q Okay.

A But there's not a contention this is the only -- are you contending this is the only study ever

done about perfusion?

Q I'm just asking questions, Doctor.

A Well, you're making contentions.

Q So on the first page, if you could look at that, that's page 318 of the publication, the very first page of the exhibit. Down in the right-hand corner, the second to last sentence on the page starts with the word "however." And can you read that sentence and the next sentence?

A "The role of PCT in evaluation of dementias is still at a nascent stage. Few studies in this context have shown conflicting results regarding the areas of brain affected and which are the most reliable parameters. Most of these studies also had limited coverage of the brain as they used lower slice count CT scanners."

Q Okay. And what was the date of this publication?

A This is 2024.

Q I think it's --

A '23 -- sorry.

Q '23. Okay. So just a year before you did

your report in this case; correct?

A Or it was -- it was released in 2022, January 2022.

Q Okay. Then if we could --

MR. MORRIS: It was accepted in 2021, at the bottom it says. Fill out the dates. Accepted December 31, 2021.

BY MR. PHILBIN:

Q Okay. So the study was completed then in 2021. Is that fair?

A Yes.

Q Okay. All right. I've handed you what's been marked as Exhibit 28. Do you recognize that?

(Exhibit 28 was marked for identification.)

A Yes.

Q Which is an article by Jian et al?

A Yes.

Q Okay. And you cited this study in your report, didn't you?

A Yes.

Q Okay. And this study conducted a perfusion

CT scan on 180 different patients. If you look at the methods there. And they were grouped into categories of there was a control, there were 30 patients with MCI, 35 with mild Alzheimer's disease, 35 with moderate Alzheimer's dementia, and 30 with severe Alzheimer's dementia. Do you see that?

A Yes.

Q Okay. Now let's turn to table 2, which is on page 4761. Are you familiar with the term p-value?

A It's a probability assessment.

Q And do you see down at the bottom of this table, it says that -- there's an asterisk against the entries on the table with a p-value of less than .05?

A Yes.

Q And that means where there was less than a 5 percent chance that the results were due to random chance; correct?

A Right.

Q Okay.

A Or stated positively, 95 percent confidence interval that that's -- that they're the normal is separate from the finding.

Q So in this table, the columns are divided up NC for the normal control; right? That's the first column.

A Yeah.

Q And then the next column is MCI. And then there's a column for mild Alzheimer's disease, a column for moderate Alzheimer's disease, and a column for severe Alzheimer's disease. Do you see that?

A Yes.

Q Okay. So for the column that's MCI, mild cognitive impairment, do you see any asterisk on any of the readings in that column?

A No.

Q Okay. So doesn't that mean that the authors here are reporting that there was no finding, no value for mild cognitive impairment with the CT perfusion being done here that had a p-value of less than .05?

A Not yet. This assessment was not able to distinguish them.

Q Okay. But so there's no asterisk in that column, no p-value less than .05?

A Yeah, not in this study.

Q Okay.
A Which is from 2015, 10 years ago. Or received 2016. Sorry.
MR. PHILBIN: Could you hand me -- okay. All right.
BY MR. PHILBIN:
Q I'm handing you what's marked as Exhibit 28 [sic].
(Exhibit 29 was marked for identification.)
MR. MORRIS: Twenty-nine.
MR. PHILBIN: Twenty-nine, yeah.
MR. MORRIS: Twenty-nine.
MR. PHILBIN: I think we've -- I think it should be 29.
MR. MORRIS: Yeah.
THE REPORTER: Oh, yeah --
BY MR. PHILBIN:
Q Okay. Actually, first I'd like to go back to pages 16 and 17 of your report.
A The main report?
Q The main report.

A Okay.

Q Okay. And down at the bottom of page 16, it refers to the article, the exhibit I just handed you, the Metting article. Do you see that?

A Yes.

Q And it says it was -- in the report here, it says it was based on a study of 191 patients?

A Yes.

Q And then on the top of page -- well, and let me just read this "where a variety of neuropsychological batteries are used and then compared to CT results," -- I'm reading from your report there at page 16 -- "impairments in executive functioning and emotion perception assessed with neuropsychological tests during follow-up were related to differences in cerebral perfusion at admission in mild traumatic brain injury cases." Is that correct?

A Yes.

