IN THE DISTRICT COURT IN AND FOR TULSA COUNTY

STATE OF OKLAHOMA

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CHRIS WIDICK, Individually and on
behalf of the Estate and Next-of-Kin
of Melissa Widick, Deceased,
Plaintiff,

vs. No. CJ-2004-01625

ST. JOHN HEALTH SYSTEM, INC.,
d/b/a Minor Emergency Center East;
ST. JOHN MEDICAL CENTER, INC.,
d/b/a Minor Emergency Center East;
EASTERN OKLAHOMA EMERGENCY PHYSICIANS,
INC., an Oklahoma Corporation; EASTERN
OKLAHOMA EMERGENCY PHYSICIANS, INC.,
d/b/a Minor Emergency Center East;
DONALD W. HAHN, D.O.; ROBERT PAULSEN, M.D.;
GERALD PLOST, M.D.; JAMES ROOKS, MD.; and
JACK MOCNIK, M.D.,
Defendants.
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VIDEOTAPED DEPOSITION OF

JOHN FULLERTON, M.D.

SAN FRANCISCO, CALIFORNIA

JULY 31, 2006

ATKINSON-BAKER, INC.
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REPORTED BY: DANUTA KRANTZ, CSR NO. 4782
FILE No.: A004FEA

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14 Defendants.
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18 Deposition of JOHN FULLERTON, M.D., taken on
19 behalf of Defendants, at San Francisco, California,
20 commencing at 2:30, Monday, July 31, 2006, before
21 Danuta Krantz, CSR No. 4782.
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25

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17 Videographer: Pater Matteson.
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1 P-R-O-C-E-E-D-I-N-G-S
2 THE VIDEOGRAPHER: I am Peter Matteson,
3 your videographer, and I represent Atkinson-Baker, Inc.
4 in Glendale, California. I am a notary public. I am
5 not financially interested in this action, nor am I a
6 relative or employee of any attorney or any of the
7 parties.
8 The date is July 31, 2006, and the time is
9 2:31 p.m.
10 This deposition is taking place at 1700
11 California Street, Suite 470, San Francisco,
12 California. This is case No. CJ200401625, entitled
13 Chris Widick versus St. John Health System, Inc.,
14 et al. The deponent is John H. Fullerton, M.D.
15 This deposition is being taken on behalf
16 the defendants. Your court reporter is Danuta Krantz
17 from Atkinson-Baker.
18 Counsel will now please introduce
19 themselves?
20 MR. BRATCHER: Kelly Bratcher of Riggs,
21 Abney for the plaintiffs.
22 MR. FIASCO: Will Fiasco here for
23 Dr. Plost.
24 MS. CALLAHAN: Karen Callahan for St. John
25 Health Systems, St. John Medical Center, Omni

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1 Physicians Group, Dr. Anderson, Dr. Paulsen, Dr. Rooks,
2 and Dr. McClintock.
3 THE VIDEOGRAPHER: Thank you.
4 Will the court reporter please swear in the
5 witness?
6 JOHN FULLERTON, M.D.,.
7 having first been duly sworn, was
8 examined and testified as follows:
9 EXAMINATION BY MS. CALLAHAN
10 MS. CALLAHAN: Q. Doctor, would you please
11 tell us your full name for the record?
12 A. John Hampton Fullerton, M.D.
13 Q. And you are a medical doctor who
14 specializes in internal medicine; is that correct?
15 A. Yes.
16 Q. Doctor, you understand that I am going to
17 be asking you some questions here today as a result of
18 some opinions that you formed related to the care and
19 treatment of one of the defendants in this case; is
20 that correct?
21 A. Yes.
22 Q. It's my understanding that you were
23 retained by Mr. Bratcher's firm to review materials and
24 to determine whether or not in your opinion the care
25 and treatment rendered to Melissa Widick was

1 appropriate; is that correct?
2 A. Yes.
3 Q. I believe that you have been through the
4 deposition process before, have you not?
5 A. Yes.
6 Q. So you have a pretty good understanding of
7 how this is going to work, agreed?
8 A. I think so.
9 Q. Obviously, if I ask a question that you
10 don't understand for any reason or because we are doing
11 this telephonically, if I cut out and you need me to
12 repeat anything, please ask me to do so, would you?
13 A. Yes.
14 Q. Also, it's not a marathon, so if you do
15 need to take a break for any reason, just let me know
16 and we will do that. Okay?
17 A. Yes. Thank you.
18 Q. I would like to start off by having you
19 identify for me the contents of your file.
20 A. Sure. I have a -- it's an eight-page
21 updated CV that has been updated as of July '06. And
22 the last page has sort of like a week-at-a-glance, my
23 clinical schedule, where I am and what I am doing, for
24 example, just an overview.
25 And then I have an additional page of notes

1 that I have not yet submitted for the record, which I
2 more recently prepared as a summary of the breaches in
3 the standard of care by Dr. Rooks and by extension
4 other health care providers.
5 And then the remainder of my file, my
6 existing file, and I don't know how you want to do
7 this, but there is certainly correspondence between
8 Kelly Bratcher's firm and myself, and I don't know if
9 any of that is work product or not, but I have it here.
10 MR. FIASCO: It's all discoverable.
11 THE WITNESS: Okay. It's all included in
12 the file.
13 There are some interrogatories and
14 responses that are included in the file.
15 There are various correspondences relating
16 to setting up this deposition with our office and
17 various e-mails with Mr. Bratcher's firm surrounding
18 these same issues.
19 Then there are the two pages of
20 contemporaneous notes that I have the originals and
21 copies of that I believe I have already submitted for
22 the record.
23 And then there are various, I believe there
24 are billing statements for my billing with
25 Mr. Bratcher's firm for my expert work today.

1 MS. CALLAHAN: Q. What about, are there
2 any medical records that are part of your file?
3 A. Yes. Now, extending beyond my manila file,
4 I have a set of medical records that include St. John
5 Clinic records from July 7, '02 to July 23, '02. They
6 include the emergency room encounter at St. John
7 Medical Center July 21, '02.
8 They include the St. John Medical Center
9 hospitalization records from July 29, '02 until Melissa
10 Widick's demise on the 31st, '02.
11 They include the autopsy report, and that
12 is in a binder that is -- that is pretty clearly tabbed
13 and marked, I believe.
14 Q. What about any depositions that you have in
15 your file?
16 A. Yes. I, in addition to what I have
17 mentioned, reviewed a total of five depositions, which
18 I brought. They include the deposition of Dr. James
19 Rooks; they include the deposition of Dr. Jack Mocnik,
20 radiologist; they include the deposition of Dr. Gerald
21 Plost, pulmonologist, critical care doctor.
22 They include the deposition of Debra Weeks,
23 the mother of the deceased, and they include the
24 deposition of Chris Widick, the widower.
25 Q. Now, in any of those depositions, at any

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1 time did you do any highlighting or annotating in the
2 margins?
3 A. No.
4 Q. Same question for the medical records that
5 you have identified.
6 A. No.
7 Q. Now, in your manila file folder, you said
8 you have some interrogatories and responses.
9 Can you -- there have been a number of
10 different interrogatories that have been exchanged.
11 Could you be more specific in identifying the ones that
12 you have in your file?
13 A. Yes. I have, it looks like -- I have the
14 defendant, St. John Medical Center, Inc.'s, first set
15 of expert discovery to John Hampton Fullerton. And it
16 is -- it's dated the 16th of February, '06. At least
17 the certificate of service is that date.
18 Then I have Defendant Plost's expert
19 witness interrogatory to plaintiff, and this is
20 certified March 15, '06.
21 And then I have plaintiff's response to
22 defendant St. John Medical Center, Inc.'s first set of
23 expert discovery to John Hampton Fullerton, M.D., and
24 that is dated -- was verified by me May 22, '06.
25 Q. Is that all of them?

1 A. No. Then I have Plost -- Defendant Plost's
2 expert witness interrogatory to plaintiff, and that was
3 certified on March 15, '06. I think -- well, I don't
4 want to speak too soon. I think that is it.
5 Q. Did you receive any of the written
6 discovery responses Dr. Rooks gave to any of the
7 plaintiff's requests?
8 A. I don't believe so.
9 Q. If I understand what you have told me so
10 far, then, you have a total of three pages of
11 handwritten notes involving your review of the case?
12 A. Yes.
13 Q. Two that you have already produced and one
14 that you have not yet produced?
15 A. That's correct.
16 Q. Okay. If we could, on the first break,
17 your updated CV and your one additional page of notes,
18 I will give you a fax number, and perhaps your office
19 could fax those to me so I could have those in front of
20 me as we talk about those items.
21 A. Yes. I would be happy to have Janice do
22 it.
23 Q. That would be great.
24 A. Sure.
25 Q. Now, let's go ahead and mark the manila

1 file folder as Exhibit 1.
2 A. Sure.
3 (Document marked Defendant's Exhibit 1 for
4 identification.)
5 THE WITNESS: Okay.
6 MS. CALLAHAN: Q. And your responses to
7 St. John's expert discovery to Dr. Fullerton, if you
8 will pull those out, and let's separately mark those as
9 Exhibit 2.
10 (Document marked Defendant's Exhibit 2 for
11 identification.)
12 THE WITNESS: Okay.
13 MS. CALLAHAN: Q. Then just go ahead and
14 keep those out of your manila file folder because we
15 are going to be talking about those at some length, and
16 that way you can have those in front of you. Okay,
17 Doctor?
18 A. Yes.
19 Q. Now, with respect to the billing statements
20 that you have identified, have you billed Mr. Bratcher
21 for all of your activities up to the beginning of
22 today's deposition?
23 A. Yes.
24 Q. So when I receive your file, I should be
25 able to tell between what I pay you today and those

1 billing statements your work generated in the case and
2 payments up to present; would that be fair?
3 A. Oh, yes.
4 Q. Okay. With respect to the discovery
5 responses that have been marked as Exhibit 2, what was
6 your participation in preparing those responses?
7 A. I would have to think back. Boy. Thinking
8 back on it, I believe that I was given a copy of the
9 interrogatories and told to respond, and then got a
10 copy of the responses to verify. I mean, that is
11 pretty much all I recall.
12 Q. Did you provide the information utilized
13 for those responses in some sort of a letter or report
14 or perhaps in the form of an e-mail?
15 A. I either did it verbally or by e-mail. As
16 I sit here today, I don't really recall. I think it
17 was verbal.
18 Q. So you believe that after you received
19 those requests from Mr. Bratcher's office at some point
20 in time, you and he had a phone conversation whereby
21 you provided him the information that should be
22 utilized to prepare those responses; is that correct?
23 A. Yes. In fact, I see a billing statement to
24 that effect, too. Yes.
25 Q. And then he -- his office prepared the

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1 responses and sent them to you for verification,
2 correct?
3 A. Yes. They were certainly prepared by his
4 office.
5 Q. Have you reviewed those responses in
6 preparation for today's deposition?
7 A. Boy. I tried to look through everything.
8 I may have looked through them. I don't independently
9 remember what they say verbatim right now.
10 Q. Are the responses set forth in Exhibit 2
11 still accurate and complete with respect to your
12 opinions and the basis for your opinions?
13 A. Let me double-check here.
14 Q. Certainly.
15 A. Yes. It is certainly -- certainly remains
16 my view, in addition to what is contained in the -- my
17 response to the interrogatories is -- I think there may
18 be two points. One is that I certainly continue to
19 believe that Dr. Rooks should have insured that Melissa
20 was evaluated and treated, whether that was with
21 anticoagulants or an IVC filter by the 30th of July.
22 I mean, I believe that still holds true
23 today after reviewing everything again, including the
24 more recent depositions.
25 But at the same time, I believe that by the

1 31st, up until -- well, after the arteriogram was
2 performed up until -- from that time until the
3 afternoon, at least at -- by 5:00 or so, that there are
4 was still an opportunity to intervene prior to 5:00
5 with the appropriate therapy and to prevent the
6 ultimate pulmonary embolism and associated death.
7 That is kind of the first point.
8 And then the second point I think is just a
9 matter of housekeeping or -- in terms of the depo here
10 today. It is a video depo, and I do charge a little
11 more per hour, so I want to be real clear for the
12 record. That is 650 an hour with a two-hour minimum.
13 Q. I believe the letter that your office sent
14 us confirming your deposition quoted 650 an hour, did
15 it not?
16 A. It did.
17 Q. Okay. So you were simply correcting the
18 interrogatory response of No. 5; is that correct?
19 A. Yes.
20 Q. Okay. Other than those clarifications you
21 just gave me, then we -- is it fair for me to
22 understand that the opinions and basis of the opinions
23 set forth in Exhibit 2 remain your complete opinions
24 and are accurate opinions?
25 A. Yes, they certainly remain accurate. What

1 I did, and I -- we will fax you -- go ahead and fax you
2 this one page, is I, in addition, included a summary of
3 the breaches in the standard of care by Dr. Rooks to
4 kind of flesh this out a little bit more. And I did --
5 I prepared this more recently.
6 Q. Do you have opinions in your one-page
7 summary that are not contained in Exhibit 2?
8 A. No. I feel like the opinions are really
9 contained in -- are contained in the -- my answers to
10 the interrogatories. There are just some subopinions
11 there that are -- become pretty apparent, I think, when
12 you see it. That's all.
13 Q. We will get those on the next break, and
14 then that may increase the number of items that we talk
15 about.
16 A. Sure.
17 Q. Now, with respect to Exhibit 2, page 2,
18 interrogatory No. 2, it is my understanding that it is
19 your intent to render testimony at the time of trial
20 regarding the care and treatment rendered by Dr. Rooks
21 and your opinion that it was below the standard of
22 care; is that correct?
23 A. Yes.
24 Q. Would it be fair for all of us to
25 understand that you do not intend at the time of trial

1 to testify regarding any alleged breaches of the
2 standard of care by other health care providers in the
3 case?
4 A. Well, I certainly am focusing on Dr. Rooks.
5 I don't plan on rendering standard of care opinions for
6 Dr. Plost, who is a pulmonologist.
7 Now, to the degree that my opinions about
8 Dr. Rooks and his breaches in the standard of care, you
9 know, interdigitate with, let's say, Dr. Paulsen or any
10 other primary care provider, whereby he is providing
11 the hospital's piece for them, then by extension, you
12 know, I may comment.
13 Q. You have done this long enough perhaps to
14 know there is a difference between a comment and a
15 criticism that somebody breached the standard of care.
16 Do you understand that there is a
17 difference between those two things?
18 A. Yes.
19 Q. My question is specific as to whether or
20 not you are going to be rendering any testimony beyond
21 what is in Exhibit 2 that any other defendant fell
22 below the standard of care.
23 A. I don't believe so.
24 Q. Okay. Let's go ahead and just start on
25 page 3 of Exhibit 2. I believe that is where your

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1 opinions begin.
2 A. Yes.
3 Q. And if you would -- well, let me just do it
4 this way. Your first opinion -- and if I misstate
5 anything, would you please stop me and correct me?
6 A. Yes.
7 Q. Okay. Your first opinion is that Dr. Rooks
8 had multiple opportunities to intervene and treat
9 Ms. Widick for thrombosis before treatment actually
10 began on the evening of July 31; is that correct?
11 A. Yes.
12 Q. Tell me what those multiple opportunities
13 are. Identify those for me.
14 A. Sure. Well, it's my belief or my opinion
15 that Dr. Rooks upon being given the admission
16 information from Dr. Paulsen that he was going to be
17 providing the hospitalist -- or hospital piece of the
18 care to Mrs. Widick on July 29th, that, I guess No. 1,
19 he had a independent obligation, which I feel like he
20 failed that, to in a timely fashion go back over
21 Ms. Widick's medical history, including her other
22 recent historical encounters at St. John's on July 7th
23 and July 21st, her follow-up on the 23rd, this kind of
24 information, with Doctors Anderson, McClintock and
25 Paulsen, and most recently with Paulsen times two, to

1 really know her medical information, including the
2 history of birth control pill usage the last couple of
3 months, and her history of the leg trauma or leg
4 lesion, if you will, on the 7th, and then the ER and
5 follow-up information on the 21st and 23rd before her
6 admitting information on the 29th.
7 So in other words, he had a -- I believe he
8 had an ability, and he certainly had an obligation to
9 go at that information, which was in the St. John's
10 system, I believe, to put it together, to put these
11 pieces together that would have -- that pointed in that
12 direction for earlier intervention, you know, and stat
13 evaluation, stat referral and stat treatment.
14 Q. Let's talk about that just a little bit.
15 Is it your understanding that he had a
16 conversation with Dr. Paulsen that provided him with
17 Dr. Paulsen's information related to the patient's
18 medical history?
19 A. Yes. It's my impression that he had
20 conversation with Paulsen and possibly with the medical
21 floor and -- about the admission, but more than that,
22 as the hospitalist assuming care for her hospital stay,
23 had access to the St. John's information through the
24 records as well.
25 Q. Which records do you believe that Dr. Rooks

1 had access to as part of that St. John's system?
2 A. The July 7th, '02 urgent medical encounter
3 for the leg lesion, the visit on the 21st, whereby she
4 was treated for bronchitis, but had shortness of breath
5 and so forth. And those are Anderson and McClintock.
6 And then on the 23rd, the followup with
7 Paulsen, and then the 29th, the emergency visit with
8 Paulsen.
9 It would be those records. Of course, the
10 x-ray on the 29th, chest x-ray, and then we can sort of
11 go on from there to other studies and information.
12 Q. Do you recall that a history and physical
13 was taken on the evening of the 29th by Dr. Plost?
14 A. Yes.
15 Q. And as part of that history and physical,
16 did Dr. Plost inquire about anything related to
17 swelling or pain in the lower extremities?
18 A. Yes, I believe he has testified that he
19 did.
20 Q. Is it also in the medical record?
21 A. Yes.
22 Q. And the patient denied that, did she not?
23 A. I believe so. As far as the record is
24 concerned, yes.
25 Q. And is it your belief -- well, strike that.