Q And it says "It further concludes that the focal cerebral perfusion data provides an objective basis for assessing the same functions that the neuropsychological testing such as facial expression

of emotional stimuli and tests, the zoom app test for behavioral assessment of dis-executive syndrome, the ADS battery, the trail-making test, immediate recall, Rey auditory verbal learning test, and two-hour battery of various neuropsychological tests." Correct? That's what it says?

A Yes.

Q Okay. So I'm still just on your report. I just want to understand what your report says for now. Doctor, you're with me?

A Yeah.

Q Okay. And so in your report, you list seven neuropsychological tests there, I think. And I'd like you just to focus on what's in the report so I understand what you're saying.

A Mm-hmm.

Q So in the report, you're saying that the CT perfusion is an objective way to test the same thing as Facial Expression of Emotional Stimuli and Tests, which is called also FEEST, isn't it? You're familiar with that?

A Mm-hmm.

Q Is that a "yes"?
A Yes. Sorry.
Q Okay. It also tests the zoom app test for behavioral assessment of dysexecutive syndrome; correct?
A Is any of this in contention?
Q Doctor, just --
A Because eventually we're going -- we're going to time out here.
MR. MORRIS: Let him get through the question.
THE WITNESS: So --
MR. MORRIS: Just let him get through the question.
BY MR. PHILBIN:
Q Doctor, if we could just focus on your report.
MR. MORRIS: Just let him get through the question --
BY MR. PHILBIN:
Q Okay. On the top of page 17, you list seven things, seven neuropsychological tests.

A You've been saying that over and over again. Come on. What's the question?

Q I just want to confirm that these are the seven. One is the --

A Yeah, it's written in there. It's written here. Those are the tests they're talking about --

MR. MORRIS: Just hear the question and move on.

BY MR. PHILBIN:

Q Doctor, you have to just answer the questions that I ask.

A Well, but at some point, I'm going to have to leave, so let's try to move it along a little bit.

MR. MORRIS: Let's take a five-minute break. I think that'll be helpful in moving this along.

THE REPORTER: Okay.

MR. PHILBIN: Okay.

THE REPORTER: So the time is currently 3:42 a.m. -- p.m., and we are going off the record.

(Off the record.)

THE REPORTER: We are back on the

record, and it is currently 3:44 p.m.

BY MR. PHILBIN:

Q Okay. Doctor, we were just on page 17 of your report at the top. And I just want to make sure that I understand the statement here about the Metting article, which is that the article concludes that focal cerebral perfusion data provides an objective basis for assessing the same functions as neuropsychological testing, such as --

MR. MORRIS: I'm sorry. We're just getting on your page. You're back on page 17 of the report; right?

MR. PHILBIN: Yes.

MR. MORRIS: Okay --

BY MR. PHILBIN:

Q Okay. Such as, and then it lists some tests. I want to make sure that we're talking about the same thing. So one is facial expression of emotional stimuli in tests. That's number one; correct?

A I think you did. He already asked these questions. He asked them one by one.

THE WITNESS: Can you read that back?

MR. PHILBIN: Doctor?

MR. MORRIS: Just answer and we'll --

BY MR. PHILBIN:

Q We had to take a break because you weren't answering the questions. Are you going to answer the questions now?

A Yes. I'm just pointing out that you're repeating yourself over and over again. And I've already said that I don't like to answer the same question twice because the point is just to get a slightly different word expression.

Q I'm trying to get the first answer, Doctor. So I just want to go through these. Is the first test there facial expression of emotional stimuli in tests?

A Yes.

Q Okay. Second is the zoom app test for behavioral assessment of dysexecutive syndrome; correct?

A Yes.

Q The third test is the ADS battery; correct?

A Yes.

Q Okay. The fourth test is the trail-making test; correct?

A Yes.

Q The fifth test is immediate recall; correct?

A Yes.

Q The sixth test is the Rey Auditory-Verbal Learning test. Is that right?

A Yes.

Q And the seventh thing that you list is a two-hour battery of various neuropsychological tests; correct?

A Yes.

Q Okay. So let's look at the Metting article. Okay. In the Metting article, if you look at the ABSTRACT, at the end of the first paragraph, it says "As the admission computed tomography (CT) often is normal, perfusion CT imaging may be a useful indicator of brain dysfunction in the acute phase after injury of these patients." Do you see that?

A Yes.

Q Okay. And so what this study was looking at is patients who had mild traumatic brain injury and a

CT perfusion was done on them in the acute phase right near the time of the injury; correct?

A Yes.

Q And then neuropsychological testing was done as a follow-up some months later?

A Yes.

Q Okay. And then -- okay. Let's look at page 25 of the article. And if you look at the top right-hand column, there's a paragraph there that says "In total, 191 patients were screened for inclusion."

A Yes.

Q Okay. But then you see it talks about several -- a lot of the subjects had to be excluded, and the conclusion is, at the end of the paragraph, 18 patients were suitable for further analysis."

A Yes.

Q So isn't it correct that this study actually reported results and was a study, ultimately, of 18 people?

A Yes.

Q Okay. Now, let's look at --

A And I'm not submitting this as proof of the

entire field. As I've said, there are hundreds of articles which I cite, you know, explain how to locate them, so that I don't think -- I mean, I understand -- I don't know where you're going with this.

Q Well, let me ask you --

A My frustration is that by pointing out a particular word or a small error on one study, it doesn't eradicate the whole field.

Q I understand that, Doctor.

A So I think it's enough to say that this study supports that, and it's one of many more.

MR. PHILBIN: Counsel, there is no question pending, and so I'm not going to have this count against my time.

MR. MORRIS: Got it.

BY MR. PHILBIN:

Q The purpose here, Doctor, is for me to ask questions to get information from you. It's not to argue the case. Okay?

A [No audible response.]

MR. MORRIS: Go ahead and ask a question, and he'll answer it.

BY MR. PHILBIN:

Q So let's look at page 26, and right at the top in the left-hand column, there's a heading 2.4, Neuropsychological test measures.

A Yes.

Q Okay. And then there are headings there that show the test measures. The first one is 2.4.1, which is the words test. Do you see that?

A Yes.

Q And it says the 15 words test is a verbal memory test.

A Yes.

Q Okay. And then the next test is the trail-making test.

MR. MORRIS: We'll just wait for a question.

BY MR. PHILBIN:

Q Do you see that?

A Yes. But didn't you just --

THE WITNESS: Didn't he just run through those three times?

MR. MORRIS: Just answer the question.

THE WITNESS: He's just trying to harass --

MR. MORRIS: Just answer the question.

BY MR. PHILBIN:

Q The third test is the Zoo Map Test. Do you see that?

A Yes, as I testified previously three times.

Q Okay. Well, let's look at page 17 of your report. What you put here is a "zoom app test." Do you see that?

A It might be a typo or from -- some -- some other shift in the lettering.

Q Okay. But then the Zoo -- in article it explains the Zoo Map Test is a subtest of the behavioral assessment of the dis-executive syndrome or BADS battery." Do you see that?

A Yes.

Q Okay. In your report on page 17, you listed the ADS battery as a separate test. Do you see that?

MR. MORRIS: On page 17 here.

THE WITNESS: Okay.

//

BY MR. PHILBIN:

Q Okay. So it's not -- there wasn't really a separate ADS test, was there?

A It looks like a -- that it should be -- it's a sub -- sub aspect of the BADS test.

Q Right. The only test that was given was the Zoo Map Test, which is a sub aspect of the BADS battery; correct?

A Yes.

Q Okay. And then the last test listed here on page 26 is the FEEST, the facial expression of emotional stimuli in tests; correct?

A Yes.

Q Okay. So there were only four neuropsychological tests actually administered in this study. Isn't that right?

A Sure.

Q Okay. Let's look at page 27. If you look in the left-hand column under the heading Neuropsychological tests and cerebral perfusion, do you see that heading?

A Yes.

Q Okay. If you go down to the second paragraph, it says "There were significant (P < 0.05) differences in cerebral perfusion between those with normal and abnormal scores on the Zoo Map test and the FEEST." Do you see that?

A Yes.

Q Okay. And then if you look on the next page, on page 28, there's a figure in figure 1. It shows a bar graph showing the results of correlation between the cerebral perfusion tests and the Zoo Map Test and the FEEST. Do you see that?

A Yes.

Q And the caption below the figure says "Cerebral perfusion in relation to neuropsychological tests. Significant" -- again -- "(P < 0.05) differences in cerebral blood volume, mean transit time, and cerebral blood flow between those with normal (dark bars) and abnormal (light bars) neuropsychological test results on the Zoo Map test and the FEEST." Do you see that?