1 With respect to the birth control
2 medication, what is your understanding as to whether or
3 not Dr. Paulsen had that information from the patient?
4 A. Well, it's my impression from reading the
5 records thoroughly a couple of times and reviewing the
6 depositions I have described, that I could not find
7 that information in Paulsen's ER record.
8 Q. You say Dr. Paulsen's ER record. I don't
9 have an ER record for Dr. Paulsen. What date are you
10 referring to?
11 A. The record from the 29th.
12 Q. His office record?
13 A. Yes.
14 Q. Okay. In other words, Dr. Paulsen's
15 records don't indicate that the patient ever reported
16 to him that she was taking birth control medication; is
17 that fair?
18 A. Yes. From the 23rd and the 29th, I do not
19 see a record of that, although I have heard deposition
20 testimony, I believe it was by her widower, Chris, that
21 he believed she told Dr. Paulsen either on the 23rd or
22 the 29th.
23 Q. The record of the Minor Emergency Center
24 visit on the 7th of July, that does not indicate that
25 the patient reported to any physician she was taking

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1 birth control medication either; is that fair?
2 A. That is fair. I didn't see it in the
3 medical record either.
4 Q. And the same would be true for the
5 emergency room visit of July 21st, that it does not
6 appear the patient reported being on any birth control
7 medication as well, correct?
8 A. Again, I don't see it in the record,
9 although there is deposition testimony about that it
10 may have happened.
11 Q. With respect to the medical records, you
12 indicated that Dr. Rooks had a duty to go back over the
13 patient's medical history, with either these physicians
14 and/or review of these records.
15 From the medical records you have available
16 to you, would it be fair to say that even had he done
17 that, as you claim he should have done, it would not
18 necessarily have told him about birth control
19 medication?
20 MR. BRATCHER: Object to the form.
21 You can answer.
22 THE WITNESS: Yeah. Based on -- based on
23 reviewing the records that -- the medical records that
24 I have described, it would not -- he probably would not
25 have found it until Dr. Plost's record on the evening

1 of the 29th.
2 MS. CALLAHAN: Q. Okay. In fact, do you
3 recall from the testimony that when Dr. Rooks inquired
4 of the patient, she did not report to him that she was
5 on birth control medication either, correct?
6 A. That is correct. I did not see a record of
7 that in the initial encounter with Rooks.
8 Q. Now, assume for me that the medical records
9 of July 7th, that being the Minor Emergency Clinic
10 records, were not part of the St. John's system records
11 that Dr. Rooks had access to.
12 A. Okay. So hypothetically, I am assuming
13 they are not part of it. Okay.
14 Q. Yes. How, if at all, does that change your
15 opinion about his access to that information in terms
16 of putting together a complete medical history?
17 A. Well, I mean, you know, hypothetically,
18 yes, if the 7th was not included in the computer system
19 for him to have access to, that would be -- that would
20 be an issue in terms of his apparent lack of an ability
21 to get at those records, on the one hand.
22 On the other hand, by the 21st, by the ER
23 visit, there should have been some reference to her
24 recent medical encounters, including that one.
25 Q. When you reviewed the ER visit for the

1 21st, did you find that the patient had made any
2 reference to having been to the Minor Emergency Center
3 on the 7th for any sort of problem or injury to her
4 lower extremity?
5 A. No, I didn't see it in that record.
6 Q. Isn't it fair, Doctor, that, really, to
7 some extent, you and your peers have to rely upon the
8 information that a patient provides you with respect to
9 their medical history?
10 A. Yes. We certainly rely on, hopefully, a
11 thorough review of the prior information we have access
12 to, along with history from the patient, along with
13 discussions from our colleagues, yes.
14 Q. Have you told me fully the basis for that
15 opinion?
16 A. Yes, but, you know, I want to -- I want to
17 reiterate that -- maybe I didn't explain it as clearly
18 as I needed to -- that, for example, by -- certainly by
19 the evening of the 29th, when -- at which time
20 Dr. Plost is getting at the admitting information for
21 Melissa in the hospital, it's clear from the record
22 that this body of information, namely, her going into
23 the St. John system recently, some of those encounters,
24 particularly the encounter of the 21st and the birth
25 control issue were available to the practitioner like

1 Dr. Plost, and like -- would have been available to
2 Dr. Rooks if he had gone there.
3 Q. Is it your testimony, Doctor, that a
4 physician has a duty, absent the patient telling them
5 what their course of care has been, that the physician
6 has a duty to search out independent records that might
7 be part of a health care system to determine whether
8 the patient is leaving something out?
9 MR. BRATCHER: Object to the form.
10 You may answer.
11 THE WITNESS: Well, you know, I mean, don't
12 get me wrong. We certainly put a strong reliance on
13 historical information coming directly from the
14 patient, you know, and their surrogates or designated
15 family members, on the one hand.
16 On the other hand, when a patient comes
17 into a health care system where there have been other
18 encounters, it is incumbent upon those health care
19 providers to go after, as much as they can, the
20 comprehensive prior record, particularly if it's
21 recent.
22 MS. CALLAHAN: Q. If you are the physician
23 who is receiving a phone call that a patient is going
24 to be admitted for you to care for as the hospitalist
25 and that this patient had been diagnosed previously

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1 with bronchitis and had failed outpatient therapy for
2 pneumonia and you are not -- you don't know about all
3 of the different providers that that individual has
4 seen, are you saying that you as a physician would have
5 a duty to search out every record that could possibly
6 be available to you, rather than sit down and take a
7 full history and assessment from your patient?
8 MR. BRATCHER: Object to the form.
9 THE WITNESS: Well, yes, you certainly have
10 the duty to sit down and get as comprehensive a history
11 from the patient as possible, on the one hand.
12 On the other hand, one also has a duty to
13 aggressively go after or assertively go after any other
14 pieces of relevant medical record, particularly if they
15 are recent.
16 MS. CALLAHAN: Q. And those would be
17 medical records that you as a physician know exist,
18 correct?
19 A. Yes, would know exist, from history or from
20 going to the -- going to the medical information system
21 and tracking down recent records.
22 Q. Dr. Rooks was aware that the patient had
23 been seen previously by Dr. Paulsen, and he had a
24 fairly comprehensive discussion with Dr. Paulsen just
25 shortly before the patient was admitted, correct?

1 A. Yes. I certainly found evidence that they
2 had an admitting discussion.
3 Q. What information did Dr. Rooks have
4 available to him that causes you to believe he should
5 have known about the July 7 visit to the MEC?
6 A. Well, my own belief, based on my own
7 experience, working within a variety of health care
8 systems, is that when a patient comes in, that there is
9 a search of recent medical encounters, typically, and
10 that if those medical encounters are available, they
11 become and should become part of the admitting package,
12 if you will, of information to be comprehensive and
13 thorough.
14 Q. Is your opinion based primarily on your
15 belief that all of these records were accessible to
16 Dr. Rooks had he decided to take on this investigative
17 effort?
18 A. Yes. This opinion is based upon my belief
19 that certainly, at least the records of the 14th of
20 July and beyond, I believe should have been available
21 to him, if not the 7th.
22 My opinion is also based upon the -- it's a
23 standard of care opinion based upon the obligation of
24 the accepting hospitalist to also assertively go after
25 this information with the patient, in other words, as

1 part of history taking.
2 Q. Would you consider asking a patient on
3 multiple occasions if they have had any problems with
4 pain or swelling trauma to the lower extremity to be
5 aggressively questioning the patient?
6 A. Well, I would certainly -- I would
7 certainly include the lower extremities in any sort of
8 discussion and/or exam in a patient who has a
9 significant new onset of shortness of breath -- that
10 has shortness of breath.
11 Q. Is it your understanding that not only did
12 the patient deny these problems with Dr. Plost, but she
13 also denied them in interviews with Dr. Rooks?
14 A. I certainly could not find evidence in the
15 medical record for Dr. Plost's initial encounter or for
16 Dr. Rooks' initial encounter that they described her
17 complaining of lower extremity swelling, current lower
18 extremity swelling.
19 Q. Now, your second opinion, according to
20 Exhibit 2, states that if appropriate treatment would
21 have been started by Dr. Rooks in a timely fashion, it
22 is medically probable Melissa Widick would not have
23 expired on July 31 of 2002, correct?
24 A. Yes.
25 Q. Now, tell me what you mean when you say

1 appropriate treatment. What is this appropriate
2 treatment?
3 A. Sure. In this particular case, my belief
4 is that the most appropriate treatment would have been
5 the institution of anticoagulant therapy, either in the
6 form of IV heparin or some sort of low molecular weight
7 heparin, like Lovenox, sub Q, the heparin would be IV,
8 to prevent the extension or propagation or migration of
9 a preexisting thrombus and to prevent additional
10 pulmonary emboli and death.
11 Q. Any other treatment that you are referring
12 to when you say appropriate treatment or is it simply
13 the institution of anticoagulant therapy?
14 A. No. I am also referring to, for example,
15 in this particular case with this particular patient,
16 again, I think anticoagulant therapy would have been,
17 as an expert looking in on this, would have been my
18 primary recommendation, on the one hand.
19 On the other hand, the institution of some
20 sort of an inferior vena cava filter, an IVC filter,
21 like a Greenfield filter, would have sufficed, for
22 example, if the patient didn't want to be on an
23 anticoagulant at that level, you know, that kind of
24 thing would have provided an alternative.
25 Q. Now, in order to place an IVC filter such

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1 as a Greenfield, that is a surgical procedure, is it
2 not?
3 A. Yes.
4 Q. And so, does that require a patient's
5 consent?
6 A. Yes.
7 Q. Is it your understanding that during this
8 hospitalization Dr. Rooks spoke with Ms. Widick about
9 such a filter as being an option for treating pulmonary
10 emboli?
11 A. Yes, there is certainly some evidence that
12 there was a discussion of anticoagulant and surgical
13 options.
14 Q. And is it your understanding that
15 Ms. Widick declined placement of such a filter on the
16 31st?
17 MR. BRATCHER: Object to the form.
18 Go ahead.
19 THE WITNESS: Well, it's -- there certainly
20 is evidence that Ms. Widick, and possibly even her
21 husband Chris, were not that keen on -- to proceed with
22 an area of risk that was outlined to them, it sounds
23 like, by Dr. Rooks about potential pregnancy-related
24 problems with a filter. That is true.
25 Now, beyond that, with what I would

1 consider more reasonable risks, I didn't see anything
2 in the record that made me believe that they would not
3 have consented.
4 MS. CALLAHAN: Q. Regardless of her
5 reasoning, is it your understanding that the patient
6 refused to consent to the placement of such a filter?
7 A. I am not sure from reviewing the records,
8 quite honestly, whether she -- whether Dr. Rooks and
9 others felt like she was of the opinion that she would
10 not consent, versus her desire to think more about
11 the -- some sort of a pregnancy issue that was
12 presented to her as a risk by Dr. Rooks. I don't know
13 from the record.
14 Q. Okay. I want to make sure I understand
15 what you are telling me.
16 Are you saying that it's your understanding
17 she would not consent at that time, but she wanted more
18 time to think about it?
19 A. Yes. My belief is that at that time, based
20 upon a presentation that included some sort of a
21 pregnancy risk by Dr. Rooks, that I have some issue
22 with, I believe she apparently didn't want to consent
23 at that time based on that issue in large part.
24 Q. Do you disagree that one of the risks he
25 informed her of related to that filter was an accurate

1 risk?
2 A. No, I don't -- I typically take the
3 position that in terms of risk language, you can't be
4 too thorough and you can't be too careful in trying to
5 inform a patient and have them operate in an arena of
6 education and informed consent. That is true.
7 But this issue of potential pregnancy
8 problems in an IVC setting, in what I will call an
9 emergency setting for some sort of a definitive
10 treatment and care, I take issue with.
11 In other words, putting it -- putting it up
12 there as a major risk factor in an emergency setting, I
13 take issue with.
14 Q. Is it fair to say you were not a party to
15 that discussion?
16 A. That's true.
17 Q. And so you are not exactly in the best
18 position to articulate just how the risks were set
19 forth in terms of what emphasis was placed on which
20 risk?
21 A. It's certainly true, particularly when I
22 look at the medical record. Now, when I, you know,
23 reviewed the depositions, including Chris, her
24 widower's deposition, it certainly appeared to -- this
25 pregnancy issue seemed to appear to stick out in his

1 mind, too, as far as a recollection.
2 So it kind of led me to believe that it was
3 featured in the discussion.
4 Q. Are there times when you as a physician
5 attempt to be comprehensive in your discussion of risk
6 associated with a particular form of treatment, and the
7 patient may choose to focus on one risk more so to the
8 exclusion of others?
9 A. Yes.
10 Q. And that can occur even though you may not
11 emphasize one particular risk to the exclusion of
12 others?
13 A. Yes, that may occur. And then what we
14 typically do is go back and help them weigh the risks,
15 because there is a risk-benefit ratio in each area of
16 risk.
17 Q. Now, you state here that appropriate
18 treatment should be started in a timely fashion. What
19 is your opinion about what constitutes a timely
20 fashion?
21 A. Sure. My opinion is that when Melissa was
22 admitted on the 29th, that Dr. Rooks, number one,
23 needed to see Melissa in a timely fashion, which would
24 have been probably around the time that Dr. Plost saw
25 her, at least by that time. Number one.

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1 And then number two, as part of seeing
2 Melissa as part of their proscription to or mandate to
3 see her in a timely fashion, that Dr. Rooks needed to
4 order, for example, stat laboratory tests, you know,
5 the stat imaging, also in a timely fashion where the
6 workup, you know, should have been completed by the
7 30th.
8 Q. Be completed by when on the 30th?
9 A. Completed by the afternoon of the 30th.
10 Q. Now, which -- when you say stat lab tests,
11 tell me which lab tests you are referring to.
12 A. Sure. I believe that the lab tests that
13 had to do with the prothrombotic workup needed to have
14 been done, you know, in a stat fashion. And I believe
15 that arterial blood gas should have been done in a stat
16 fashion. At least those two.
17 Q. When you say a stat fashion, just so I know
18 what you mean, tell me what your time frame is for
19 that.
20 A. That those tests should have been -- well,
21 for a blood gas, for example, when you order it stat,
22 you really like to see the result back, you know,
23 within the hour. I mean, some programs it may be a
24 couple of hours, and that would be okay. But that --
25 certainly that day.

1 With the prothrombotic workup, we are
2 talking about sometime by the next day.
3 Q. And when you say stat imaging, please
4 identify for me the imaging that you are referring to.
5 A. I thought that the, you know, the choice of
6 a -- well, first of all, doing the chest x-ray, there
7 is certainly -- you know, it was a fine thing to do
8 upon admission on the 29th.
9 Ordering the stat CT scan of the chest, the
10 spiral CT, that's a nice test in this setting. It's a,
11 you know, very nice test to do. Again, it should have
12 been done stat on the 29th.
13 And then the tests that followed, for
14 example, if they ended up after the stat CT having a
15 debate about whether or not they wanted an arteriogram
16 or not, I mean, there is nothing wrong with doing an
17 arteriogram here.
18 That is a nice test to do stat, too,
19 particularly if you want to verify some sort of
20 vascular cutoff, whether it's intrinsic or extrinsic,
21 that is fine to do, but again, done in the stat fashion
22 where all of this stuff was -- that I am talking about
23 was done by -- I am being -- giving a lot of latitude
24 here -- was done by the afternoon of the 30th.
25 Q. Is it your opinion that all of the testing

1 that was done with this patient should have been
2 completed 24 hours earlier than when it was completed?
3 A. Yes. And by this -- excuse me. Just as a
4 corollary to that, I want to be real clear about this,
5 that Dr. Rooks should have seen the patient -- I think
6 he saw her 21 or 22 hours after her admit, so he
7 certainly should have seen her the prior day, too.
8 Q. It's your opinion he should have seen her
9 on the evening of the 29th?
10 A. At the latest.
11 Q. She was not admitted until the evening of
12 the 29th, was she?
13 A. Well, evening of the 29th would have been
14 appropriate.
15 Q. When you said at the latest, that led me to
16 believe you thought she had been admitted sometime
17 prior to that.
18 A. Well, I think I was just trying to
19 emphasize that this is a stat situation.
20 Q. Okay.
21 A. And it should have been apparent to be a
22 stat situation.
23 Q. When you were acting as a hospitalist in a
24 hospital setting, how were your shifts structured?
25 A. The -- well, the place I was a hospitalist

1 at the longest during most of the '90s, I was mostly a
2 daytime hospitalist. So we were, by contract, needed
3 to come in, I believe it was by 7:00 in the morning,
4 and we left by 6:00 in the evening, and we were on site
5 that whole time.
6 Now, more recently, when I have worked as a
7 hospitalist, and this was during 2001, 2002, I think it
8 was part of 2003, at least the first quarter, I did
9 more of the -- of the night shifts, too. I was sort of
10 a new person in that group.
11 So I have experience with predominantly
12 working on the daytime shifts for many years, and then
13 more recently, and in fact, over this relevant time
14 period, doing some daytime work, but quite a bit of
15 nighttime work.
16 Q. When you were acting as a hospitalist under
17 the contract that ran from a shift of 7:00 a.m. to 6:00
18 p.m., who would see your patients in the evenings?
19 A. We had house doctors that had contracts
20 that ran from 7:00 p.m. -- I am sorry, 6:00 p.m. to
21 7:00 a.m. They slept in the hospital, in other words.
22 Q. What is your understanding as to how the
23 hospitalist program and shifts are structured at
24 St. John's? When I say are structured, I mean at that
25 time.

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1 A. It appears that there are -- in some of the
2 areas there are some nighttime coverage people. I
3 mean, for example, with Dr. Plost, I think he mentions
4 a Dr. Lang was covering on, I think the night of the
5 30th for him, just to give you an example, for their
6 call arrangement.
7 And then -- I could not get from the record
8 whether or not, or glean from the record whether or not
9 the hospitalist who admitted a patient, let's say, in
10 the evening, slept in the hospital or not. I couldn't
11 figure that out from the record.
12 Q. You mentioned Dr. Plost. You understand
13 that Dr. Plost is not a hospitalist?
14 A. Yes. I was referring to his call schedule
15 of coverage.
16 Q. I want to just talk about the hospitalist
17 and the way it's structured. I certainly don't want to
18 limit you to just the medical record. I would like you
19 to utilize whatever information you have gleaned from
20 all of the materials that you have reviewed.
21 But do I fairly understand you are telling
22 me you are not really sure how it was structured at
23 that time?
24 A. No, I am not really sure how it was
25 structured, other than the fact that it's clear to me

1 the hospitalists made themselves -- on duty made
2 themselves available to the ER for admissions.
3 And now, did the daytime people cover their
4 own call at night? It's possible here. I just don't
5 know.
6 Q. So if Dr. Rooks was not on shift at the
7 time the patient was admitted on the 29th, is it still
8 your opinion that he had a duty to come back in and see
9 this patient on the evening of the 29th?
10 A. Yes, or get his designee to see the patient
11 when he got the call.
12 Q. If he had a designee, you don't know who
13 that was?
14 A. That's correct.
15 Q. If his designee on the evening of the 29th
16 was Dr. Paulsen, would you agree that Dr. Paulsen did
17 indeed come over to the hospital for this patient's
18 admission?
19 A. Yes. Dr. Paulsen saw the patient on the
20 29th.
21 Q. You go on to say in this opinion, that,
22 "Had the appropriate treatment been instituted in a
23 timely fashion, it's medically probable that the
24 patient would not have expired."
25 Tell me the basis for your opinion

1 regarding the medical probability of her death.
2 A. Sure. In my experience, in patients like
3 Melissa, at least like Melissa up until 5:00 p.m. on
4 the 31st of July, that they have, in terms of the odds,
5 that they have a more probable than not ability to
6 survive either the extension or a new PE in this
7 setting, meaning, you know, the setting of discovering
8 a significant pulmonary embolic lesion on the left and
9 having some new smaller lesions, almost complete
10 occlusion on the left, and having some new lesions on
11 the right.
12 That, in other words, as long as the
13 treatments I have outlined before in this deposition
14 are instituted, that the odds are in their favor in
15 terms of preventing further extension of the lesions,
16 of the clots, or additional pulmonary emboli resulting
17 in death.
18 Q. A couple of times in the deposition, you
19 have talked about 5:00 p.m., and you have said, you
20 know, she should have had the medication by at least
21 5:00 p.m.
22 Tell me what it is that is causing you to
23 get focused on that time.
24 A. Well, I am focused on that time because I
25 believe based upon Dr. Rooks' deposition, he indicates

1 that after the arteriogram he went back by to see
2 Melissa by 4:35 p.m., something like that, and then
3 wanted to make sure that she received her first dose of
4 anticoagulant treatment.
5 And it's my impression from reading the
6 deposition in particular and then the medical records
7 that are behind it, that she was medically stable
8 enough to -- in terms of her potential for
9 survivability, in other words, was still there.
10 Q. At 5:00 p.m.?
11 A. Yes.
12 Q. Now, is it your recollection from reviewing
13 the record and the testimony that as late as 6:45 p.m.,
14 Dr. Plost made rounds on the patient, and she was
15 medically stable?
16 A. Yes. There was certainly reference I saw
17 either in the record or Plost's depo to that, yes.
18 Q. When did she get her dose of Lovenox?
19 A. I believe it was sometime during the early
20 evening of the 31st.
21 Q. What is your understanding, if any, as to
22 why she did not get it sooner than that?
23 A. Well, first of all, it's very -- it's an
24 area that seems very remarkable to me, because it's my
25 impression that the arteriogram was completed during

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1 the morning of the 31st, and I think there are various
2 family members that were coming into the hospital,
3 having family meetings and so forth, that corroborate
4 that in the record.
5 And that at that point when it had to be
6 abundantly clear that there was an intrinsic vascular
7 blockage on the left, with some new lesions on the
8 right, that stat therapy needed to be administered, and
9 preferably stat anticoagulant treatment like the
10 Lovenox.
11 So I can't explain why they were not
12 standing ready, at least at this point, with the stat
13 treatment.
14 Q. Anything else with regard to your opinions
15 in that first paragraph on page three of Exhibit 2 or
16 are we -- have you fully discussed those with me and we
17 are ready to move on to the next paragraph?
18 A. Well, I think that I have said everything,
19 but I want to make sure that this subissue, because we
20 talked about, I talked about stat labs for Rooks. I
21 talked about stat labs and seeing the patient in a
22 timely fashion, and stat imaging, and the workup being
23 done in a more expedited way.
24 And to me, the other issue there is -- to
25 add is that he -- Rooks also needed to make sure that

1 the pulmonary consult was done stat.
2 Q. Wasn't the pulmonary consult carried out on
3 the evening of the 29th a few hours after her
4 admission?
5 A. Yes. It was done in a timely enough
6 fashion.
7 Q. Okay.
8 A. But I didn't want to leave out the point
9 that when you, you know, you got the hospitalist coming
10 in there and talking to Paulsen, and if the hospitalist
11 in this setting, like you should do, weighs in that
12 this consult is not just important, but needs to be
13 done stat, and the reasons it needed to be done stat
14 that I think I have outlined, it influences
15 pulmonologists in a nice way, in a proper way.
16 Q. Well, Dr. Plost certainly saw this patient
17 in a timely fashion, did he not?
18 A. Yes.
19 Q. And he wrote a number of orders to be
20 carried out on this patient which were ordered in a
21 timely fashion, were they not?
22 A. Yes.
23 Q. Do you believe there was something else
24 Dr. Rooks needed to somehow emphasize to Dr. Plost that
25 didn't get emphasized?