A Yes.

Q So -- but this is not reporting any

significant correlations for the other two neuropsychological tests that were done?

A Yes.

Q And one of those was a memory test; correct?

A Yes.

Q Okay. And similarly, if we go to page 29, in the left-hand column, there's a paragraph right before the heading 4.3. There's a paragraph that starts with the words "explanation."

A Yes.

Q And it says "An explanation for the absent relation between cerebral perfusion and the 15 Words test and the Trailmaking test part B, could be that these tests contain more structure compared to the FEEST and Zoo Map tests." Do you see that?

A Yes.

Q So this is acknowledging that there was no statistically significant relation between the cerebral perfusion results and the 15 Word test and the Trailmaking test part B; correct?

A Yes.

Q Okay. So this article doesn't provide any

evidence for a conclusion that CT perfusion can provide a substitute for those tests, does it?

A Not for those tests.

Q Okay.

A It says "In conclusion, impairments in executive functioning and emotion perception were related to the cerebral perfusion tests." So it says it right in the conclusion. You're not -- you're trying to assert it says things that they didn't conclude and they didn't conclude them. You are right. And that took about 15 minutes. And my position feeling is that you're running out the clock.

MR. MORRIS: Just answer the question, and then we'll move on.

THE WITNESS: Because, you know, this is just one of many, many papers, so -- but it -- it does show a utility for this.

MR. PHILBIN: All right. Do we have -- yeah.

THE WITNESS: Sometimes it turns out that the neuropsychological tests weren't very good, and that is why they don't get confirmed by biology.

BY MR. PHILBIN:

Q All right. I've handed you what's been marked as Exhibit 30, I believe, which is an article by Latchaw. Is that correct?

(Exhibit 30 was marked for identification.)

A Yes.

Q And this is cited at page 27 of your report. And the paragraph starts on page 26 of your report, which says "Current reports indicating the relevance of Perfusion CT (and ASL-MRI), and their role in replacing neuropsychology evaluations as a result of the perfusion studies' much higher relevance and accuracy, are set forth in" -- and then it says "Dash and Zhang." We've looked at those. And then on the next page it cites Latchaw.

And I just want to understand, because I couldn't find it in here, where in this article is there the conclusion that the CT perfusion can replace neuropsychological evaluations?

A So what they're doing is they're looking at the results of a number of different studies. And

they're trying to decide on a guidelines basis if there's sufficient information to recommend replacing the test. So in the course of that, they cite a number of studies where the perfusion CT proves sufficient or helpful.

And, you know, to do a segment-by-segment analysis, which I would like to do, it will take me several hours now before answering your question, because, you know, there's a lot going on in this paper. However, it clearly concludes not that the studies are useless, but that they -- a number of different types of studies are helpful in a number of ways and more research should be done.

It's a -- it's a very typical summary. I think it was useful to cite because it provides an overview to the field and shows a number of areas where the imaging test is helpful. If they found it was not helpful, they would have recommended no further work. So it's an attempt to -- to present a guidelines. It has not -- and I don't say that it's been decided that all neuropsychology and MOCA should have to be abandoned as of today or you're

practicing -- or engaging in malpractice.

But I'm saying that there's evidence from that whole literature, some of which appears or -- or is recited in this article, that shows that this is a useful way and an objective. See, the other thing that has to do is it's more objective than when a -- a party engaged in litigation hires someone to do a talk-based analysis on their behalf.

So if the court hires a neuropsychologist in order to try to disprove the person's claims that they're fine, they feel an obligation to perform for those -- for their employer. So whereas if you have an objective test, it's more immune to those biases.

Q Okay. So I just had a simple question because this article was cited for the proposition that studies show that imaging can replace neuropsychological testing. And I couldn't find a sentence in here that seemed to suggest that.

A No, I think --

Q I take it that, as you sit here today, you can't point me to a sentence in here --

A Well, I can --

MR. MORRIS: Object to the characterization of the report --

THE WITNESS: -- I can stop for an hour and I'll -- I'll find a number of answers. It's a complex report. I read through it and reached that conclusion. My -- my citation isn't fine enough. I can find those if you want to stop, but I am going to have to leave at a certain point, and it's on your clock.

MR. MORRIS: Okay. Just answer the questions, and we'll move forward.

BY MR. PHILBIN:

Q Okay.

A I've not answered yet. I told you I was going to go through and do the analysis, but it's on your clock.

Q No, no, my question was --

MR. MORRIS: There's no question pending.

THE WITNESS: Unless you're going to withdraw the question.

MR. MORRIS: Dr. Filler, there's no

question pending.
BY MR. PHILBIN:
Q My next question, Dr. Filler, is back to your report at page 40.
UNIDENTIFIED SPEAKER: Forty?
MR. PHILBIN: Yes.
MR. MORRIS: Okay. Let's go on to the next exhibit, Dr. Filler, because he's on to the next question.
THE WITNESS: Okay. Thank you.
BY MR. PHILBIN:
Q On page 40 of your report where you have the summary of evaluation and testing --
A Yes.
Q -- under the second numbered paragraph, there's a sentence about in the middle that begins with the word "moreover." And it says "Moreover, there is exceptionally high flow bilaterally in the hippocampus which rules out all of the known causes of MCI, mild cognitive impairment, and any dementias." Do you see that?
A Yes.

Q Okay. So I think -- and I just want to confirm this, because I think we discussed that earlier, that I think you said you're not saying that the imaging rules out necessarily all forms of dementia or all forms of cognitive impairment. So I just want to understand, given this sentence, should this be modified a little bit to say all the major forms of dementia? All the major forms of mild cognitive impairment?

A Sure.

Q Okay. And then one question related to this statement that on the CT perfusion results, there is exceptionally high flow bilaterally in the hippocampus. So does that mean that the CT perfusion results that you got allows you to compare the cerebral blood flow on Judge Newman to other people? Is that what it means by exceptionally high, exceptionally high compared to other people?

A Yes. So in the tests that found utility for -- for hippocampal flow studies, they indicated that in several forms of dementia, the value of the flow was abnormally low. So in this case, for Pauline

Newman's scan, the -- the flow parameters were normal or high normal. So these did not show the decreased flow that's found in those patients demonstrating dementia in those studies that found the difference.

Q Okay. If I could direct you to page 35, it might help to look at the image.

A And there's a more complete set of that images in the supplement --

Q So on page 35, this is an image that has the label rCBF, which is cerebral blood flow. Is that right?

A Yes.

Q And this is the one with the arrows on the right and the left sides that say "High Focal Blood Flow" --

A And remember, this is one slice of a volume.

MR. MORRIS: Let him get his question out.

THE WITNESS: So I included this slice as a demonstration, but you have to look at the whole set to see the volume of the region that has the flow assessment. So basically the problem is that if you

were to measure the -- the flow at just one moment, you wouldn't get all the flow. But if you cover a sufficient volume, you'd get the entire volume that passes through the region in the period that's being assessed for flow.

MR. PHILBIN: Okay.

THE REPORTER: If we could just remember to wait for other people to stop talking before we start talking. I'm getting a lot of cross talk right now.

MR. MORRIS: Understood.

BY MR. PHILBIN:

Q What I'd like to understand is the data that you get from this -- I think it's ischemia from the software that's used on this. Is this showing you, whether by virtue of the red color or some other way, is it giving you an absolute measure of flow, which I would think is something like milliliters per second or something like that? Is it an absolute measure of flow? Or is it just comparing the left and the right-hand sides of her brain?

A No. It --it's the -- the actual reported

report, which, you know, again, I put in I think this PowerPoint, but -- and I have it more extensively demonstrated. So we attach the actual images. Okay. So you're just -- this -- so what we did in the report was just did a few frame grabs, but the images are the images. And what you see in the images is that they have quantitative metrics, and the color is used not to compare right and left, but to provide a quantitative metric.

Q So the color is something like different colors suggest different levels of milliliters per second or something like volume per unit of time?

A Yes.

Q And so it's on an absolute scale, the color. So if you've got red on this person's CBF, that's the same flow as red on that person's CBF scale?

A Right. And you may compare different -- you may compare different parts of the brain that may or may not be affected by a particular condition. So let's say you have a condition that causes impaired flow in just the hippocampus, which several of these conditions did, then you would see in the report that

they see in those patients, although normal flow in other parts of the brain, that there's a lower flow indicated by a different color in those patients in the parts of the brain that have the impairment.