1 A. Yes.
2 Q. What was that?
3 A. That is the substance of what I described
4 as far as the need for this stat evaluation to rule in
5 or rule out, evaluate and treat pulmonary emboli here.
6 In other words, putting together the -- helping to put
7 together the picture, the medical narrative from the
8 medical facts and the medical evidence that was
9 available for Plost by Rooks.
10 Q. Anything else?
11 A. No.
12 Q. Your next opinion is that Dr. Rooks had
13 adequate information at his disposal to at least
14 presumptively diagnose and treat Mrs. Widick for
15 thrombosis before the evening of July 31st; is that
16 correct?
17 A. Yes.
18 Q. Tell me what you mean by presumptively
19 diagnose and treat.
20 A. Well, I want to be real clear here. I
21 mean, the way the workup was done here, I have already
22 testified to the fact that I believe it was done sort
23 of, unfortunately, at least a day late, as far as
24 pertains to Rooks.
25 So in other words, by the 30th, I feel like

1 this -- the same workup that they did should have been
2 done anyway, so this presumptive diagnosis is sort of
3 even being more conservative about it.
4 I should say that, in other words, that,
5 because the workup should have been done by the 30th,
6 the patient should have been, you know, put on --
7 should have been treated for this problem, the emboli,
8 by the 30th, as the first part of what I am saying
9 there.
10 The second part has to do with, okay, well,
11 they did the workup late, but even doing the workup
12 late and completing the arteriogram by the morning of
13 the 31st, they still had an opportunity to intervene,
14 and whether it was presumptively or after the diagnosis
15 had been made, to prevent additional pulmonary emboli
16 and prevent the death here.
17 Q. And the presumptive treatment that you are
18 referring to is the anticoagulation that you mentioned
19 to me a little earlier, correct?
20 A. Yes.
21 Q. Are there risks associated with the use of
22 anticoagulation medication?
23 A. Yes.
24 Q. What are those risks?
25 A. Well, first of all, the most obvious one is

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1 that there is a risk of doing sort of the opposite to
2 somebody and causing their thrombosis and causing
3 bleeding. And the bleeding can occur, you know, at
4 various sites in the body and cause various degrees of
5 morbidity and mortality.
6 Q. Are there any other risks associated with
7 the use of those medications?
8 A. Yes.
9 Q. What are they, please?
10 A. Sometimes people can have allergic
11 reactions or untoward reactions to some of the various
12 anticoagulants, would be the second one.
13 And then the third one is drugs like
14 heparin can additionally cause heparin-associated
15 thrombocytopenia and various -- they are called HATS,
16 and various other hematologic abnormalities or bone
17 marrow abnormalities.
18 Those are the big ones. And, you know,
19 again, the bleeding can occur, that I mentioned is
20 No. 1, can occur in the head, it can occur through the
21 bowel. They can lose a lot of blood or a little bit of
22 blood. So it's a calculated risk.
23 Q. One of your responsibilities as a physician
24 before you write orders for any medication is to weigh
25 the risks and benefits of the use of that medication

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1 for the condition that you believe exists; is that
2 correct?
3 A. Yes.
4 Q. Now, is there a risk associated with
5 utilizing anticoagulation in a patient prior to them
6 undergoing a bronchoscopy?
7 A. Yes.
8 Q. What is that risk or those risks?
9 A. Well, the -- certainly the risk -- this is
10 based on my experience, and I clinically teach quite a
11 bit over the years, so I am just going to give you sort
12 of approximate numbers.
13 Without -- in the face of not doing a
14 procedure, for example, you know, the risk of a serious
15 bleeding event is certainly under -- under 4 percent, I
16 think, in most of the things I have heard about or read
17 about or seen over many years. So it's not a very high
18 risk.
19 Q. That would be absent a surgical procedure,
20 you are saying, just a general risk associated with the
21 administration of anticoagulation, bleeding would only
22 be about a 4 percent risk?
23 A. It would certainly be less than 4 percent,
24 somewhere between 1 and 4, and then with the procedure
25 it would go up.

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1 Q. And are you going to be testifying as to
2 how high that risk reaches?
3 A. Well, I think that as far as those kinds of
4 numbers with those kinds of procedures, you know, I
5 will defer to our hematology expert for that for more
6 absolute numbers, but the risk certainly goes up from
7 the 1 to 4 percent with a procedure being done,
8 particularly if there is an interbronchial lesion or
9 something like that.
10 Q. Certainly bleeding out from the use of
11 anticoagulation during a bronchoscopy is a known risk,
12 is it not?
13 A. Yes.
14 Q. In fact, anticoagulation in the setting of
15 bronchoscopy is described in the literature as a
16 relative contraindication, isn't it?
17 A. Yes, that is true.
18 Q. And there are also risks associated with
19 anticoagulation prior to the performance of a pulmonary
20 arteriogram, correct?
21 A. That's true, too.
22 Q. And those risks are greater than just the
23 simple risk associated with the use of the medication
24 absent such a procedure?
25 A. Yes, that is true.

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1 Q. And is the use of anticoagulation prior to
2 pulmonary arteriogram also considered to be a relative
3 contraindication?
4 A. Yes.
5 Q. Now, are you, as a physician, going to
6 presumptively treat every patient in whom you might
7 include pulmonary embolus as part of your differential
8 diagnosis?
9 A. Well, no, I am not going to treat
10 everybody, on the one hand. On the other hand, those
11 patients like Melissa who are at a young age, in other
12 words, they tolerate anticoagulation or other
13 treatments better than people at an older age, and
14 people who don't have any of the other obvious
15 contraindications to starting an anticoagulant, namely,
16 recent head trauma or recent other bleeding episode,
17 you know, unrelated to this hemoptysis that she was
18 having, you know, those kinds of things, then I
19 certainly would go down the road of looking into
20 presumptive treatment for protection here.
21 And I don't want to be remiss. I know we
22 have just been talking about anticoagulants, but in my
23 experience, if one really gets oneself worked into a
24 lather about it, the use of an anticoagulant, you
25 certainly can slip in the Greenfield filter.

1 So I mean, if that is really an issue that
2 someone is making here, then I opt for plan B, which
3 was the filter here.
4 Q. But as you discussed earlier, you can't pop
5 in one those filters unless your patient agrees to
6 that?
7 A. That's true. You need a consent.
8 Q. Okay.
9 A. It has to be informed, you know, informed
10 consent.
11 Q. Exactly. Whether or not you are going to
12 order anticoagulation for your patient where PE might
13 be part of your differential, it is going to depend on
14 each patient and their set of circumstances and your
15 workup, is it not?
16 A. Yes.
17 Q. And we talked a minute ago about your
18 responsibility to weigh the risks and benefits of a
19 medication, but to make that a more general statement,
20 in all fairness, one of your responsibilities as a
21 physician is to weigh the risks and benefits of any
22 particular type of therapy?
23 A. That's correct in each case.
24 Q. And to weigh the risks and benefits of any
25 type of invasive procedure?

1 A. Certainly also holds true.
2 Q. And in doing so, you are called upon to
3 utilize your medical judgment to make the best decision
4 that you can for your patient on each of those
5 occasions; is that correct?
6 A. Yes.
7 Q. Even though you disagree with the decision
8 that Dr. Rooks made, do you believe, from your review
9 of all of the information, that he tried to utilize his
10 medical judgment to make the best decisions he could
11 for this patient?
12 MR. BRATCHER: Object to the form.
13 You may answer.
14 THE WITNESS: In order to try to answer
15 your question fully, and I have thought about this, a
16 good deal about it, in this particular case, I feel
17 like -- I feel like Dr. Rooks -- I felt Dr. Rooks
18 probably went against his better judgment in not making
19 sure this patient was adequately protected or
20 anticoagulated by the 30th.
21 And based upon his deposition testimony, I
22 think that it's something he may still be thinking
23 about, or thinking about a what if sort of thing.
24 MS. CALLAHAN: Q. What is it that leads
25 you to believe that Dr. Rooks feels that he went

1 against his better judgment?
2 A. Well, through the deposition a couple of
3 things became clear about Dr. Rooks' position. I think
4 first of all, he certainly -- and I take his background
5 into account here with a familiarity with oncologic
6 principles -- he certainly felt like there may be a
7 tumor here.
8 And I -- there is certainly no reason to
9 really dispute that in terms of going through this
10 process in him having to process the information as it
11 came at him, you know, in real time.
12 There certainly was evidence that there may
13 be a tumor here, and that was certainly supported by
14 the pulmonologist, including his deposition testimony.
15 And -- but it's also clear from the
16 deposition that if there was -- that there is a belief
17 that if there was a tumor here, it was not something
18 that was going to be surgically addressed.
19 In other words, it was something that was
20 going to be addressed later on after more of a workup,
21 for example, by chemotherapy and/or radiation therapy
22 or both.
23 And it may have been, you know, either a
24 Hodgkins or non-Hodgkins lymphoma, for example, to give
25 you an idea of what they were thinking, I think, or at

1 least Rooks was thinking.
2 So you have that sort of piece of
3 information, but also that realization in his own depo
4 that this was not something that was going to
5 necessarily -- that it was going to probably be life
6 threatening for Melissa, for example, during this
7 hospitalization. Now, you have that sort of body of
8 things. Okay.
9 Now, in the same deposition, you -- I
10 think -- I believe we have a primary care physician,
11 hospitalist physician here saying, in effect, that if
12 she had received anticoagulation by the 30th that the
13 outcome would have been different here.
14 In other words, this bad outcome would have
15 been prevented. So, you know, there is this sort of a
16 conflict within his own depo about, I think, what he
17 was going through in thinking through it, you know, in
18 hindsight.
19 Q. And you bring up a good point. That was
20 something that Dr. Rooks said with hindsight, correct?
21 A. That's correct.
22 Q. And you as well as any other physician know
23 that at the time you are taking care of a patient,
24 unfortunately, you don't have the benefit of hindsight,
25 correct?

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1 A. That is correct.
2 Q. And it's very natural for a physician, when
3 they have a less than desirable outcome with a patient,
4 particularly where they have autopsy information
5 available to them, to utilize hindsight and go back
6 through all of the information; is that not correct?
7 MR. BRATCHER: Object to the form.
8 You may answer.
9 THE WITNESS: Yes. It's certainly -- there
10 is certainly a difference in looking back on a case and
11 hindsight, on the one hand, and going through it in
12 real time perspectively on the other, you know, on that
13 other hand.
14 But in this particular case, and I am
15 including the deposition testimony in my answer here of
16 Dr. Rooks, there is certainly -- there certainly was
17 abundant evidence already that Melissa had probably
18 been throwing PEs, or at least could have been throwing
19 PEs.
20 For example, she had the -- what they are
21 now calling, I guess more recently calling a fainting
22 episode that brought her into the ER originally. And
23 the whole issue of the birth control pill and the leg
24 lesion and so forth, there are a lot of things there,
25 together with the shortness of breath and lack of

1 response to antibiotics and so forth that add up to an
2 unexplained -- an unexplained ventilation or profusion
3 issue in her lungs.
4 And so we are trained at the earliest
5 levels -- and I do a clinical teaching in -- at Yale
6 Medical School, the students come out here, and at UCSF
7 Medical School, and I teach the medical residents from
8 a number of different programs as well, and at the
9 earliest levels of clinical teaching, pulmonary
10 embolism is one of those things that, I could list the
11 top 10 or 15, we can't miss. We just can't miss.
12 And we are trained as medical students,
13 before we graduate, to make sure that people don't have
14 a PE, because if they do and you miss it, they may die.
15 And so it's a long-winded way of answering
16 your question, but I think that in this particular
17 case, there was enough evidence there to make an
18 expedited workup for a PE to rule in or to rule out a
19 stat, a mandate here from the beginning of the
20 hospitalization and maybe beyond.
21 MR. BRATCHER: Karen, we have been going
22 about an hour and a half. I would like to take a break
23 so I can run to the restroom. But before we go, can we
24 get the fax number from you, because I don't have it
25 with me, so we can fax this to you?

1 MS. CALLAHAN: Sure. It's 918-295-7800.
2 THE WITNESS: And attention to?
3 MS. CALLAHAN: You can just put "Karen" on
4 it.
5 THE VIDEOGRAPHER: We are off the record at
6 3:55 p.m.
7 (Short recess.)
8 THE VIDEOGRAPHER: We are back on the
9 record at 4:05 p.m.
10 MS. CALLAHAN: Q. Doctor, what is a
11 differential diagnosis?
12 A. A differential diagnosis is -- I think it's
13 best described as that A or assessment part of a SOAP
14 note, in other words, the assessment part of the
15 evaluation or examination of the patient includes a
16 list of the possible diagnoses that should be
17 entertained or included. So we denote that as sort of
18 a differential diagnostic list.
19 Q. When you are doing a differential diagnosis
20 or when you are teaching students, interns, residents,
21 how to do a differential diagnosis, is it common to
22 list more toward the top of that list the diagnosis
23 that you think is most likely and work your way down to
24 that which is least likely?
25 A. Yes, in general, I think that starting

1 with, you know, common things are common, starting with
2 the more probable things in the differential is
3 appropriate, of course, but also making sure that the
4 differential includes other things, even though they
5 may be less probable, that are red flags, you know, or
6 might -- whereby the person might die or get very
7 harmed. So it's both.
8 Q. Up until the results came back on the
9 bronchoscopy for this patient, is it your understanding
10 that in the -- that the physicians that were caring for
11 this patient during the July 29 hospitalization, they
12 felt the more probable diagnosis was some type of a
13 lymphoma as opposed to PE?
14 A. Yes. I think that -- I think -- and even
15 based on the deposition -- the subsequent deposition
16 testimony of Plost and Rooks, for example, I believe
17 that they were not thinking PE. In other words, they
18 were putting PE beneath -- beneath tumor-like lymphoma
19 on the differential list, yes.
20 Q. If you are caring for a patient in whom you
21 believe the more probable diagnosis for their
22 presentation is lymphoma, are you going to order
23 anticoagulation?
24 MR. BRATCHER: Object to the form.
25 You may answer.

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1 THE WITNESS: Yes. It depends on the
2 clinical circumstances, you know, the whole picture.
3 And in this particular case, even if the thinking was
4 that this patient may have lymphoma, the issue of
5 pulmonary embolism had not been effectively ruled out,
6 for example, and because that is such a red flag or
7 more emergency issue or more highly mortal issue for
8 that hospitalization, I certainly -- no, you would
9 certainly not rule out anticoagulation or consider it a
10 absolute contraindication.
11 MS. CALLAHAN: Q. The spiral CT results
12 that came back on this patient were felt not to be
13 indicative of PE; is that fair?
14 A. Yes. I believe that the spiral CT results
15 appear to be more indicative of an extrinsic mass or
16 compression on the vessel, the main vessel on the left,
17 which would have been most compatible with a non-PE
18 mass.
19 Q. Is it -- if you are the physician caring
20 for a patient in whom you have a CT scan that tends to
21 rule out PE, and you have pleural effusion, bloody
22 pleural effusion at the time of the thoracentesis and
23 you are going to proceed to bronchoscopy, would you
24 agree that in all medical probability, you would not
25 anticoagulate the patient?

1 MR. BRATCHER: Object to the form.
2 THE WITNESS: Yes. There is certainly -- a
3 case could certainly be made for -- as long as the
4 bronchoscopy was expedited as part of an expedited
5 workup, for -- they were not starting the
6 anticoagulation treatment until after the bronchoscopy,
7 I feel like I have sort of already outlined that, and
8 if that -- if that sort of was the line of thinking,
9 then getting an informed consent for an IVC filter
10 would have sufficed as a plan B here.
11 MS. CALLAHAN: Q. Basically, you don't
12 take issue with withholding anticoagulation in this
13 patient until after the pulmonary arteriogram; what you
14 take issue with is the fact that the tests were not all
15 completed until the 31st?
16 MR. BRATCHER: Object to the form.
17 MS. CALLAHAN: Q. Is that fair?
18 A. Yes. Under these circumstances, not
19 providing the anticoagulation treatment until the
20 completion of the arteriogram, I believe like was
21 reasonable, but an IVC filter should have then been
22 placed in the interim, you know, with the presumptive
23 diagnosis.
24 Now, after the arteriogram was completed, I
25 have no qualms with asserting that anticoagulation was,

1 you know, needed to be administered stat.
2 Q. Now, there is a difference between a
3 thrombolitic medication and anticoagulation, is there
4 not?
5 A. Yes.
6 Q. Thrombolitics, are those what are commonly
7 referred to by lay people as clot busters?
8 A. Yes.
9 Q. Whereas the, I think you said earlier the
10 anticoagulation is to prevent the propagation of or
11 development of the new clots?
12 A. That's correct.
13 Q. I take it, then, you are not critical of
14 the decision to not administer thrombolitics at a time
15 prior to the patient's code blue?
16 A. Yes. In other words, I am not critical of
17 not utilizing thrombolitics by that time. But I want
18 to be real clear about the -- that is what the caveat
19 is, that the workup needed to have been expedited in
20 the first place and completed by the 30th at the
21 latest.
22 Q. I think you have -- I think you have made
23 that opinion very clear up to this point, so I
24 understand that is ultimately your opinion.
25 A. Yes.

1 Q. Would anticoagulating a patient with known
2 bloody effusion place the patient at higher risk for
3 bleeding complications?
4 A. Probably.
5 Q. When you were including for me the list of
6 depositions that you reviewed, I am sorry, I can't
7 recall, did you tell me whether or not you had seen
8 Dr. Lind's deposition, L-I-N-D?
9 A. No, I had not.
10 Q. Okay.
11 A. It was Mocnik, Plost and Rooks, as far as
12 the doctors were concerned.
13 Q. And now, on the 30th, were her signs and
14 symptoms consistent with diagnoses other than PE?
15 A. Yes. The differential was wider than PE.
16 Q. What other diagnoses do you believe that
17 were consistent with her condition on the 30th?
18 A. Well, a complicated bacterial pneumonia.
19 Q. Anything else?
20 A. That includes -- well, I will leave it at a
21 complicated bacterial pneumonia. Yes. Malignancy
22 should have still been included in the differential.
23 Q. Even after the arteriogram was performed in
24 this patient, do you recall that there was still some
25 doubt by members of the treatment team about this mass

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1 on the left side being a PE?
2 A. Yes, I recall that there was some -- there
3 was still some discussion amongst team members trying
4 to reconcile the arteriogram, for example, with the CT
5 imaging and trying to understand if there was more than
6 a PE there.
7 Q. As far as the autopsy is concerned, you
8 would agree that the mass that was found on the left
9 through the various tests during the hospitalization,
10 that is not what killed her?
11 A. No. I believe that the mass on the left is
12 not the -- there was an organizing clot, is not what
13 killed her.
14 Q. And the small pulmonary emboli at the third
15 and fourth level in the right lung that was found on
16 arteriogram, that is not what caused this patient's
17 death either, correct?
18 A. No. I believe that the right pulmonary
19 emboli lesions at that time were not lethal.
20 Q. After the patient received her Lovenox on
21 the evening of the 31st, most likely she threw a new
22 clot, correct?
23 A. Yes. On the 31st, most likely, her demise
24 was caused by right pulmonary emboli that developed as
25 either new lesions or extension of the known lesions.

1 Q. Do you agree, Doctor, that patients taking
2 anticoagulation can still develop blood clots while on
3 that medication?
4 A. Yes, it still may happen.
5 Q. There is no guarantee that if you are on
6 anticoagulant medication, you are not going to develop
7 a PE, correct?
8 A. That is correct. They still may happen.
9 Q. Now, would you agree that the physician who
10 is treating the patient at the bedside and doing the
11 assessments and talking to the patient is in a better
12 position to exercise medical judgment than somebody who
13 is not involved in the patient's care?
14 A. Well, I mean, I certainly would like to
15 hope that a treating physician would put themselves in
16 a -- in the very nice, at times unique position of
17 comprehensively evaluating the patient and assessing
18 the patient and knowing the history and knowing the
19 records and examining a patient thoroughly and so
20 forth, knowing the situation thoroughly and so forth,
21 to play that role, and that is the role that needs to
22 be played, but that is not the role that I think was
23 played here.
24 Q. What do you mean when you say you don't
25 believe that is the role that was played here?

1 A. Well, I agree with your statement that a
2 physician who practices standard of care medicine and
3 is thorough in his review of the record and evaluation
4 of the patient and timely and reasonable treatment of
5 the patient, it does occupy that really nice position,
6 on the one hand.
7 But on the other hand, in this particular
8 case, I can't agree that the physician here was in a
9 better position because I don't feel like Dr. Rooks,
10 for example, practiced standard of care medicine. I
11 feel like he didn't.
12 Q. You go on to state in your discovery
13 responses that the patient's signs and symptoms
14 evidenced a pattern consistent with a diagnosis of
15 thrombosis, correct?
16 A. Yes.
17 Q. Tell me specifically the signs and symptoms
18 to which you are referring to.
19 A. Okay. Which paragraph are you on, just so
20 we are in synch here?
21 Q. On page three. I am still on paragraph
22 two. It's the sentence -- it's the last sentence of
23 that paragraph.
24 A. Okay. Okay. Yes. Well, I think that,
25 first of all, having some -- at times having the vital

1 signs, such as, she is tachycardic, and I went back
2 over the records again last night. At times she was in
3 the 90s, at times in the hundreds, so it was an
4 unexplained sinus tachycardia. That is one of the
5 nicest early signs of a -- or nicest signs of a PE.
6 And requiring oxygen at times, supplemental
7 oxygen, and/or being short of breath, then moving on
8 to -- and cough. She had had hemoptysis, of course.
9 And so moving on to, you know, bloody
10 pleural effusion, certainly compatible with pulmonary
11 embolism, and actually infarction at that point. And
12 on the chest x-ray, having the wide mediastinum is
13 compatible with it. I mention the pleural effusion.
14 The CT signs I have already talked about
15 being compatible on the spiral CT with extrinsic mass
16 or still with an organized clot, as it was in this
17 case.
18 In addition to that, the cutoff on the
19 arteriogram intravascularly is a sign of blockage there
20 in the pulmonary vessel, then the lesions on the right
21 side that showed up, too.
22 The Doppler showing the saphenous vein
23 thrombosis was certainly above the knee, but not deep,
24 rather superficial, but a marker for thrombosis, of
25 course, at the minimum. Her lack of response to

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1 antibiotics. And now it's a series of antibiotics.
2 Her fainting episode I have already
3 commented on as a -- call it sort of a heralding event,
4 when she probably initially threw the lesion, pulmonary
5 embolism lesion on the left.
6 So these are just some that I can think of
7 as I sit here. I am sure I can come up with more.
8 Q. When you say the chest x-ray, you are
9 referring to the chest x-ray of the 29th or 30th or
10 which one?
11 A. The 29th.
12 Q. The signs and symptoms which you just
13 listed for me, would they also be consistent with an
14 obstruction of the left pulmonary artery from an
15 extrinsic mass?
16 A. Yes, that would still be included in the
17 differential, but a lower probability.
18 Q. A little earlier you talked about the birth
19 control medication in this patient.
20 Do you -- as a physician, do you prescribe
21 birth control medication to patients?
22 A. Yes.
23 Q. In your experience, how often do your
24 patients develop PE as a result of oral contraceptives?
25 A. Well --

1 Q. Is it rare?
2 A. It's certainly -- it's certainly not
3 common. In my experience when I have seen it, it's
4 been in the face of also having underlying blood
5 clotting abnormalities, like genetic abnormalities.
6 Q. This patient was later determined to have
7 such abnormalities, was she not?
8 A. Yes.
9 Q. And in all fairness to her, she was not
10 aware that she had these abnormalities during the month
11 of July while she was receiving this care, correct?
12 A. Yes. I have no reason to believe that she
13 was aware of it prior to the 31st.
14 Q. And you don't have any reason to believe
15 that these physicians should have been aware of it
16 prior to the time that they were either, correct?
17 A. Well, I believe I have already testified to
18 the fact that I believe, you know, Dr. Rooks should
19 have ordered -- we should turn this clock back 24
20 hours, you know, so that these results are coming back
21 on the 30th rather than later.
22 So in other words, I believe she should
23 have known at least by the 30th at the latest.
24 Q. What is it that leads you to believe that
25 the -- that Dr. Rooks could have even had the results

1 on the Factor V and prothrombin 2 gene mutation prior
2 to the time he did?
3 A. I don't know their particular lab and if
4 they are even on stat orders or if there are, you know,
5 certain days that they are not done, for example, that
6 is possible.
7 But in general, again, because I believe
8 that Dr. Rooks should have ordered the blood work,
9 including those prothrombotic workup or studies stat,
10 you know, I have every reason to believe they should
11 have been done on the, you know, on the 29th and been
12 available by the 30th.
13 Q. Is it your belief that St. John had the
14 capacity to run those labs as opposed to having to send
15 them to an outside lab to be handled?
16 A. I don't know whether they ran them
17 internally or not, but in my experience, if they are
18 ordered stat, they typically can turn them around.
19 That's why I was giving a day to it rather than like a
20 blood gas, giving an hour or two, giving at least a
21 day.
22 Q. I want to make sure I understand what you
23 are saying.
24 Is it your belief that if the blood work
25 has to be done by an outside lab, even if it's ordered

1 stat, it can be returned within 24 hours?
2 A. That is my experience. But, you know,
3 again, I don't know this hospital's capabilities for
4 stat outsourcing of the heme labs.
5 Q. Now, do you have some familiarity with the
6 Factor V Leiden and prothrombin 2 gene mutation
7 condition?
8 A. Yes, in that as part of doing a lot of
9 prothrombotic workups, you know, screening workups over
10 the years, I certainly have had my share of patients
11 come back with those kind of deficiencies or problems.
12 Others, too. I mean, just sort of a general
13 smattering.
14 Q. In fact, you have actually been involved in
15 at least one case where Factor V Leiden was an issue,
16 have you not?
17 A. It -- I don't remember a particular case,
18 but I believe that Factor V Leiden has more familiarity
19 that way, yes.
20 Q. Do you recall giving previous testimony
21 that less than one percent of the population is
22 positive for Factor V Leiden?
23 A. That sounds familiar to me.
24 Q. Okay.
25 A. Yes.

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1 Q. Is it your understanding that women who
2 have this condition and know they have this condition
3 should avoid estrogen-containing oral contraceptives?
4 A. Yes.
5 Q. And that is because these contraceptives
6 significantly increase the risk of developing blood
7 clots; isn't that correct?
8 A. Yes. It's a prothrombotic kind of
9 situation, and it's a -- yes. It's the wrong kind of
10 prescription to have. Yes.
11 THE VIDEOGRAPHER: Counsel, excuse me.
12 This is the videographer. I am going to need to change
13 the tape within five minutes.
14 MS. CALLAHAN: Why don't you just go ahead
15 and change it?
16 THE VIDEOGRAPHER: This is the end of tape
17 No. 1, in the deposition of John H. Fullerton, M.D. We
18 are off the record at 4:30 p.m.
19 (Short recess.)
20 THE VIDEOGRAPHER: This is the beginning of
21 tape No. 2 in the deposition of John H. Fullerton,
22 M.D., on July 31, 2006. We are back on the record at
23 4:35 p.m.
24 MS. CALLAHAN: Q. Doctor, given the fact
25 that less than one percent of the population has -- is

1 positive for Factor V Leiden, do you know what
2 percentage of the population has a combination of both
3 the Factor V Leiden and the prothrombin 2 gene
4 mutation?
5 A. It would certainly be much lower than that.
6 Q. Do you agree that those two conditions
7 combined create even a greater risk of the development
8 of blood clots?
9 A. Yes.
10 Q. Do you know how much greater risk?
11 A. No. I will defer to our hematology expert
12 for that, but I know that it's increased.
13 Q. Do you know if it's considerably increased?
14 A. I don't have a magnitude factor for you.
15 Q. Okay. Are oral contraceptives considered a
16 medication?
17 A. Yes.
18 Q. I want to talk just a minute about this
19 lower extremity injury.
20 What is your understanding as to the cause
21 of the injury that led her to see Dr. Anderson on
22 July 7?
23 A. Well, I go by the -- if I go by the medical
24 records from the encounter, there is some reference to
25 her tripping over a cat or cats and having a fall, on

1 the one hand.
2 On the other hand, going by the deposition
3 testimony of her widower -- and I am not sure if her
4 mother corroborated that or not. But at least going by
5 Chris's deposition testimony, he didn't feel like
6 there -- that he had heard about an actual fall or
7 actual trauma to the medial thigh.
8 And, in fact, to kind of expand my
9 testimony a little bit, the mom did weigh in a little
10 bit about the fact that she had, I think, talked to
11 Melissa about the need to explore that sort of inner
12 thigh issue about the fall because it was not real
13 compatible with a typical fall.
14 So there were a couple of different sort of
15 areas of deposition testimony from family members about
16 discussions that they had had with Melissa concerning
17 the -- actually the low likelihood of sort of a classic
18 mechanical fall causing this.
19 Q. Regardless of those discussions by the
20 family with Melissa, is it your understanding from your
21 review of the materials that Melissa never directly
22 reported this information to her physicians at St. John
23 during the hospitalization, despite them asking
24 numerous occasions whether or not there had been such
25 an injury?

1 A. Yes. I certainly do not find the evidence
2 in the medical record of -- I don't find evidence in
3 the medical record of this sort of dispute about
4 whether there was some sort of a witnessed fall, you
5 know, and related medial thigh trauma. I only get this
6 from comparing the medical records to the depositions.
7 Q. Is it your understanding that Dr. Rooks
8 eventually learned of the problem with the lower
9 extremity, that being the pain and swelling, when he
10 was talking to her husband on the morning of the 31st
11 following their bronchoscopy?
12 A. Yes. I believe that Dr. Rooks has
13 indicated that he didn't hear about that piece of her
14 medical history until the 31st, but I did find other
15 evidence in, I believe it was Dr. Plost's -- from
16 Dr. Plost's evaluation and from the Doppler record's
17 requisition, you know, to the contrary.
18 Q. Now, speaking of the Doppler, your next
19 opinion in Exhibit 2, you say that -- the fourth
20 paragraph down, "After admission to the hospital the
21 ultrasound completed at St. John on July 30 showed
22 clotting in a superficial vein, however, the clot was
23 above the knee," correct?
24 A. Yes.
25 Q. What is the significance to, in your mind,

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1 the fact that the clot was above the knee?
2 A. Well, I think in terms of just general
3 medical teaching, that one of the ways we delineate
4 clots and how severely we look at them, in other words,
5 there are real risks to the patient of having
6 complications -- is whether or not they are below the
7 knee or above the knee. And in this particular case it
8 was a saphenous -- I believe it was a saphenous vein
9 clot and was above the knee, not below the knee.
10 So below the knee, we really don't take an
11 issue -- take issue with there being a real significant
12 risk of pulmonary embolism or other complications, so
13 in other words, not an emergency. So that is what that
14 refers to.
15 Q. Do you have some medical evidence to
16 support an opinion that clots above the knee is
17 significant for PE?
18 A. Boy. I mean, to continue sort of in the
19 vein of, so to speak, of general teaching, you know,
20 the deep veins in the legs are considered the -- to
21 have the real significant risk for PE, not the
22 superficial veins.
23 Q. According to this ultrasound, there was no
24 clot in the deep veins, correct?
25 A. That's correct.

1 Q. The clot that was found in the superficial
2 vein, is it fair to say you are not in a position to
3 say how long that clot had been present?
4 A. No. You know, I am not sure how long that
5 clot had been present, although because this patient
6 had been started, I believe, on birth control pills in
7 May of '02, it probably started sometime, you know,
8 sometime in May or June of '02.
9 Q. Is that speculation on your part or is that
10 based on some scientific medical evidence?
11 A. Well -- all right. It's not based on
12 speculation. My belief here is that this is a --
13 because this is a patient who did not previously have
14 an episode of spontaneous blood clots, that we know
15 about, and because we have evidence that she went on
16 the birth control, the oral birth control pills in May
17 and June of '02, it was sometime in this time frame of
18 May, June, early July '02 that this -- that this clot
19 developed from the combination of prothrombotic factors
20 that we have already -- that I have already talked
21 about. That is the probable scenario.
22 Now, it -- maybe it was there before that
23 because she -- we know she has a preexisting
24 prothrombotic tendency. It's possible. But the more
25 probable scenario is what I outlined.

1 Q. You go on to say in Exhibit 2, "There was
2 no medical reason for Dr. Rooks not to believe a clot
3 could have migrated from Mrs. Widick's lower
4 extremities."
5 Is that a double negative there? Are you
6 able to rephrase that and tell me what you are saying
7 without a double negative?
8 A. Sure. Let me just -- I think I can say it
9 a little more clearly in general.
10 Again, there is certainly -- the teaching
11 is there is certainly a difference between blood clots
12 that are below the knee or above the knee, and this was
13 a blood clot above the knee, on the one hand.
14 On the other hand, the teaching is that
15 deep vein clots are the ones that are -- have the real
16 significant risk of causing pulmonary emboli. So this
17 was not a deep venous thrombosis. So I am not in a
18 position to say that the pulmonary embolism in this
19 case probably came from the saphenous vein thrombosis.
20 I don't want to imply that.
21 Q. Okay.
22 A. All right. So, but in this case, was the
23 probable recent development of a saphenous vein clot,
24 you know, in this lower leg issue, vein issue, a marker
25 for her heightened prothrombotic tendency?

1 In other words, preexisting congenital
2 abnormalities combined with the more recent birth
3 control pills created the recipe for her to develop
4 additional blood clots and pulmonary emboli. That is,
5 I believe, what happened here.
6 Q. So is your assumption based on the fact at
7 the time this ultrasound report comes back, Dr. Rooks
8 is aware of her prothrombotic tendencies combined with
9 her taking oral contraceptives?
10 A. That he should have been, yes.
11 Q. At this point in time, though, you would
12 agree that the test result for the prothrombotic
13 tendencies had not yet been returned?
14 A. I may have misspoke a little bit. Again, I
15 am -- I am talking about the lower extremity Doppler in
16 conjunction with her OCP or birth control pill history
17 at this point.
18 Q. Tell me why you believe that Dr. Rooks
19 should have been aware of the birth control at this
20 point in time, when the patient is not -- did not
21 reveal that she was on that medication when questioned
22 by him.
23 A. Well, again, to me there is a bit of a
24 dispute in the records, in that, yes, I do not see
25 birth control pills listed by the -- by the 20 -- by

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1 the -- in the record before Dr. Plost weighs in, you
2 know, late on the 29th. I don't find it, on the one
3 hand.
4 On the other hand, I do -- taken from
5 deposition testimony of associated family members,
6 their belief that she would have considered this a
7 medicine, would have mentioned this, is all I have to
8 go by.
9 Q. Do you agree that superficial thrombosis in
10 and of itself does not predispose a patient to PE?
11 A. Yes, that is true.
12 Q. What is the location of the proximal
13 portion of the greater saphenous vein?
14 A. The location is up toward -- up toward the
15 hip. So it's up pretty high on the, you know, on the
16 thigh.
17 Q. Now, at least looking at the time frame of
18 summer of 2002, would you agree that the literature
19 during that point in time was consistent that really
20 only the superficial thrombosis involving the very
21 proximal portion of the greater saphenous vein is
22 described as something that could potentially develop
23 PE?
24 MR. BRATCHER: Object to the form.
25 THE WITNESS: I better have you repeat the

1 question, just because I am not so sure I understood
2 the whole thing.
3 MS. CALLAHAN: Q. Okay. Sure. I don't
4 want you to speculate about what my question is. It
5 probably just wasn't a very good question.
6 Would you agree that superficial thrombosis
7 involving only the very proximal portion of the greater
8 saphenous vein was described in the literature as of
9 2002 as something that could develop PE?
10 A. Yes, it certainly could develop. Yes.
11 Q. You agree that she did not have a clot in
12 the proximal portion of the greater saphenous vein?
13 A. I would have to go back in the record -- to
14 the Doppler and see if it was proximal or distal. I
15 mean, the record speaks for itself, I think.
16 Q. Okay. The -- I am trying to think how I
17 want to ask this question.
18 Would you agree that a patient can have
19 superficial thrombophlebitis from a hypercoaguable
20 state?
21 A. Yes, the hypercoaguable state may cause
22 superficial thrombosis.
23 Q. There is a number -- there were a number of
24 things that can cause a patient to be in a
25 hypercoaguable state, correct?