Whereas in a person that does not have the flow impairment, they're seeing a similar rate of flow in the hippocampal tissues as in the other tissues not known to be affected by the disorder.

Q Okay. Then on page 41 of your report, Doctor, in the paragraph that begins with the word "Second."

A Yes.

Q There in sort of in the middle of the paragraph, there's a line that says "Perfusion CT" -- "the Perfusion CT results should be determinative." Do you see that?

A Okay.

Q And I just want to understand, in your opinion, in the opinion you've given in this case, how different parts of what -- of your evaluation fit together. Are you saying here that the perfusion CT results on their own, if all there is is the perfusion

CT, that's determinative? That's all you need to see?

A So what I'm trying to say is that, you know, based on my overall -- okay. So I found that she had excellent recall. She seemed to demonstrate -- legal capability to, when I -- argued before her as an attorney, in terms of identifying the relevant patent issues so that I would not be surprised if it were shown that she did indeed write her opinions, which seemed to be not -- not conceivably coming from a demented person.

I mean, when I showed doctors those reports and said, they're saying someone with dementia could write this, and they just laugh, you know, so -- because it's a misunderstanding of dementia. So I'm saying that, based on the exam and an objective test, that the underlying concern. So let's say their underlying concern is that there is a dementia taking place that jeopardizes the court and its -- and the parties that come before it.

So I would say, based on the things that I've looked at, this is part of this whole summary, which includes her opinions, the review of her

opinions by others who have reviewed them, my interview with her on complex technology and patent law, my neurologic examination, and an objective imaging test showing that she does not at least demonstrate any one of the major common forms of dementia.

That this information should be sufficient for them to halt the suspensions because it appears she is able to do her job. And that's -- that's my opinion, but I understand that that's just my opinion.

Q Okay. But what I'm trying to get at -- I understand we talked about earlier, in the part of your report that says "structure of the report," you set out sort of three areas: neurologic exam, neurological exam, the interview involving these three hypothetical cases that you gave her in evaluating her responses to those, and then the imaging. Is that right? Do you remember that?

A Yes.

Q And what I'm trying to get at is, let's say that somebody looking at your opinion said "I don't really buy this stuff about asking her the

hypothetical questions, and the neurological exam. I don't know. It was unconventional." And they were not persuaded by those. Is what you're saying here, the perfusion CT scan in itself, that you would have this result, you can stand alone just on the image? Or for you to have your opinion, do you need the image and the other parts as well?

A Well, let's say it was impossible to get an interview with her. And let's say it was impossible to do a neurologic exam. And impossible -- and all you had was, "We wonder if this judge is okay, and we've done a test." The test does not demonstrate any abnormality. So if you couldn't get any information on the other things, and the only basis you had was this objective test, it looks like she's fine.

Now the fact is that their opinion is going to be based on a number of things that I also address. So I don't think that they should be taken - I -- I did the other parts 'cause I understand they each play a role.

Q You think they each play a role. But I'm just trying to get your opinion. Would it be your

opinion that you could rely on the image alone? That's all I want to know is your opinion.

A No, if I would have -- could have done that, I would have just got the image, and I wouldn't bother to examine her or look at her work output. I've done all those things, including the interview examination, because I believe that taken together, you know, for this is not just to say she is not suffering from a particular dementia, this is to say can she be a practicing Court of Appeals Federal Circuit judge, which is far -- goes far beyond the level of competence that the usual dementia evaluation pursues and whether you can draw a zebra or, you know --

Q Okay. On page 36 of your report, towards the bottom, there's the heading there, COGNITIVE INTERVIEW FOR TECHNOLOGY AND PATENT LAW.

A Yes.

Q And in the first paragraph there, you acknowledge that written output is often dependent on assistance of law clerks and other staff members.

A Yeah. It's going to vary from judge to judge how they use them, but -- and I have no idea

what the process is in this court, because they -- they keep that -- unless you've actually been a clerk there, so I don't know. I mean, for some reason, the court -- the Judicial Council is treating her opinions as of not -- no convincing value. And I don't know. I -- have to guess why they -- it doesn't -- they don't consider that.

Q Okay. But you, for purposes of your evaluation, it seems like you didn't want to rely on her opinions either because you don't know how much help she gets with them.