1 A. Yes.
2 Q. Lymphoma is certainly one of them, would
3 you agree?
4 A. Sure.
5 Q. I want to make sure I understand what you
6 told me a minute ago is that you do not believe that
7 the PE in this case developed from the superficial vein
8 thrombosis; is that correct?
9 A. I want to be real clear about this. In
10 this particular case the PE certainly may have
11 developed from that. Okay. It may have. But going on
12 odds in terms of PEs developing more often from the
13 deep veins, you know, it may not have.
14 So it's -- I want to make it real -- what I
15 want to make sure is that in this particular case, I
16 believe that the more superficial saphenous vein
17 thrombosis was at least a marker, if not a nidus, for
18 the embolism.
19 Q. Do you agree that more often than not,
20 superficial vein thrombosis is benign?
21 A. Yes, most of the time, in the setting of no
22 other prothrombotic tendencies and when someone is not
23 on birth control pills, yes, and healthy, yes.
24 Q. Would you agree that the risk of PE from
25 superficial vein thrombosis is lower than the risk of

1 bleeding complications from the administration of
2 anticoagulation prior to bronchoscopy or arteriogram?
3 MR. BRATCHER: Object to the form.
4 THE WITNESS: What I can say to answer that
5 question is that, taking into account the clinical
6 context in this particular case, Melissa having
7 superficial venous thrombosis was very significant even
8 prior to her throwing the PEs.
9 And it was significant because of these
10 other conditions, namely, being on the birth control
11 pills and having more than one prothrombotic congenital
12 tendency. That is all true.
13 Now, am I going to sit here and agree that
14 the risk of every superficial thrombosis, now thinking
15 of Melissa, is less than a bleeding risk for a
16 bronchoscopic test on anticoagulation, I can't sit here
17 and say that because the risk was so high in this
18 setting for progressive thrombosis.
19 The other reason I can't answer your
20 question more fully is that I think I have already
21 testified to the fact that I was going to defer to
22 the -- our hematologic expert as far as giving you hard
23 numbers on the bronchoscopic risk of -- with
24 anticoagulation.
25 MS. CALLAHAN: Q. And any time I ask you a

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1 question that you don't feel that is within your scope
2 of practice or purview to answer, just tell me that and
3 I will move on.
4 A. Sure.
5 Q. Your next opinion is that the ultrasound
6 should have been ordered for completion on July 29th
7 and July 30th. And I think that we have already
8 discussed that, have we not?
9 A. Oh, yes.
10 Q. Now, it's not necessarily your belief that
11 had the ultrasound been completed on the 29th, the
12 findings would have been any different, correct?
13 A. That's correct.
14 Q. It's just that you believe that information
15 would have been available sooner to be factored into
16 the decision-making process?
17 A. Yes. And along with the other information
18 I have already outlined that should have been available
19 sooner, I believe.
20 Q. Do you agree that all of the evidence prior
21 to the bronchoscopy on the morning of the 31st
22 supported an extrinsic mass over a PE?
23 A. No.
24 Q. Why not?
25 A. Because I believe that if we go back and we

1 look at the evidence of Melissa being on birth control
2 pills, the evidence of surrounding acute presentation
3 following the leg symptoms, the abrupt leg symptoms,
4 the acute respiratory symptoms, and the sudden or
5 abrupt nature of a variety of things happening to her,
6 and I think I have already outlined what they are now
7 calling a, sort of a -- more recently calling a
8 fainting episode, which brought her into the hospital
9 to be looked at by a colleague, the abruptness of her
10 shortness of breath and coughing and hemoptysis and so
11 forth, all of this speaks to a more acute process than
12 some enlarging extrinsic mass like a tumor with normal
13 tumor kind of evolution.
14 Q. You referred to the fainting process a
15 couple of times. That came from her husband's
16 deposition, correct?
17 A. Yes.
18 Q. When you reviewed the medical records, did
19 you find any evidence that the patient had reported to
20 any health care provider she had experienced a fainting
21 episode?
22 A. I am not so sure I saw the phrase "fainting
23 episode." It may have been words like "fatigue" used.
24 Q. Is there a difference between a patient who
25 is fatigued and one who faints?

1 A. Yes.
2 Q. As a physician, if you are taking care of a
3 patient who has had a fainting episode relatively close
4 in time to when you are providing care, is that the
5 type of thing you might expect them to tell you about?
6 A. Well, I mean, we always hope the patients
7 are going to tell us when they have significant events,
8 particularly if they could shed light on the etiology
9 of the problem.
10 Sometimes with fainting, for example, the
11 people around the person who fainted are the better
12 historians because the person has sort of lost
13 consciousness, you know, and is not -- can't really
14 speak for when they were out. So that is sort of a
15 mixed thing. I mean, I would love to get that
16 information and -- but it's not always readily
17 available.
18 Q. Certainly, if the medical records do not
19 depict certain events in process as going on with the
20 patient because the patient does not report it, and the
21 patient then doesn't report it to you, you really are
22 at a loss to gather that information anywhere else,
23 aren't you?
24 MR. BRATCHER: Object to the form.
25 THE WITNESS: You bring up a point, and

1 that is that, in a situation where we are just relying
2 on the history, that is true. In a situation where
3 there should be other either colleagues or other
4 records available for getting at history from these
5 multiple sources, we tend to rely on these multiple
6 sources.
7 And so we also rely on our ability and our
8 colleagues' ability to be thorough in our assessments
9 and in our own history taking and record reviewing and
10 the like to get at this information.
11 In other words, if the relevant
12 questions -- the relevant records are not looked at and
13 the relevant questions are not asked, it's very hard to
14 get at that. I think we call it the 80 percent power
15 that a good history gives us in making a diagnosis.
16 You can't get there if you don't get at that
17 information.
18 And there are certain standard of care ways
19 of getting at that information, which I feel like are
20 part -- are at issue here.
21 MS. CALLAHAN: Q. Well, if the records
22 themselves don't reveal it and the patient doesn't tell
23 you about it, what else does the standard of care say
24 that you as a physician have a duty to do in order to
25 determine that information?

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1 A. Well, I mean, for example, in a case where
2 one is thinking about pneumonia, new infection, one is
3 thinking, should be thinking about pulmonary emboli,
4 and one might even be thinking about having a chest
5 mass, albeit that's less likely.
6 You know, there are certain lines of
7 inquiry that we go down to get at more information. I
8 just -- I didn't see that done here.
9 Q. What lines of inquiry do you believe that
10 Dr. Rooks should have gone down that he didn't?
11 A. It has to do with -- well, I mean, part of
12 the problem is that he doesn't see the patient on the
13 29th. He sees the patient on the 30th. So there is a
14 delay there.
15 And in the meantime, Dr. Plost has seen the
16 patient and elicited part of the kind of history that I
17 am talking about, which is the birth control piece.
18 And it's these kinds of pieces of
19 information that I think that, again, in hindsight
20 looking back were readily available, because Plost got
21 at part of it at least on the 29th, and Rooks didn't
22 even get at it on the 30th or the information on the
23 29th that was already revealed.
24 Q. So is it your belief, then, that Dr. Rooks
25 didn't know about the oral contraceptives because he

1 just didn't ask about it?
2 A. That's certainly one reason.
3 Q. Could another reason be he asked about it
4 and the patient, when she told him her medications,
5 didn't list it?
6 A. It's certainly possible here.
7 Q. I mean, it's not -- it's not unusual, for
8 instance -- let me back up and ask you.
9 Have you ever worked shifts in the ER?
10 A. In training we did, but since then I have
11 not worked a shift in the ER. As a hospitalist, I have
12 gone into the ER to see patients.
13 Q. Let's use the outpatient setting, then.
14 Certainly you have had many, many times of seeing
15 patients in your office practice?
16 A. Yes.
17 Q. Have you found that there are occasions
18 when your nurse goes in and kind of asks the patient,
19 why are you here, what is going on, and then you go in
20 and make the same inquiry, that sometimes the patient
21 will tell you different information than he or she told
22 the nurse?
23 A. Yes, certainly it does happen that certain
24 situations may stimulate a more full response.
25 Q. So it's not outside the realm of

1 probability that the patient could have told Dr. Plost
2 different information than what she told Dr. Rooks?
3 A. It's certainly possible. And, you know, I
4 don't want to mean that -- I don't want to imply that
5 it's not. But I also want to point out that, based on
6 review of all of the information -- of the records plus
7 the depositions, that Melissa had gone into the
8 St. John's system and been involved, I think, in
9 medical records and then more in patient care more
10 recently on 10 East, and so, I don't -- I more
11 typically see this kind of thing that you are talking
12 about in really medically naive situations, and I can't
13 say that she would have been medically completely naive
14 here.
15 Q. That is a good point. But in somebody who
16 has worked in a health care system, you would expect
17 them to have a little bit better understanding of what
18 is meant by a medication or the importance of providing
19 concise, clear history when inquired of, correct?
20 A. Yes.
21 Q. Now, I think the remainder of that
22 paragraph with respect to your opinion that Dr. Rooks
23 should have seen the patient earlier and that the
24 testing schedule was below the standard of care, we
25 have already fully discussed those opinions earlier,

1 have we not?
2 A. Yes.
3 Q. With respect to your opinion that Dr. Rooks
4 should have seen the patient earlier than the afternoon
5 of the 30th, do you know whether he made rounds to see
6 the patient sooner than that?
7 A. No, I don't, other than, I believe, there
8 is a piece of his deposition whereby he talks about the
9 patient was going for some sort of testing before he
10 saw the patient, but I don't -- beyond that I don't
11 know.
12 Q. Has that ever happened to you when you were
13 acting as a hospitalist where you went to make rounds
14 on a patient and you got to their room and found that
15 they were in some other area of the hospital undergoing
16 testing?
17 A. It has certainly happened before.
18 Q. And when that happens, then do you make an
19 effort to get back around to see the patient again?
20 A. Yes.
21 Q. Is that reasonable and appropriate to do
22 that?
23 A. Yes. If he was truly blocked from seeing
24 the patient, that can happen.
25 Q. Are you able to perform an assessment and

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1 take a history and evaluate a patient while they are
2 getting a CT scan performed?
3 A. No, not while they are actually in the CT
4 scanner. You might in the hallway, you know, while
5 they are waiting. I mean, there are various things we
6 do to still be able to take a look at a patient and get
7 the information and so forth in between the testing.
8 Q. I think your next opinion in Exhibit 2 is
9 that she should have been treated aggressively for
10 thrombosis?
11 A. Yes.
12 Q. Have we fully discussed that opinion
13 already?
14 A. I think so, yes.
15 Q. Next you mention the treatment should have
16 begun before July 31st with Lovenox or IV heparin.
17 Again, something we have already discussed, correct?
18 A. Yes.
19 Q. Next opinion, that if Dr. Rooks had
20 adequate evidence to be concerned about bleeding
21 complications, that an IVC filter should have been
22 ordered and utilized. And again, something we have
23 already fully discussed?
24 A. Yes.
25 Q. Do you believe that Dr. Rooks had adequate

1 evidence to be concerned about bleeding complications
2 in this patient?
3 A. Yes. I believe that -- I believe that
4 Dr. Rooks was certainly in a position where he needed
5 to think about bleeding complications and have the
6 discussion with the patient and a risk-benefit analysis
7 of bleeding complications.
8 But I believe in this particular -- in this
9 particular case, with the type of evidence and
10 abundance of evidence I have described being -- that
11 should have been available and I think was available to
12 Dr. Rooks, about the probability of a -- something more
13 emergently life threatening, namely PE being present
14 here and/or developing more, that that certainly
15 outweighed any risk of the potential for a less common
16 or rare tumor bleeding or some other complication from
17 a minor procedure, that kind of thing. I think I have
18 already testified to that.
19 And again, if Dr. Rooks was truly concerned
20 about bleeding from something real or imagined, then an
21 IVC filter should have been right there.
22 Q. I appreciate your desire to explain
23 responses and everything, but I think my question was a
24 little more simpler, perhaps maybe even called for a
25 yes or no response.

1 It was simply, did Dr. Rooks have adequate
2 evidence to be concerned about bleeding complications,
3 period?
4 A. Yes.
5 Q. You go on to say that, "Further,
6 thrombolitics should have been available in the room as
7 it was the only significant chance to help Mrs. Widick
8 in the event she suffered an arrest due to thrombosis,"
9 correct?
10 A. Yes.
11 Q. Are you aware of some delay in
12 administering thrombolitics at the time of the code?
13 A. No, I am not.
14 Q. You would support Dr. Rooks' decision to
15 give thrombolitics at that time, correct?
16 A. Yes. I feel like that was her last chance
17 for survival, albeit a low one.
18 Q. It was a long shot, correct?
19 A. Yes.
20 Q. But nevertheless, he did order that those
21 be given, correct?
22 A. Completely appropriate to order it and give
23 it. Yes.
24 Q. Then I think your last paragraph, it's
25 probably more of a summary or a wrap-up of everything

1 about -- take a look at that and tell me if there are
2 new or different opinions in your concluding paragraph
3 than what we have already discussed.
4 A. Yes. Let me see. Yes, that pretty well
5 sums it up.
6 Q. With respect to your opinion that he should
7 have taken a more complete history, I know we talked
8 about the oral contraceptives and the lower extremity
9 swelling. Is there anything else that you believe had
10 Dr. Rooks taken a more complete history, he would have
11 had that information?
12 A. Yes. I have already -- I think I have
13 already mentioned this. I know I have already
14 mentioned this, but it has to do with eliciting the
15 history of her fainting episode.
16 Q. You are correct. I overlooked that.
17 Anything else?
18 A. I think also her history of -- I believe
19 there has been testimony from family members she missed
20 work after that 21st visit until the time of the
21 admission, and so -- because of her symptoms, including
22 her respiratory, her new respiratory symptoms, and that
23 that was very important here to elicit. In other
24 words, the seriousness of it all.
25 Q. How is it that you -- do you believe that

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1 Dr. Rooks had an obligation to, as part of his
2 questioning, say, By the way, have you missed work? Or
3 how is it that you believe he should have elicited that
4 information?
5 A. Well, I mean, you have asked a pretty good
6 one. But what I am trying to illustrate is that from
7 the 21st -- in other words, going after that
8 information, what the heck brought you in on the 21st,
9 I mean, you had a leg thing going on before, and what
10 the heck brought you in on the 21st, and how bad was it
11 to bring you in like that, and then I think she was
12 left with the instructions that if she failed
13 antibiotics on the 21st, you know, to come back, and
14 then, of course, she was seen on the 23rd by Paulsen
15 and then by Paulsen again on the 29th.
16 And so how badly did she fail stuff? And
17 this, you know, apparent sudden bronchitis in a
18 previously healthy gal like that, with all of the
19 shortness of breath and everything else, it's just so
20 suspicious for something serious.
21 Q. Okay.
22 A. And --
23 Q. Definition of medical judgment?
24 A. Well, you know, yeah. I wanted to sort of,
25 in terms of finishing the last answer --

1 Q. I am sorry. I didn't -- I thought you were
2 done. I apologize.
3 A. Almost. So it gets to the point of, the
4 fact that -- the fact that Rooks could, in effect, sort
5 of stay away for over 20 hours after the formal
6 admission to the hospital, you know, kind of goes in my
7 mind, goes along with this sort of a lack of, early on,
8 the lack of awareness of the sort of the seriousness of
9 the situation, and the potential, you know, potential
10 seriousness or consequences of the situation.
11 I think there was this lack of -- lack of
12 awareness or lack of taking it seriously enough early
13 on in her care.
14 Q. Do you attribute that to him just not
15 understanding or do you attribute that to him just
16 being uncaring or to what do you attribute that belief?
17 MR. BRATCHER: Object to the form.
18 THE WITNESS: I attribute that belief to
19 something -- some sort of a fragmentation of her care
20 that occurred between the, you know, the Paulsen
21 connection to Rooks as the hospitalist, you know, or
22 the other primary care people to Rooks as the
23 hospitalist responsible for her hospital care, some
24 sort of fragmentation that went on from some -- from
25 probable lack of meeting the standard of care.

1 MS. CALLAHAN: Q. Can you tell me -- I am
2 not sure I follow what you mean when you say
3 fragmentation.
4 A. Well, for example, if Rooks gets the call
5 to go see Melissa on the 29th and doesn't see her until
6 kind of late on the 30th, that no matter what he says
7 his reasoning is for seeing her later, I mean, this is
8 a woman who Paulsen felt strongly enough to get a
9 pulmonologist in already, and the pulmonologist, from
10 his note, is already onto the birth control pills and
11 worried about pulmonary embolism and thrombosis and so
12 forth. So that is by the 29th.
13 So I just think that there was a lag there
14 for some reason that I can only surmise was frag -- I
15 call it fragmentation, you know, between the
16 hospitalist getting up to speed in the inpatient
17 setting and the docs getting up to speed in the
18 outpatient setting.
19 Q. Were Dr. Paulsen's admitting orders for
20 this patient appropriate in your mind?
21 A. Hang on one second. No.
22 Q. In what respect?
23 A. As I have already testified to for
24 Dr. Rooks, that by extension here, Dr. Paulsen I feel
25 like needed to order the pulmonary consult stat. I

1 also think he -- I already testified to for Rooks, but
2 I think he needed to order arterial blood gas stat,
3 too.
4 Q. With respect to the term "stat," you told
5 me that that can mean anywhere from one to two hours
6 upwards to the next morning, correct?
7 A. Depending on the type of test, yes.
8 Q. With respect to, let's say, the consult of
9 the pulmonologist, would stat be one to two hours?
10 A. Stat would be one to two hours, and I am
11 not going to quibble if it's the same day.
12 Q. Okay. And, in fact, Dr. Paulsen wrote his
13 orders at 1800, and within one to two hours she was
14 seen by a pulmonologist, was she not?
15 A. That's correct.
16 Q. So you quibble with his not ordering the
17 ABG?
18 A. I still quibble with not ordering the
19 pulmonary consult stat, simply because it denotes a
20 recognition that this girl is sick and that this girl
21 could get a lot sicker, and I think there is enough
22 information there to know that.
23 So I am -- that's why I am taking issue --
24 you asked about the orders. And then, yes, the ABG
25 would be the other one.

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1 Q. You are critical of him not ordering it
2 stat, even though it was carried out stat?
3 A. Correct.
4 Q. Isn't that criticism basically moot because
5 it was carried out in a timely fashion?
6 A. It is as far as any harm to the patient
7 from that pulmonary order, that is true. But I am
8 trying to paint what I believe is the accurate picture
9 here of a lack of awareness of the seriousness of the
10 situation with this patient upon presentation.
11 Q. Do you have any reason to believe that the
12 deviations that you have identified are the result of
13 physicians that were uncaring or lacked
14 conscientiousness?
15 A. No. I have no evidence. Other than sort
16 of indirect evidence from family testimony in their
17 depos, I have no direct evidence that these physicians
18 are not caring or not empathetic. I have no evidence
19 of that.
20 Q. Now, what is medical judgment, Doctor?
21 A. Medical judgment comes into play when there
22 are several sort of competing different forces, if you
23 will, that weigh in on risks and weigh in on benefits
24 in terms of deciding, you know, a course of therapy or
25 how much to weigh a -- weigh the seriousness of an

1 issue.
2 Q. Would you agree that two physicians can
3 have a difference in medical judgment in the care and
4 treatment of a patient without either one of them
5 practicing below the standard of care?
6 A. Yes. There are certainly -- those
7 situations exist.
8 Q. Would you agree that the earlier a process
9 is in the development of the disease process, the more
10 difficult it can be to diagnose?
11 A. Yes, oftentimes. Again, depends on the
12 disease process.
13 Q. And any given clinical presentation can be
14 consistent with multiple disease processes or
15 conditions, correct?
16 A. Yes. Oftentimes a constellation of signs
17 and symptoms, it's compatible with multiple things
18 within the differential.
19 Q. And that's where actually the differential
20 diagnosis comes into play, does it not?
21 A. Yes.
22 Q. As the differential diagnosis is created, a
23 doctor must use his or her medical judgment to work
24 through that differential, performing tests and making
25 observations in order to try and get to the diagnosis

1 of that condition?
2 A. Yes, that is true. And while the
3 physicians are doing that, it is incumbent upon them to
4 weigh the real risk of very common sorts of maladies
5 with benefits of treatment, for example, and also
6 include more rare maladies to make sure that their
7 differential is like an umbrella, you know.
8 Q. Depending upon the medical complexity of
9 the situation and the resources available, working
10 through a differential diagnosis can take time, can it
11 not?
12 A. Yes, it can certainly take time. And while
13 we work through differential diagnostic sets, we
14 continue to try to protect the patient from the kinds
15 of disease processes that have been yet -- that have
16 yet to have been ruled out, but could still come and
17 either urgently or emergently harm them or kill them.
18 Q. And that is where your medical judgment and
19 that risk-benefit analysis takes place, correct?
20 A. Yes.
21 Q. When you were acting as a hospitalist, did
22 you have occasions like Dr. Rooks did with this patient
23 where you involved a number of other consultants and
24 specialists to work with you on developing the
25 diagnosis and treatment plan for a patient?

1 A. Yes.
2 Q. And did you find that there were occasions
3 when you gave some degree of deference to the opinion
4 of these specialists depending upon their skill level
5 and your familiarity and respect of that skill level?
6 A. Yes, based on those kinds of attributes or
7 qualities and based on the, you know, the types of
8 disease processes that we were looking at, or potential
9 processes.
10 Q. I think, unless you correct me, we have
11 gone through and discussed all of the opinions that are
12 outlined in Exhibit 2?
13 A. Yes.
14 Q. All right. Now, at the very beginning of
15 this deposition when we were talking about whether or
16 not Exhibit 2 was a comprehensive set of your opinions,
17 you said that you had some additional opinions, one,
18 that Dr. Rooks should have insured the patient was
19 evaluated and treated with anticoagulation or IVC
20 filter by the 30th, but that is something we have
21 already discussed, correct?
22 A. That's correct.
23 Q. And the other opinion that you stated at
24 the beginning of the deposition was that by the 31st
25 after the arteriogram was performed, by 5:00 p.m. there

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1 was still an opportunity to intervene with appropriate
2 therapy. And we have already discussed that, correct?
3 A. That's correct.
4 Q. So have we discussed -- have you told me
5 all of your opinions?
6 A. I think so. Let me just double-check.
7 Q. Okay.
8 A. Yes.
9 Q. As we have discussed these opinions already
10 in the deposition, have you developed any more opinions
11 that you have not told me about or we have not
12 discussed?
13 A. No, I have not, but subject to me receiving
14 additional materials for review and developing
15 additional opinions, I -- these are all of the opinions
16 I have today based on what I have been sent.
17 Q. And certainly, if you receive additional
18 materials and develop new opinions, you will promptly
19 notify Mr. Bratcher of that so he can notify me and I
20 would have the opportunity to talk to you about those
21 new opinions, correct?
22 A. Of course.
23 Q. Have you acted as an expert witness in any
24 other cases in which you have opined that there was a
25 failure to timely diagnose and treat PE leading to a

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1 patient's death?
2 A. Over the last six years, I probably have
3 had a couple.
4 Q. Did you -- a couple of PE cases?
5 A. A couple of delay in diagnosis of PE. I am
6 just thinking back. I probably had at least a couple.
7 Q. Have you ever testified on behalf of a
8 defendant where that individual was accused of failing
9 to timely diagnosis and treat a PE?
10 A. It's possible, but I think they were
11 plaintiff cases.
12 Q. Have you yourself ever had a patient expire
13 from a PE?
14 A. Yes.
15 Q. How many?
16 A. Well, I want to be real clear about this.
17 I certainly had a number of patients expire from PE.
18 But as far as me as a doctor evaluating a patient,
19 making the diagnosis of PE, treating the PE, I can't
20 think of any patient who I have lost over the years.
21 Now, as far as inheriting patients that as
22 part of either a code blue team or emergency response
23 team that I ran for years, I certainly had reason in
24 the field to suspect people were getting PEs and trying
25 to treat them and resuscitate them. So hopefully

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1 that --
2 Q. Have you had the experience where you felt
3 a patient may have had a PE, and in trying to treat
4 that patient for PE, the patient ultimately dies of it
5 anyway?
6 A. No.
7 Q. In the instances where you have had
8 patients expire from PEs, it's fair to say you don't
9 believe that you were negligent in any way in those
10 patients' care?
11 A. No. In the patients who died of probable
12 PE and I had to provide ACLS on, for example, as part
13 of leading a code blue team, that kind of thing, I did
14 a lot of codes over the years, I feel like we sort of
15 inherited that and gave them their best shot, and kind
16 of like what I think Rooks did here, you know, in
17 trying to give them thrombolitics and turn them around
18 if they are in pulseless electrical activity, that kind
19 of thing.
20 Q. Continuing on with Exhibit 2, looking at
21 interrogatory No. 5 where I asked you to set forth the
22 compensation that you are to be paid for various
23 activities in this case, you corrected the response to
24 B in telling me that it's actually 650 for a video
25 deposition. Are subsections A and C still accurate?

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1 A. No. Subsection A, it's off a little bit.
2 Instead of 325, it's 375 per hour for review.
3 Q. Was that a typo or have you just increased
4 your charges?
5 A. That was a typo.
6 Q. And C is still accurate?
7 A. Yes.
8 Q. What is it about being videotaped that
9 causes you to charge more than if I was asking you
10 these same questions without a videographer?
11 A. Oh. Well, in my experience, sometimes the
12 video depositions, there is also an intent to use them
13 at trial as trial depos, and so I made an adjustment a
14 long time ago.
15 Q. I am not sure I follow the basis for that.
16 Could you explain that to me?
17 A. Well, there have been times in my
18 experience where, you know, a video discovery
19 deposition has been -- there has been an attempt to use
20 it as a video -- you know, as trial.
21 Q. You are saying it's been used in lieu of
22 actually calling you to testify live?
23 A. Yes.
24 Q. So on the off chance that you might not be
25 called to testify live and be paid $6,000 a day, you

1 charge more for the video?
2 A. I think you summed it up as well as I
3 could.
4 Q. Okay. Now, Interrogatory No. 6, I asked
5 you to give me a list of cases in which you have
6 testified at trial or deposition within the past four
7 years, and your response is that you do not keep a
8 list; is that correct?
9 A. Yes. My custom and practice is to not keep
10 a list.
11 Q. Have you ever testified in Federal Court?
12 A. No.
13 Q. Have you ever been asked to review a case
14 as an expert in Federal Court?
15 A. I may have received a case that was a
16 federal case years ago, but I am not sure if it was a
17 case I turned down or what happened with it, but it
18 didn't go forward. So that -- I may have been sent a
19 case over the years, but I never got very far with it.
20 Q. Let's take a quick break, and I am ready to
21 move into your notes, and that will allow me a minute
22 to run down to my fax machine and get the other page.
23 A. Sure.
24 THE VIDEOGRAPHER: We are off the record at
25 5:35 p.m.

1 (Short recess.)
2 THE VIDEOGRAPHER: We are back on the
3 record at 5:44.
4 MS. CALLAHAN: Q. Doctor, I would like to
5 move to your notes, your handwritten notes, if we
6 could.
7 A. Yes.
8 Q. And I did get the fax, by the way. Thank
9 you very much.
10 A. Great.
11 Q. I am actually able to read your notes on
12 this last one that you said you prepared yesterday and
13 faxed me. Unfortunately, I can't really read your
14 handwriting very well on the two pages that you did
15 sometime ago.
16 A. Yes.
17 Q. So if you would, just start at the
18 beginning of the first page, and just read those to me.
19 I may stop and ask you some questions. Be sure that
20 you read them in a fashion that is at least slow enough
21 that the court reporter can get it all down, please.
22 A. Sure. I have the plaintiff's name at the
23 top, and deceased, the name of the law firm at the top,
24 Kelly's name, along with Tulsa, Oklahoma. And this
25 date of June 15, '04 must have -- my custom and

1 practice in and around the date is that I would have
2 gone through my initial review of records and had a
3 preliminary verbal report with counsel.
4 Q. So you would have been contacted sometime
5 prior to June 15 of '04 to review the materials?
6 A. That's correct.
7 Q. Okay.
8 A. Then I have, the next line is, "Versus,"
9 period, "St. John Medical Center," and I have
10 parentheses, "HMO," end of parentheses, and then I have
11 another parentheses there, "07-07-02 to 07-31-02 to
12 death," end of parentheses, as a time period, comma,
13 "Dr. Paulsen," comma, "Dr. Rooks," and I have
14 parentheses on top of it, "H-O-S-P." I believe that
15 denotes hospitalist, end of parentheses, comma,
16 "Dr. Plost," parentheses, "Pulmonary," end of
17 parentheses.
18 Q. Is there any significance to your
19 description of St. John Medical Center as an HMO?
20 A. No.
21 Q. Okay.
22 A. I think in this case I noticed -- I just
23 noticed, I think in reading through all of the records,
24 there was an HMO mentioned for -- on a policy statement
25 or something, but I didn't -- I didn't attribute

1 anything else to that.
2 Q. Okay. Please continue.
3 A. Next line was "Medication," and then I have
4 "OCP," with -- denotes birth control pills, or oral
5 contraceptive pill, "06-02."
6 Then I have under that, "Swelling legs --
7 six weeks before," and then, "times 10 to 14 days."
8 Then I have, next a few lines down,
9 underlined, "Outpatient/clinic records." I have,
10 "No. 1, MCL," which I think stands for medial
11 collateral ligament, dash, "strain secondary to fall
12 07-07-02."
13 And then I have next to that, "Red," comma,
14 "swollen," comma, "warm." And then I have a line going
15 up, which I believe says RX or treatment, and I believe
16 that says superficial -- either superficial phlebitis
17 or strain. I can't read that second word there. But
18 it's "treatment."
19 Then -- oh, I think that actually says,
20 "treatment," and then that second word is "ibuprofen."
21 Makes more sense.
22 Q. Okay.
23 A. Then No. 2 is, "Bronchitis and pleurisy
24 07-23-02 -- fever." No. 3, I have written down,
25 "Advair/amoxicillin/Vicodin," and then, "Outpatient

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1 switched to Avelox," and then parentheses, "from
2 amoxicillin," end parentheses.
3 No. 4, "ER pleuritis/chest
4 pain/bronchitis/shortness of breath." Next line, "EKG,
5 chest x-ray WNL," meaning within normal limits.
6 Next line, "Admit 7-29-02." Next line,
7 "Dr. Plost," I have "BP," meaning bacterial pneumonia,
8 slash, and that's effusion, "EFF/rule out DVT/PE," or
9 pulmonary embolism.
10 Then I have on the bottom, "Left
11 thoracentesis/chest CT/left hylar mass," question mark,
12 slash, "bronch," meaning bronchoscopy, "negative/
13 arteriogram -- thrombus," and I have, "left" -- it's
14 hard to see what that first line is, but I think it's
15 pulmonary artery.
16 So it would be left pulmonary artery. And
17 then under that, "Lovenox," and then, "left lower lobe
18 bacterial pneumonia plus left effusion."
19 Let's see. The next line is, "Decision
20 made not to administer," and then I have a next line,
21 "thrombolitics or IVC filter."
22 Q. So the last two lines are all one sentence?
23 A. Yes. So that would read, "Decision made
24 not to administer thrombolitics or IVC filter." That
25 is the first page.

1 Then the next page, same date on the top,
2 No. 1, I have, "Described etiology," and I have
3 parentheses, "OCP."
4 Q. There is a word on my page before
5 "described."
6 A. Yes. It says -- it looks like it says
7 "wall," but I don't know what that means.
8 Q. Okay.
9 A. Or maybe "will." I can't tell. But it's
10 something about describing etiology. In other words, I
11 felt like OCPs were at the center of it.
12 No. 2, "Family history/cigarettes,"
13 question mark. "Well-described symptoms/sign -- lower
14 extremity."
15 No. 3, "No clotting disorders." That was
16 initially that we knew about. "Antithrombin III,
17 protein C, protein S, antiphospholipid antibody, lupus
18 anticoagulant," or LA, " dysfibrogenemia, tumor,
19 increased sedentary."
20 These are the other factors.
21 No. 4, "Multiple opportunities in
22 outpatient and inpatient setting to intervene over
23 several weeks."
24 No. 5, "If do not intervene, even in sudden
25 death setting, almost no chance of survival. If

1 intervene early -- survival high."
2 No. 6, "Thrombolitics therapy/thrombectomy
3 would have decreased extension of PA clots," pulmonary
4 clots.
5 7, "Otherwise young, vital patient,"
6 parentheses, "in medical profession," end of
7 parentheses, period.
8 Then I have on the bottom here, No. 8,
9 "Need pulmonary expert." And then I have the next
10 line, "Hospitalist role of what should have been,"
11 looks like what should have happened or been what
12 happened.
13 Next line, "Should have known about." Next
14 line, "More difficult to discuss survivability," that
15 is at the time of the code. And then, "21st, more" --
16 that would mean the 31st, "More likely than not
17 hospitalized" -- actually, that is the 21st, it looks
18 like, "More likely than not hospitalized and treated
19 with hospitalist in emergency setting."
20 No. 2 -- and then I have -- I am sorry,
21 last line is, "OCP July 31." I think that is all of
22 it.
23 Q. I don't have that last line.
24 A. Okay. It has "OCP," meaning oral
25 contraceptive pill, and then it has, "July 31st."

1 Q. What does that mean, OCP, hyphen,
2 July 31st?
3 A. I believe that is denoting when the
4 discussion took place with Rooks.
5 Q. I see.
6 A. Yes. Again, my survivability comment, I
7 believe, had to do with in a code setting the chance of
8 getting someone back, even with thrombolitics, is low.
9 Q. On that second page under No. 6 when you
10 say, "Thrombolitic therapy" --
11 A. Slash, thrombectomy. That means cutting
12 the thrombus out.
13 Q. -- "would have decreased extension of the
14 pulmonary artery clot"?
15 A. Yes.
16 Q. Are you saying -- are you saying that
17 thrombolitics should have been used prior to the time
18 they were used?
19 A. No. No. No. The fact that -- I mean, as
20 an expert, I don't believe like the risk-benefit was
21 there to give thrombolitics earlier. But the point is,
22 you know, if you give someone thrombolitics, does it
23 have a chance of dissolving the clot, yes.
24 If you cut out the clot, it's called a
25 thrombectomy. Does that take care of it, yes. Should

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1 that have been done here, I don't believe so. But I am
2 just sort of listing things. I am doing this for
3 myself as I contemporaneously go through a record.
4 Q. Are these two pages notes that you made
5 strictly from record review?
6 A. Yes, this is strictly from record review
7 and in, I believe, in preparation for talking with
8 counsel.
9 Q. Counsel being Mr. Bratcher?
10 A. Yes. For like a verbal report, yes.
11 Q. Did you make any notes of any of your
12 communications with Mr. Bratcher or anyone in his
13 office?
14 A. No.
15 Q. Then the third page of the notes that you
16 just faxed to me today is nothing more than a summary
17 of the breaches in the standard of care, which we have
18 already discussed?
19 A. That is correct.
20 Q. Okay. Let's talk about you a little bit,
21 then.
22 A. Okay.
23 Q. On your most recent CD that you faxed me
24 today, you pointed me to the back page, which is an
25 attachment that says Weekly Clinical Schedule, correct?

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1 A. Right.
2 Q. For what period of time has this been
3 your -- I take it this is your professional schedule?
4 A. Right.
5 Q. For what period of time have you had this
6 schedule?
7 A. This schedule has been, or something very
8 similar to it, has been in -- certainly over the last
9 four years. Yes, with some minor sort of
10 modifications.
11 Q. On Mondays and Tuesdays, if I am reading
12 this correctly, your mornings are spent at the
13 San Francisco Free Clinic, and your afternoons are
14 spent seeing office patients?
15 A. Yes.
16 Q. And then on Wednesdays -- I don't know how
17 to pronounce that word.
18 A. It's Aegis, A-E-G-I-S.
19 Q. What are Aegis patients?
20 A. That is a long-term care facility where I
21 have an office near our home, across the Golden Gate
22 bridge in Marin, where I typically see more geriatric
23 patients a couple of half days a week.
24 Q. So you see them in the morning on
25 Wednesdays, and then you are back in your San Francisco

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1 office practice in the afternoon?
2 A. Yes.
3 Q. On Thursdays, you see your office patients
4 in the morning, and you go back over to the free clinic
5 in the afternoon, correct?
6 A. Yes.
7 Q. Fridays -- I am sorry if I am a little bit
8 slow here. I am trying to pick up on your little
9 acronyms down here at the bottom. From 10:00 to 1:00,
10 are you doing precepting with residents?
11 A. Yes. And that -- working with the
12 St. Mary's Medical Center locally, their internal
13 medicine residency program, has been more recent for
14 me. And actually, I am expanding that a little bit to
15 Thursday mornings -- I am sorry, to Friday mornings and
16 Monday afternoons, but that is the only variation,
17 really.
18 Q. Is that the -- is that the only hospital at
19 which you currently have staff privileges?
20 A. No. I also have privileges at Marin
21 General Hospital in Greenbrae, which is in Marin near
22 our home and near the Aegis office.
23 Q. When you have an office patient that needs
24 to be hospitalized, do you follow that patient in the
25 hospital setting or do you utilize a hospitalist?

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1 A. Well, that situation has varied from time
2 to time. Depends on how busy we are, depends if I have
3 other physicians helping out in our practice working
4 with me, or PAs or not.
5 Sometimes I follow them myself. Other
6 times I certainly enlist the hospitalist system. There
7 is a program at St. Mary's and at Marin General.
8 Q. How long have you held hospital privileges
9 at St. Mary's?
10 A. Not sure of the exact timing, but it's been
11 over -- over a year.
12 Q. And same question for Marin General?
13 A. Marin General has probably been about
14 somewhere between two and four years. Now, before
15 Marin General, I was up at Petaluma Valley Hospital
16 where I was seeing a lot of hospital patients over
17 2001, 2002 and early 2003.
18 Q. 2001 to roughly 2003, you were at Petaluma?
19 A. Petaluma Valley Hospital, seeing a lot of
20 inpatients. Yes.
21 Q. Has there been a period of time since
22 completing your residency and going into practice that
23 you have been without privileges at any hospital?
24 A. There certainly may have been some months
25 when, for example, I would be moving my office or

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1 moving my practice from one hospital to another one.
2 So in terms of the resigning from one hospital and
3 ramping them up at another hospital, there may be gaps
4 like that, but most of the time I have been on a
5 hospital staff.
6 Q. What size facility is St. Mary's?
7 A. St. Mary's is a -- called a comprehensive
8 local -- you know, San Francisco Medical Center. It
9 has a good sized internal medicine residency program
10 that I help out with clinically, and, you know, it's
11 one of the three dominant private hospital systems in
12 the city.
13 Q. Do you know how many beds it is?
14 A. It's probably no more than a couple hundred
15 beds. It may be less now. Marin General is bigger
16 than that.
17 Q. I kind got off track a little bit, but then
18 Friday afternoons you spend, looks like a small amount
19 of time at the Redwoods, and then you go back over to
20 Aegis and see patients again Friday afternoon and early
21 evening?
22 A. Yes, that is right. And those are --
23 again, that -- mostly the geriatric piece of my
24 practice. We also see the employees for their employee
25 health. We also see patients from outside the medical

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1 center, many of whom are general medical patients.
2 Q. On your CV, you differentiate between being
3 an assistant clinical professor of medicine and being a
4 clinical preceptor. Are those two things different?
5 A. Not necessarily. I think that just
6 generically, I use the word "precepting" to denote
7 clinically instructing medical students or medical
8 residents, in other words, seeing patients with them.
9 I have different faculty positions at different places
10 clinically, depending on that training program.
11 Q. Now, on Friday mornings when you are doing
12 your clinical precepting at St. Mary's, are you doing
13 that with residents from all five of the medical
14 schools that you have, or programs that you have
15 designated on your CV on page one under Present
16 Academic Rank and Position?
17 A. No. On Friday mornings I am just seeing
18 the St. Mary's internal medicine residents who are in
19 that training program. I see the Yale medical
20 students, the UCSF medical students and some of the
21 UCSF and other surrounding medical residents, at the
22 San Francisco Free Clinic, you know, where I spend
23 those three half days.
24 That's where I have my clinical --
25 assistant clinical professor of medicine faculty

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1 position at UCSF. They are kind of like a satellite
2 teaching facility for them. And then the Stanford
3 students I mostly bring into my other office at the
4 assisted living facility in Marin and teach them
5 general medicine and geriatrics from the Stanford
6 primary care program.
7 Q. So when I look at your weekly schedule and
8 I see that during the period of time you are at your
9 long-term dare facility, that is when you are also
10 doing your clinical precepting of these residents?
11 A. That is -- no, that is when I am doing my
12 clinical precepting of the medical students from
13 Stanford.
14 Q. I am sorry. That's what I meant.
15 A. Okay.
16 Q. In other words, when I look at this
17 attachment A, which is your weekly clinical schedule,
18 outside of any expert witness work you are doing for a
19 case such as this or some other case, this should tell
20 me how you spend your professional time?
21 A. Oh, yes.
22 Q. Okay. What about, are there any committees
23 that you serve on at any of these clinics or long-term
24 care facilities or hospitals that take up additional
25 professional time?