A Well, I assume that they didn't -- that didn't convince -- it obviously didn't convince her colleagues, and I -- I'm only just suspecting because I thought, "How would that not be convincing? How do you write opinions that win in the Supreme Court if you're actually demented?" I mean, so I don't think I can imagine, and I'm just -- I admit I'm just guessing, is that they wonder if maybe she had assistance in writing them, and therefore that's not convincing to them.

'Cause really, if you were at the -- at --

looking at Harvard faculty and they were producing brilliant papers, I don't think we'd assume it would be coming from a graduate student say that that guy, that's what he's done all his life, and I don't see who could do that.

But here I don't know, so it occurred to me that I should question her directly, both with regard to recall and with regard to legal analysis, as if she had no time to prepare, which would be this situation, that it would be useful. So whether that's convincing or not, I don't know, but I felt it was helpful for me in reaching my conclusions.

Q Okay. And so then in the cognitive interview, I think you gave her some hypothetical situations that required some analysis involving patent law. Is that correct?

A Yes, which I think I outlined there.

Q And you were also comparing her responses to your prior experience with her as an advocate in cases you had argued in the Federal Circuit. Is that correct?

A Yes.

Q Okay. In your clinical practice, your regular practice, have you ever evaluated a patient based on some kind of similar analysis of that patient's performance to hypotheticals compared to your past experience with that patient?

A I don't think so. That is -- I'm not usually trying -- so the only time it comes up, and I maybe do this a little bit, is say somebody is the managing partner of a law firm and actively involved in litigation, and it's -- because it's an ethical issue, and he's coming to say, "I really want to continue my practice, and I know I'm having trouble."

So -- 'cause you might want to say, "Well, if you're representing clients and you're having trouble, you need to stop. Okay? And let me just deal with your personal medical condition." And, you know, I'll make that point, okay. And then I don't know that there's a -- a -- particularly with an attorney, with a group of attorneys, how you really sort out what that person does.

But here it seemed to me that -- that what they do is to take a complex technology in a patent

and in pleadings, generate an opinion. That's the job. So I thought it would be valuable. So I think it's hard to know that I would have enough prep -- I would take the time to prepare a test like that for a particular patient, but it has come up a few times.

And I will ask targeted questions to somebody to see if I believe that they should or should not be continuing their profession while treatment goes on.

Q But those would not involve comparing the person's performance and response to your prior experience with that person, would they?

A Yeah. So it's occasionally the case that a -- that I have prior experience with a person, because let's say they came in for a nerve problem, injury in their leg, and then they turn up 15 years later concerned about a cognitive. I still don't know if I have a close enough assessment. 'Cause here -- it's because here I see her twice in a row as late as 2022, when this is just before this is supposed to have started.

So also had an assessment of their cognitive

function, which if someone came for their leg, I might sort of remember they seemed okay. But I really went through a high -- you know, a high-performance cognitive activity, I believe, when a judge, you know, deals with a matter in open court on an appeal, complex appeal.

So that there -- there was, I think, certainly a possibly unique opportunity to make that comparison if I devised a useful test, and I don't think it's perfect, but I felt it was helpful.

MR. PHILBIN: Okay. I think if we take a break, and I can go over my notes, we might be done.

MR. MORRIS: All right. How long do you need?

MR. PHILBIN: Ten -- yeah, ten to fifteen. But I also then -- are we off the record?

THE REPORTER: No -- okay. So the -- we are -- the time is currently 4:23 p.m., and we're going off the --

(Off the record.)

THE REPORTER: We are back on the record, and the time is currently 4:41 p.m.

You're good to begin.

BY MR. PHILBIN:

Q Okay. Dr. Filler, just a few more questions. I think earlier you described that you have created a questionnaire that you use with patients whom you're evaluating to see if they have a cognitive impairment. Is that correct?

A Yes.

Q And in this case, you had that questionnaire up on a computer screen as you were talking to Judge Newman and used it to guide your interview with her. Is that correct?

A Yeah. I said I want to -- among other things, I said, "I would like to just run through these questions 'cause it's helpful for me to just address these points, even if they're all negative."

Q Okay. And is that -- that's something that you created?

A Yes. I mean, it -- it -- there are components that are similar to some other, but they're much smaller forms. So, for instance, they're sort of the tests that you're supposed to use for sidelines

where kids are playing soccer and things like that. So they ask for the different categories, but this is based on my talking to, you know, I guess, thousands of patients over years.