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1 A. Well, yes. I think my being the medical
2 director at Aegis of Corte Madera, just getting a new
3 medical directorship in the skilled nursing facility at
4 The Redwoods, and doing some classroom teaching, not a
5 lot, that is didactic, and, you know, sitting on the
6 laboratory liaison committee at one of the hospitals,
7 that kind of thing, takes up no more than two percent
8 of my time. It's been that way.
9 Q. And do you still estimate that less than
10 ten percent of your time is spent doing expert witness
11 work such as this?
12 A. Oh, yes. I am clinically seeing patients,
13 some of that teaching while seeing them, and other
14 times in my private practice, easily six and a half
15 days a week.
16 Q. Even though less than ten percent of your
17 time is spent doing expert witness work, is it still
18 your testimony that at least ten percent of your income
19 is derived from expert witness work?
20 A. Yes, probably.
21 Q. Do you still advertise and do referral work
22 with -- I don't know if I am going to pronounce this
23 right -- Reibach or Reibach Agency?
24 A. Well, I do not advertise, or I don't, to my
25 knowledge, participate in any advertising programs

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1 directly. I do continue to work with a couple of
2 referral groups who send me cases from time to time.
3 One of them is Reiback Medical/Legal in
4 Fort Lauderdale, Florida. And the other one is
5 Benchmark Medical/Legal Consultants in Sacramento,
6 Florida -- I am sorry, Sacramento, California. And
7 then I get referrals from a direct attorney referral,
8 so those are my three sources for referrals over the
9 last five, six years.
10 Q. Have you heard of a company called Global
11 Integrated Medicine?
12 A. I have certainly heard of that company and
13 been a consultant for them before, yes.
14 Q. But you are not currently doing any
15 consulting work with them?
16 A. No.
17 Q. Was that also like an expert witness
18 referral service like these other two entities that you
19 described?
20 A. No, no, no. That was a -- that was a real
21 estate company that tried to get into health care areas
22 through opening clinics and weight management, that
23 kind of thing. I have no association with them at this
24 point.
25 Q. So Global Integrated Medicine was not a

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1 consulting firm whereby you did expert witness work in
2 a litigation setting?
3 A. No. No. It was a private company that
4 asked me to consult a little bit for them.
5 Q. Looking at your CV, I noticed that in
6 addition to holding a license in the state of
7 California, you also have a medical license in the
8 state of Florida. Is that still correct?
9 A. Yes.
10 Q. Have you ever had a medical practice in
11 Florida?
12 A. No. I did go back there in late '98, early
13 '99 to pursue a reciprocal license. And I am from
14 there. My family is back there. And while I was back
15 there, I got recruited to come back out here again and
16 resume.
17 But other than that little period of time,
18 before my license came in -- by the way, you know, I
19 have been out here doing my clinical practicing and
20 teaching. I do maintain an active license back there,
21 however, and hopefully someday I can go back there and
22 try to convince my wife.
23 Q. Did you actually move back to Florida
24 sometime in this late '90s time frame in order to start
25 a practice?

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1 A. Yes.
2 Q. Did you start a practice?
3 A. No. My reciprocal license, and in my mind
4 reciprocity means you apply for something and you do it
5 the right way and it's granted, you know, immediately.
6 That is not necessarily what reciprocity means.
7 So I definitely got my license, but I had
8 to kind of wait, and while I was waiting, got some nice
9 offers back here, so I came back here instead.
10 Q. You started the process of trying to get
11 your Florida license in August of 1996. Does that
12 sound right?
13 A. Anything prior to ten years -- let's see, I
14 think the reciprocity only held if it was ten years
15 after you got your California license. So I got my
16 California license in -- sometime in 1986, so that --
17 it would have to be the case.
18 Q. Can you help me understand why it took from
19 August of '96 until January of '99 to obtain your
20 Florida license?
21 A. Well, I mean, I can't explain it fully,
22 other than reciprocity, you know, is not necessarily an
23 immediate process, No. 1.
24 No. 2, I really didn't push on the process
25 at first. I just got my application in because I

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1 really wanted my Florida license because I wanted to go
2 back there someday as sort of my own fantasy to bring
3 my wife back and my daughter and everything, go be with
4 my side of the family as they age more. And so I had
5 that in my mind even back then.
6 So I got the application in under the wire,
7 and then didn't start pushing on them until sometime in
8 '98 or '99, and it took them that long to do what it is
9 they do in their own way.
10 Q. Were there any particular aspects of your
11 application that they were questioning?
12 A. Not that I recall. I mean, it was
13 considered a reciprocal application, and the
14 reciprocity, when they granted it, they granted it as a
15 reciprocal license, and I have maintained it as an
16 active license in good standing ever since that time.
17 Q. Have you ever failed a state board/national
18 board or a U.S. MLE examine?
19 A. No.
20 Q. How did you answer that question on your
21 Florida application, if you recall?
22 A. Well, because I have never failed a test
23 like that, I would have hoped I would have said no.
24 Q. Have you ever been required by any
25 licensing jurisdiction to enter into an impaired

1 practitioner program?
2 A. No.
3 Q. During the course of your medical
4 education, training or practice experience, have you
5 ever undergone counseling, therapy or treatment for any
6 mental or physical illness or condition that impacted
7 your ability to practice as a physician?
8 A. No.
9 Q. Have you ever been criminally or civilly
10 charged with any intentional or negligent action
11 related to use or misuse of drugs, alcohol or illegal
12 chemical substances?
13 A. No.
14 Q. When you were completing your application
15 for your Florida license, do you recall receiving
16 information from the Florida Board of Medicine
17 regarding discrepancies between your application and
18 their primary source verification status?
19 A. No. All I remember about the process is
20 that it was a very lengthy reciprocal process that,
21 according to them, was a very standard thing, and
22 according to me, I wanted it on a certain time line.
23 That's what I remember.
24 Q. When you moved back to Florida, where did
25 you move to?

1 A. I moved to Miami.
2 Q. Did you live anywhere in Florida other than
3 Miami in those -- that, I guess late '90s time frame
4 when you were kind of in transition?
5 A. No.
6 Q. Did you ever live in Coral Gables?
7 A. As part of Miami, yes.
8 Q. Is that a suburb of Miami?
9 A. Technically it's in Miami. I mean, they
10 have their own township. Just like Pinecrest, where I
11 lived, has it own township, but it's Miami, Florida.
12 Q. Did you start medical school upon
13 completion of your undergraduate program?
14 A. Yes.
15 Q. So you would have started sometime in 1980?
16 A. Yes.
17 Q. My recollection is that most medical
18 schools are four-year programs, but I see that you
19 graduated in 1985. Was yours a five-year program?
20 A. No, mine was a four-year program, and I
21 only went four years.
22 Q. Help me understand. Did you have a
23 sabbatical for a period of time?
24 A. No. I actually got a -- I had a hand
25 injury that was pretty serious at the time, and it

1 required me going into the hospital, actually at the
2 University of Miami where I was a medical student, near
3 the end of my second year.
4 And there were some fears that I wouldn't
5 even regain the function of my hand back, and thanks to
6 a brilliant hand surgeon named Dr. Burkhalter, he not
7 only operated on my hand, it was very extensive, and
8 debrided it and so forth, got me through occupational
9 therapy and the like, but I was able to regain, you
10 know, at least as far as clinical medicine goes, full
11 function in that right hand, even though I had a little
12 bit of gangrene at the time from an injury that I had
13 sustained at the end of my second year.
14 The medical school in Miami gave me a
15 medical leave of absence.
16 Q. Okay.
17 A. If you want any more information about
18 that, I am happy to give it to you.
19 Q. No. I think that helps me understand why
20 it took five years for a four-year program.
21 When we were talking about gaps in the
22 hospital privileges, one of those periods of time when
23 you had gaps was after you had moved to Florida and you
24 were trying to get your Florida license?
25 A. Probably, yes.

1 Q. Do you remember what that -- like how many
2 months that was?
3 A. No. I do remember being back on staff at
4 CPMC by probably October or November of '99. And then
5 I do remember being on staff at Petaluma Valley
6 Hospital, which is over this relevant time period,
7 2001, 2002, part of 2003.
8 Q. So you believe it would have been maybe
9 somewhere between six and 12 months?
10 A. Again, I don't have that kind of knowledge,
11 but it's certainly possible, yes.
12 Q. Are you still on staff at Novato Community
13 Hospital?
14 A. Well, they are supposed to give you
15 reciprocal privileges with Marin General Hospital, but
16 it doesn't necessarily work that way. They are in the
17 midst of their own political stuff.
18 So, do I have reciprocal privileges there?
19 I haven't really applied for them. So, you know,
20 currently I consider Marin General and St. Mary's my
21 two hospitals that I have privileges at and I see
22 patients and I go to.
23 Q. I don't know what you mean by reciprocal
24 privileges. Looking at page three of your CV, and I am
25 looking at the one actually that was produced with your

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1 discovery responses, you have a heading for hospital
2 privileges, and it has that hospital listed underneath
3 it, but there aren't any dates.
4 A. Sure. Again, I can get into this history,
5 you know, going back years and years if you want
6 because I have been in San Francisco for so long, but
7 Sutter Health Systems has been involved with both
8 hospitals for sometime.
9 There have been some politics that are
10 actually currently driving Sutter out of Marin General
11 Hospital again. And there is something about the
12 combination of -- Novato Community is owned by Sutter,
13 and as they are coming out of Marin General, there were
14 certain reciprocal privileges they told us we were
15 going to have, that I'm not alone, a lot of docs at
16 Marin General have looked and haven't seen our names
17 show up.
18 Now, other than being led to believe we
19 were going to have reciprocal privileges for political
20 reasons, and occasionally I do have patients go up
21 there, I haven't pursued in any way being active in
22 that hospital.
23 So to answer your question, legally, do I
24 have reciprocal privileges there? Probably. Am I
25 going to pursue it, you know, by suing them or

1 something? I doubt it. Is it important enough to me
2 on a little community hospital there? No.
3 If my patients really want me to, like I
4 usually do, I will try to get in there more and go
5 there, but currently the last time I checked, I was not
6 listed under reciprocal privileges. So that is why I
7 want to be really accurate and clear for the record.
8 Q. I don't mean to be dense, but I am truly --
9 I had never heard of the term "reciprocal privileges,"
10 so can you just explain to me what that means?
11 A. Yes. In terms -- I am just telling you
12 what we were led to believe as medical staff at Marin
13 General, that when Sutter worked out their arrangement
14 between the two hospitals, and again, they own Novato
15 Community, that one of the by-products was going to be
16 all of the staff at Marin General got privileges at
17 Novato Community.
18 Well, they have come in and they have gone
19 out, and they have come in again, as far as Marin
20 General is concerned, and that really has not happened,
21 to my knowledge.
22 So have I pushed them on that? You know,
23 as I sit here today, it's just not that important to my
24 patients or to me to have an additional hospital in
25 Marin be my community hospital.

1 Have I listed it at times when other people
2 have told me I am supposed to be listed? Yes. I hope
3 you follow all that, but it's from being out here for
4 21 years or something.
5 Q. So if you had a patient today at Novato
6 Community Hospital, do you have privileges to go take
7 care of that patient?
8 A. The last time I checked, I thought I did --
9 I didn't, and I asked the hospitalist to do it.
10 Q. Now, there has been a period of time during
11 your career when you actually acted as a hospitalist,
12 correct?
13 A. Yes.
14 Q. Has there been a period of time in your
15 career where you acted as a hospitalist on a full-time
16 basis like Dr. Rooks?
17 A. Yes.
18 Q. When was that?
19 A. Well, back in -- as far back as 19 -- parts
20 of 1989 after I got out of chief residency, I did.
21 Q. Can you show me where that is on your CV?
22 Because I am just having a hard time piecing it
23 together.
24 A. Sure. If you go back to -- if you go to
25 page six.

1 Q. Okay.
2 A. And go to the very end there where, as you
3 see Kaiser Permanente Hospital, there is a hospital
4 before it. It says, "Medical attending, hospital based
5 and outpatient, vice chief of medicine, acting chief of
6 medicine," it has '89 to '90 there. You see it?
7 Q. Okay. That is not on the one I am looking
8 at. Are you looking at the most current one that you
9 just faxed me?
10 A. Yes.
11 Q. Okay. Let me get that one. Where it says,
12 "Medical attending, urgent care medical clinic"?
13 A. Yeah. That is the first thing -- I did
14 that during chief residency, if you want to go back
15 that far, and once I got out of chief residency for
16 another few months. So I did it for over a year and a
17 half, I think.
18 And that was the urgent care clinic at
19 Kaiser San Rafael. Then while I was waiting on my
20 hospitalist job, which showed up here, you can see, in
21 '91, April of '91. I am not sure I have it on the CV.
22 This same period of time in late '89, mid
23 to late '89, I was working as a hospitalist at Garden
24 Sullivan Hospital. I probably didn't put that on
25 there, but it's just another piece of information.

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1 Then I went to the Middle East, accepted a
2 position there. It was both hospital based and
3 outpatient based, and teaching, clinically teaching.
4 Q. Let me stop you just a minute, because this
5 is not matching up with either one of the CVs I have.
6 First off, is there a difference between a
7 hospital and an urgent care medical clinic?
8 A. Yes.
9 Q. The kind of Kaiser Permanente, was that in
10 an urgent care medical clinic or was that in the
11 hospital?
12 A. That was in the urgent care clinic. In
13 conjunction with that, and you are right, it may not be
14 on the CV. Over some of that same time period I worked
15 as a part-time hospitalist over at Garden Sullivan
16 Hospital. I just didn't put it in there. I didn't
17 think anyone would ask.
18 Q. On the previous CV you sent me it does have
19 Garden Sullivan Hospital --
20 A. That's right.
21 Q. -- from 1991 to 1997, vice chair of
22 medicine and clinical director of the Garden Unit,
23 described as AIDS HIV Hospice and Palliative Medicine.
24 A. That's right.
25 Q. Is that what you are referring to?

1 A. Yes. And I was back there in '88, '89,
2 too. Same thing.
3 Q. It just doesn't have '88, '89 on the CV.
4 A. That's right. I will have to revise it.
5 Q. Now, when you were at Garden Sullivan
6 Hospital, were you -- are you telling me you were
7 functioning in the capacity as a full-time hospitalist?
8 A. Yes. But I want to be real clear. I also
9 did some outpatient, too, but I certainly worked also
10 full time as a hospitalist, yes.
11 Q. For what period of time did you function in
12 your career as a full-time hospitalist?
13 A. From 1991 through '97. Now, again, I saw
14 some outpatients also during that time, but I was a
15 full-time hospitalist.
16 Q. And when I say full-time and you say
17 full-time, are we talking about five days a week?
18 A. Yes.
19 Q. 40 hours day?
20 A. Yes. Or more.
21 Q. I just want to make sure we are using the
22 same term.
23 A. Or more, yes. Within that there may have
24 been variations in the quarter or something, but I
25 mean, I was known as a hospitalist, too.

1 And then fast forwarding, not just hospital
2 care, but fast forwarding to 2001, 2002, and the
3 beginning of 2003, where it says at the top of that
4 same page, "Active medical staff, hospital based and
5 outpatient." I was a hospitalist up at Petaluma Valley
6 Hospital. That was not full time. That was part time.
7 Q. My earlier question was full time, and so
8 the full time was at Garden Sullivan?
9 A. That's right.
10 Q. Then you have had some opportunities at
11 facilities to be a part-time hospitalist before and
12 after that?
13 A. That's right. You got it exactly.
14 Q. All right. Is it fair to say you have not
15 functioned in the capacity of a hospitalist on a
16 full-time basis since 1997?
17 A. That's probably true.
18 Q. And the last time, if I look at your weekly
19 schedule and take into consideration your testimony and
20 the CV, the last time you functioned in the capacity of
21 a hospitalist was 2003?
22 A. The first quarter, yes.
23 Q. Now -- I am sorry. I was getting ready for
24 your deposition looking at your old CV, so give me just
25 a second here. I would like to compare the two.

1 On page five of your new CV that you sent
2 me, about midway down the page it talks about a Sonoma
3 office?
4 A. Yes.
5 Q. And it says, "Large hospital-based practice
6 in adjacent Petaluma Valley Hospital while functioning
7 as a de facto hospitalist."
8 A. That's right.
9 Q. What does that mean?
10 A. That means a part-time hospitalist.
11 Q. Okay.
12 A. I didn't know how else to say it.
13 Q. I understand. I just want to make sure I
14 am giving it the right interpretation.
15 What is it that led you to go to the Middle
16 East?
17 A. Well, I mean, in hindsight, I am certainly
18 glad I went when I went. Boy. It was before Gulf
19 War I. And I got to travel a lot. But basically, I
20 was coming out of chief residency. I got a taste of my
21 hospitalist job working at Garden Sullivan part time
22 already.
23 And they told me I was going to be working
24 there the following year, but the woman who was
25 supposed to leave was going to wait an extra year, that

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1 kind of thing. So they worked out an arrangement where
2 I had a contract, but it was not until the following
3 year in '91.
4 So I was meeting with another internist in
5 Pacific Heights who wanted me to come into her
6 practice, even, you know, knowing I was going to be a
7 hospitalist later on, at least for that 15 months or
8 whatever it was.
9 And she had just come back from the Middle
10 East. And she said that, you know, Dr. Fullerton, you
11 are a new grad, you just came out, you know, you are
12 not going to stay with our office because you have
13 already accepted this hospitalist job later on.
14 So let me tell you about this job in the
15 Middle East, and maybe you should call Dick Forster,
16 you know, who was the guy over there, who was, I think,
17 the medical director.
18 And so she told me about it, and it really
19 sounded interesting. And it satisfied my desire to
20 work in the hospital, to also do outpatient work, to
21 run the employee health for 4,000 people living on the
22 compound, be able to do some research and be able to
23 teach.
24 And suddenly this 15-month chunk of time
25 seemed really fruitful in terms of not losing skills

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1 and doing something interesting. And it was probably
2 the only time in my life I would have that opportunity
3 to go out, you know, that far away from way home and do
4 something that interesting.
5 Q. Have you ever been a defendant in
6 litigation?
7 A. No, I haven't. And I am knocking on wood
8 here.
9 Q. Have you ever been a plaintiff?
10 A. You mean in a malpractice litigation?
11 Q. No, just any litigation.
12 A. Yes.
13 Q. On how many occasions?
14 A. I can think of just two.
15 Q. When was the first occasion?
16 A. First occasion was about -- it was just a
17 couple of years ago, the plaintiff -- I became the
18 plaintiff in a case against the Florida Medical
19 Association.
20 And then the other case is I am a -- I was
21 a shareholder in a company out here during the dot-com.
22 And I joined several other shareholders in filing a
23 co-plaintiff -- not a class action, but it's a
24 co-plaintiff suit for some stock that we bought in a
25 music company.

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1 Those are the two, you know, two cases.
2 Q. Are both of those cases still pending?
3 A. Yes, they are both areas of active
4 litigation.
5 Q. What were the circumstances that gave rise
6 to you suing the Florida Medical Association?
7 A. Well, there was a -- first of all, again,
8 it's an area of active litigation. And I am happy, you
9 know, for you to get more details from John Vail, who
10 is the senior litigator at the Center for
11 Constitutional Litigation in Washington, D.C. And then
12 Mr. McKenzie is in Tallahassee as local counsel in
13 Florida.
14 But basically, the case arose out of a case
15 where -- it was following a case where I was a
16 plaintiff expert in a stroke case in Tampa. And on the
17 heels of that verdict, the three defendant doctors
18 wrote a very libelous letter to the Florida Medical
19 Association and wanted to put me in their peer review
20 program.
21 And the way that it was all sort of
22 orchestrated and the maneuvers they used and so forth,
23 were really bald-face witness intimidation and very
24 libelous.
25 So I contacted counsel, and we filed

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1 suit -- it was a couple of years ago. And the case was
2 recently up on appeal at the First Circuit in Florida,
3 and we had a unanimous verdict in our favor.
4 It was a three-judge verdict that basically
5 reversed the lower court decision and remanded the case
6 back to the trial court. And I am really delighted
7 that I am going to be able to air my complaints in
8 front of a jury, which is all, you know, all I ever
9 wanted to do in the first place.
10 And I think all we ever want to do, as an
11 expert, whether we are on the plaintiff or defense
12 side, is be left in a position where we are not
13 intimidated, and we are able to discuss the case and
14 get cross-examined, and if a case has merit, go in
15 front of a jury and let the jury decide.
16 So that is kind of where I am with it all,
17 and I think where the case is, too. And since that
18 time of filing, we have had a couple of experts take a
19 look at my testimony in the Tampa case in court, and
20 they found it to be mainstream, scientifically sound
21 and actually very, very strong as an internist.
22 So, anyway...
23 Q. Do you recall the name of the, I guess it
24 would be the underlying case, in which you gave the
25 malpractice testimony?