And then mostly where, you know, I'll ask them a certain question, and they'll say, "No, I don't have that, but here's what I experience." And then you -- so eventually I have it sorted out and have organized it and then gone through a few iterations. But now over the past four years or so, I've -- I've used a -- a fixed set of questions for purposes of consistency for a big analysis.

Q And as far as you're aware, does anybody else use that, your set of questions?

A Well, no, we haven't really released it for general use, but there's -- they're -- they're out there. I mean, I occasionally see something that looks very similar because they've been used in many, many, many cases, and so many physicians and attorneys have seen them.

Q Have seen them in the context of litigation where they've been used?

A Yes.

Q I see. Okay. And then I think you said that before the CT perfusion scan was performed, you had gotten some information from someone you thought may be a clerk for Judge Newman, including things like that she has a pacemaker, that there were emails or something. Is that right?

A Right. We just have -- the front desk in my office for anybody that we image, will ask those -- will inquire those things. So we don't want someone to travel, let's say, to a place for imaging and then find out they can't be imaged. So we -- and a lot of times you can head that off if -- if you can obtain the notes from the surgeon who implants it and then the matching statement from the manufacturer.

Q So those communications would just be about factual or medical record information about Judge Newman?

A Yes.

Q Okay. So we'd like to get a copy of those.

MR. MORRIS: We'll follow up.

MR. HARRINGTON: I will just tell you

that in that email that I found, my first response to Dr. Filler, back in September something, 2023, I advised him that the judge wanted the pacemaker in the reporter and -- so he's known that for quite some time. Was there any additional emails, that's -- and he hasn't --

MR. PHILBIN: Okay. I think those are all the questions I have.

MR. MORRIS: Okay. We do not have any questions. We are set.

THE REPORTER: Okay. And before we go off the record, I just need to clarify orders. I already have one in here for -- to be sent to you, Mr. Philbin. A normal transcript, normal turnaround time, ten days. Do you want exhibits included?

MR. PHILBIN: Yes, exhibits included.

THE REPORTER: Okay. And normal turnaround time is okay?

MR. PHILBIN: Yes.

THE REPORTER: Perfect.

Mr. Morris, would you like to place an order with a copy as well?

MR. MORRIS: Same thing we've ordered before. Normal turnaround is fine.

THE REPORTER: And exhibits?

MR. MORRIS: Yes, with exhibits included, please.

THE REPORTER: Okay. Perfect.

Then the time is currently 4:46 p.m., and we're going off the record.

(Signature reserved.)

(Whereupon, at 4:46 p.m., the proceeding was concluded.)

CERTIFICATE OF DEPOSITION OFFICER

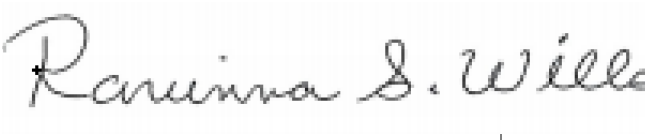
I, SYDNEY BROWNING, the officer before whom the foregoing proceedings were taken, do hereby certify that any witness(es) in the foregoing proceedings, prior to testifying, were duly sworn; that the proceedings were recorded by me and thereafter reduced to typewriting by a qualified transcriptionist; that said digital audio recording of said proceedings are a true and accurate record to the best of my knowledge, skills, and ability; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

SYDNEY BROWNING
Notary Public in and for the
Commonwealth of Virginia

[X] Review of the transcript was requested.

CERTIFICATE OF TRANSCRIBER

I, RAVINNA WILLS, do hereby certify that this transcript was prepared from the digital audio recording of the foregoing proceeding, that said transcript is a true and accurate record of the proceedings to the best of my knowledge, skills, and ability; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.



RAVINNA WILLS

Andrew Morris, Esquire
andrew.morris@ncla.legal

July 7, 2025

RE: In Re Complaint No. 23-90015
6/20/2025, Aaron G Filler (#7411738)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at cs-midatlantic@veritext.com.

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

In Re Complaint No. 23-90015

Aaron G Filler (#7411738)

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Aaron G Filler Date

In Re Complaint No. 23-90015
Aaron G Filler (#7411738)

ACKNOWLEDGEMENT OF DEPONENT

I, Aaron G Filler, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

_____ _____

Aaron G Filler Date

*If notary is required

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20___.

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NOTARY PUBLIC

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted

fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.