1 A. Yes. I think that case, the last name was
2 Luskin.
3 Q. The last name of the physician or the last
4 name of the patient?
5 A. No. The three defendant doctors, who were
6 the defendants in that malpractice action, and who are
7 currently the defendants in my plaintiff case, are
8 Drs. Warrick Zala, Z-A-L-A, and Krebs, K-R-E-B-S.
9 Krebs is the internist.
10 Q. I thought you said you just sued the
11 Florida Medical Association. Did you sue the
12 physicians as well?
13 A. I should have said, et al. Yes.
14 Q. So I am presuming, then, from what you have
15 said that you testified as the plaintiff in the
16 malpractice case, but there must have been a defense
17 verdict?
18 A. There was a defense verdict.
19 Q. And so the result of the defense verdict,
20 the physicians or physician against whom you testified
21 sought to have your testimony reviewed by the Florida
22 Medical Association?
23 A. Well, again, I don't want to get into areas
24 of active litigation, but basically, you know, there
25 were just certain witness intimidation tactics used,

1 there were certain libelous public documents that were
2 disseminated.
3 And we filed claims for abuse of economic
4 advantage and conspiracy, and it actually turned into a
5 racketeering case, too. So beyond that, you know, you
6 can go to the public record and review stuff.
7 Q. I am not asking you to say anything that is
8 going to compromise yourself in that litigation. I am
9 hoping though, what you are telling me is a matter of
10 public record, but I am just trying to -- you know, I
11 can go look at that record and it may generate more
12 questions, and I don't have the opportunity to come
13 back and ask you more questions.
14 So I kind of have to ask you what I think I
15 can ask you today about this.
16 A. Sure.
17 THE VIDEOGRAPHER: Counsel, I am sorry to
18 interrupt. This is the videographer. I am going to
19 have to change the tape within four or five minutes.
20 MS. CALLAHAN: Go ahead and do it. I have
21 got more than four or five minutes, so we will just
22 stop right here for a second.
23 THE VIDEOGRAPHER: This is the end of tape
24 No. 2 in the deposition of John H. Fullerton on
25 July 31, 2006. We are off the record at 6:35 p.m.

1 (Short recess.)
2 THE VIDEOGRAPHER: This is the beginning of
3 tape No. 3 in the deposition of John H. Fullerton,
4 M.D., on July 31, 2006. We are back on the record at
5 6:42 p.m.
6 MS. CALLAHAN: Q. Doctor, when we went off
7 the record, we were talking just a little bit about
8 your case against the Florida Medical Association.
9 I certainly don't want to get into the
10 details of all of the allegations, but just summarily,
11 in trying to understand it generally, was the
12 precipitating event, I guess, the physicians, in
13 whatever format they did it, asking or mandating that
14 the Florida Medical Association somehow review the
15 testimony that you gave in the underlying malpractice
16 case?
17 A. Yes. I think, you know, the most accurate
18 way to talk about it is on the heels of a defense
19 verdict.
20 Q. I am correct?
21 A. Yeah. I just want to be clear. On the
22 heels of the defense verdict, I flew back -- I flew
23 back even before I knew the verdict. I mean, I just
24 testified, did my part, did my job, flew back, and --
25 to San Francisco, and subsequently was led to believe

1 that, I think the plaintiff was probably going to
2 appeal the case, so I had been thinking about it a
3 little bit. And then I got a, what I thought was a
4 solicitation from the Florida Medical Association.
5 And I am in, I think, at least -- you can
6 look at my updated CV -- at least 20 societies and
7 organizations like that. And -- but I was not a member
8 of the FMA. So I thought it was a solicitation,
9 because I am a member of the Florida Geriatric Society
10 and a few other things in the state.
11 And it was a letter from the three
12 defendant doctors, signed by the three defendant
13 doctors, which was one of the most incendiary letters I
14 have ever seen, whether it was written about me or
15 someone else. It was incredible. And not only not
16 true, it was just an abomination.
17 So I got counsel and told them not to
18 disseminate this kind of correspondence, and they
19 persisted. And I said I was not a member, you know,
20 et cetera, et cetera. And they just persisted.
21 There were other things which I really
22 can't go into, which are clearly witness intimidation
23 tactics, in addition to the libel. And then, you know,
24 as the case has gone on, it's become -- then we filed
25 our complaint, it became clear that there was a real

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1 abuse of economic advantage between the docs and the
2 FMA, kind of a conspiracy of the way it all happened.
3 And it became -- I think there were
4 predicate acts. It became a racketeering case in
5 Florida.
6 So that is just sort of the history, and
7 now, you know, I am very pleased to say that, you know,
8 that the courts have gotten it right. And not only do
9 they have no jurisdiction to peer review me as a
10 nonmember of their society, but they have no immunity
11 from saying libelous and very untrue kinds of things
12 and making them public and disseminating them.
13 And that part has come in very clearly, and
14 again, we are looking -- we are very excited -- we are
15 all very excited about having our day back in court in
16 front of a jury, to -- where I get a chance to air
17 these claims that I have been telling you about. So we
18 are real excited about that.
19 Q. What kind of things were they saying about
20 you that, I guess, were -- that you contend, I guess,
21 were libelous?
22 A. Well, again, this is the kind of
23 information -- and I want to answer all of your
24 questions, of course, but this is the kind of
25 information that I can't tell you how readily

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1 accessible it is in terms of portions of the letter and
2 the complaint and the more recent appellate opinions,
3 you know, ruling.
4 And it's all there. I can direct you to
5 the websites and everything else if you want.
6 Q. Why don't you go ahead and just give me the
7 website?
8 A. Sure. A good way of going at it is, go
9 ahead and go to the Florida First Circuit Court of
10 Appeals, and you can go on their website. You can
11 actually view their oral argument. That was May 31st
12 of this year.
13 And then it will direct you to where their
14 opinions are. And actually, I think you can find a
15 copy of the underlying complaint that way, too.
16 Q. Where would I find a copy of the letter?
17 A. The letter is -- believe me, the letter is
18 all through -- the salient pieces of the letter are all
19 throughout the -- what you will find there because that
20 is, you know, that is part of my case.
21 Q. Is there actually a copy of the letter on
22 some website in its entirety that you are aware of?
23 A. I think so, yes.
24 Q. What website would have that?
25 A. If you go to where I am telling you to go

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1 to, you can find the letter.
2 Q. Okay.
3 A. You will find a lot more than that, too.
4 Happy for you to.
5 Q. Taking it out of the specifics of your
6 case, do you generally agree that it's appropriate to
7 have a forum whereby -- and by forum I mean outside of
8 the malpractice case itself, whereby an expert
9 testimony can be reviewed to determine its credibility?
10 A. Currently, looking around, I certainly do
11 not believe that there is a role for extra judicial
12 peer review of what happens in the courtroom.
13 And in other words, our current jury
14 system, where injured patients get to, hopefully, if
15 they have meritorious cases, get to be heard in front
16 of a jury, and you have experts for the defense and
17 experts for the plaintiffs, and you have dueling
18 experts, if you will, that this -- and you have
19 everything under the light of day under the force of
20 cross-examination, that this system works, and I can
21 live with the verdicts, and I will live and die with
22 what a jury says, and that is fine with me.
23 So I do believe in our current system, and
24 I believe in the jury system, and I believe in
25 constitutional rights for patients and for independent

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1 experts.
2 Q. If I understand that thought, you don't
3 believe that there are any safeguards that should be
4 put into place outside of the underlying malpractice
5 litigation system itself to insure that experts are
6 testifying to opinions that are consistent with
7 accepted standards of care?
8 A. Listen, what I am trying to say, and I feel
9 very strongly about this, is if we let local peer
10 review societies review, for all intents and purposes,
11 only the plaintiff's testimony in courtroom cases and
12 be allowed to come after, to come after doctors who are
13 testifying in legitimate cases and testifying in a
14 mainstream fashion, and let them come after them in
15 order to either intimidate them or prevent them from
16 testifying and -- either later in that case or in
17 subsequent cases, the system is really, really
18 compromised.
19 Q. I --
20 A. And -- I am not done. And patients who are
21 injured then do not have an ability, it's a prejudiced
22 system, because the plaintiff's experts are
23 preferentially gone after, and they are gone after for
24 other reasons, because these are local societies and
25 it's a white code of silence that goes on in these

1 local communities.
2 I think we all know that. And we know what
3 happened decades ago, and they are trying to make it
4 happen again. So that's kind of where we are with it
5 and why I have my position.
6 Now, as a mainstream practitioner who has
7 testified on defense cases and on plaintiff's cases,
8 you know, am I open to hear new ideas that can add to
9 our jury system? As long as they don't trample on
10 patients' rights and both defense and plaintiff
11 experts' constitutional rights, you bet I am open.
12 But the system that was back in Florida
13 with the FMA was an abomination and just disgusting,
14 wrongminded, misguided and shortsighted.
15 Q. Doctor, I think maybe you missed my
16 question. I don't know. I certainly did not say
17 plaintiff's expert in my question -- my question
18 applies globally to plaintiff's and defense experts.
19 And so -- and I didn't limit it to local peer review
20 associations. I was trying to kind of pull out of your
21 case and be a little more broad with my question.
22 Maybe your answer is the same, but whether
23 you are a plaintiff's expert or defense expert, just,
24 do you believe that there should be any safeguards put
25 into place by any organizations, whether it be

1 certifying boards, local peer review organizations,
2 whatever, that is done to try and insure that testimony
3 that is provided, regardless of whether it's a
4 plaintiff's expert or a defense expert, is done so
5 consistent with appropriate standards of care?
6 MR. BRATCHER: Object to the form.
7 THE WITNESS: I believe that our current
8 system of jury trial and the power of cross-examination
9 in the courtroom, on both the plaintiff and defense
10 side of the aisle, is adequate and also safeguards us
11 constitutionally and gives injured patients a right to
12 air their cases in front of a jury. That's what I
13 believe.
14 Now, as far as a third party getting into
15 this for some other reason and not either tainting the
16 process or stepping on someone's constitutional rights
17 or having another agenda, I have yet to see it, but I
18 am open to hear about it.
19 MS. CALLAHAN: Q. And you have just talked
20 about patients' rights, and I think you are telling me
21 patients have rights to put on their case and be able
22 to find experts who are willing to testify to the care
23 that was provided. Is that fair?
24 A. Yes. If a patient has a legitimate
25 negligence case, they certainly should have a right to

1 be able to get a plaintiff's expert hired, have that
2 plaintiff's expert not be afraid they are going to be
3 intimidated simply because they were hired, and have
4 that plaintiff's expert not be afraid to go and
5 testify, that even if he testifies accurately and
6 scientifically and soundly, that his license may be
7 threatened simply because he is testifying on the
8 plaintiff's side of the aisle, that's what I am talking
9 about.
10 Q. Certainly you would agree that defendants
11 have rights, too?
12 A. Sure.
13 Q. I mean, doctors who are sued in malpractice
14 litigation, they have rights, don't they?
15 A. Of course, they do.
16 Q. And again, pulling out of your Florida
17 Medical Association case, just generally, doctors that
18 are sued and accused of breaching the standard of care
19 when they didn't breach the standard of care, they have
20 rights to put on their case and find experts just like
21 plaintiffs have rights?
22 A. Of course, they do. And they have an
23 opportunity to, hopefully, for them get a defense
24 verdict.
25 Q. Have you had any other cases in which you

1 have testified on behalf of a plaintiff that have
2 resulted in a defense verdict?
3 A. I don't keep those kind of records because
4 I am an independent expert. There probably have been
5 other defense verdicts. I know there have been
6 settlements. I do this to speak out in cases that I
7 believe in, and I let the chips fall.
8 I am not -- you know, if it's a defense
9 verdict or a settlement, I live with what the jury
10 decides. So I don't know how to answer it other than
11 that.
12 Q. You knew of one where that happened, so I
13 just wasn't sure if you knew of any others or not.
14 A. My dealings with the FMA -- I am talking
15 about the FMA in particular. I mean, that is the only
16 time I have had interaction like that with a medical
17 society, especially one I am not even a member of.
18 But, you know, outside of that, I don't know how else
19 to answer your question.
20 Q. I think you have been doing expert witness
21 work since 1999. Does that sound accurate?
22 A. Either '99 or 2000, that time frame, yes.
23 Q. How many cases have you reviewed as an
24 expert?
25 A. I don't keep and compile those numbers, per

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1 se. I mean, I can give you an approximate number. I
2 think I am up probably over 200 cases now that I have
3 reviewed.
4 Q. Of those, are you able to give me your best
5 estimate as to the percentage that are plaintiff versus
6 defendant?
7 A. Again, I don't keep those kinds of lists or
8 that kind of breakout, but I can give you some ballpark
9 stuff, approximations, for example. Historically, I
10 believe that it's been probably nine plaintiff for
11 every defense, at least.
12 There was a period last year where I seemed
13 to be getting a lot more defense referrals. I couldn't
14 really explain it. For a while there, I thought it was
15 going to be like 50/50, just ballparking it, you know.
16 But by the end of the year I am sure it was more
17 plaintiff again.
18 So historically, it's certainly more
19 plaintiff than defense.
20 Q. What about in, I think you said, excess of
21 200 cases, on how many of those occasions have you
22 testified at trial?
23 A. Again, I don't have exact numbers for you,
24 anything. It's probably in the range of maybe 15
25 times.

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1 Q. If you don't have an exact number, you can
2 give me your best estimate if you are able to.
3 A. Sure.
4 Q. On those roughly 15 occasions, have any of
5 those been on behalf of a defendant?
6 A. Yes.
7 Q. On how many?
8 A. One or two. No more than that.
9 Q. Of the 200-plus cases that you have
10 reviewed, on how many occasions, roughly, have you
11 given deposition testimony?
12 A. Again, I don't keep those kind of numbers.
13 I think I just try to keep a general sense of it all.
14 I probably have been in over 60 depos, something like
15 that. And the breakout there, at least ten percent of
16 them are defense.
17 Q. Other than your concerns that you have
18 expressed to me with regard to these peer review
19 organizations maybe keeping plaintiffs from being able
20 to find experts and put on their cases, was one of your
21 concerns about that lawsuit that you might sustain some
22 sort of loss of income as a result of the exchange with
23 these physicians on the Florida Medical Association?
24 A. Well, I mean, I don't -- you know, I am not
25 a lawyer, and I'm just a doctor. And, you know, it

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1 seems like a pretty big libel case to me. And so I
2 don't -- you know, I am not talking certain monetary --
3 you know, a certain number -- throwing it out there for
4 monetary damage or anything.
5 But do I think I was harmed? You bet I do.
6 But the main thing I want to do in this case, like I
7 have done all along, and I have done from the beginning
8 of this case, is shine the light on it, get it all out
9 there.
10 I am happy -- I am comfortable with my
11 life, my work as an expert, and get it in front of a
12 jury of peers, and let them make the decision on my
13 claims. That is -- you know, I am really delighted
14 actually that is -- you know, that is where we are
15 headed here.
16 Q. Doctor, I was not asking you to necessarily
17 tell me what your monetary damages were. I just was
18 generally trying to sort out if an opportunity or a
19 loss of an opportunity to generate income as an expert
20 was one of your concerns in this litigation.
21 A. I mean, I feel like I was certainly harmed
22 as an expert. I was certainly harmed as a doctor, and
23 my reputation was butchered, yes. It was pretty
24 disgusting, really.
25 Q. Since you are not a member of the Florida

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1 Medical Association, then I take it, even if they had
2 reviewed your testimony and found some problem with it,
3 there was no mechanism for you to face any sort of
4 disciplinary action; is that your understanding?
5 A. Again, you may need a legal determination
6 for this, but basically, yeah, they certainly didn't
7 have any jurisdiction to make some sort of peer
8 reviewed thing, No. 1.
9 No. 2, they had no immunity from misusing
10 that so-called peer review process to try to libel and
11 try to intimidate an expert from testifying either
12 again in that case or in later cases.
13 And I guess No. 3, you know, trying to
14 misuse even the specter of the FMA looking at me in a
15 peer review fashion in subsequent cases to try to knock
16 me off those cases as a plaintiff, too, as a plaintiff
17 expert.
18 That is really kind of how this thing
19 played out. And again, there were two experts who
20 looked at this testimony, and, you know, thought it was
21 some of the strongest testimony in the courtroom that I
22 gave that they had ever seen.
23 There are other issues I won't even go into
24 as far as the other side trying to hire me afterward
25 and so forth. It just kind of goes on and on. I don't

1 know where to begin.
2 Q. Has your license, medical license in any
3 state ever been disciplined, challenged, suspended,
4 revoked, limited in any way?
5 A. No.
6 Q. Same question about your hospital
7 privileges, ever been, in any facility, disciplined,
8 reprimanded, limited, in any way?
9 A. No, never before. I don't anticipate them
10 getting limited.
11 Q. Have you ever made application to be on
12 staff at a hospital where you were denied privileges?
13 A. No.
14 Q. Have you ever undergone any type of
15 disciplinary investigation that you are aware of?
16 A. No. Not even through the FMA.
17 Q. Did you review any specific literature for
18 your role as an expert testimony -- or your role as an
19 expert witness in this case?
20 A. No.
21 Q. Are there any particular textbooks or
22 journals which you consider to be authoritative in any
23 way?
24 A. No.
25 Q. As part of your review of materials in this

1 case, did you glean some understanding as to Dr. Rooks'
2 background, education and training?
3 A. Yes.
4 Q. Do you feel that he has the appropriate
5 medical education, training and background to function
6 as a hospitalist?
7 A. Yes, I do. In terms of in most instances,
8 yes.
9 Q. Are there some instances in which you feel
10 he is not capable of functioning as a hospitalist?
11 A. Well, I just meant in this case, I thought
12 he was negligent, but there may be nine other cases he
13 did fine.
14 Q. Have you ever reviewed any cases for
15 Mr. Bratcher or his firm?
16 A. I don't believe so.
17 Q. Did Mr. Bratcher -- are you working through
18 one of the expert referral services in this case?
19 A. No.
20 Q. Have you ever been to Oklahoma?
21 A. Oh, boy. I certainly don't know Tulsa.
22 You know, I don't know the state. Have I either driven
23 part of the way through or flown through somehow,
24 somewhere? It's possible. I can't recall.
25 Q. Let's take a break for a few minutes. I

1 think I am just about done or done. Let me just look
2 back at my notes.
3 A. Sure. I will use a quick energy bar break
4 here.
5 THE VIDEOGRAPHER: We are off the record at
6 7:05 p.m.
7 (Short recess.)
8 THE VIDEOGRAPHER: We are back on the
9 record at 7:08 p.m.
10 MS. CALLAHAN: Q. Doctor, we spent a lot
11 of time during this deposition talking about your
12 criticisms of Dr. Rooks' care and your opinions
13 regarding the various breaches in the standard of care.
14 What I would like to know now is, is there
15 anything that Dr. Rooks did in his care and treatment
16 of this patient with which you agree with his medical
17 judgment and decision?
18 A. Yes.
19 Q. Can you tell me what those items are,
20 please?
21 A. Sure. The -- let's see. When Melissa went
22 for her bronchoscopy, he showed up. You know, he was
23 there. And he looked, you know, at the area along with
24 Dr. Plost. I thought that was very impressive.
25 When Melissa went for her arteriogram, he

1 was there again and was with Dr. Mocnik -- I hope I am
2 pronouncing it right -- the radiologist, the
3 interventional guy.
4 And on the morning of the 31st, I think
5 Dr. Plost, you know, may have been caught up in a lot
6 of stuff. And, you know, I get from the family's depos
7 that he was not really able to talk that much, and
8 Dr. Rooks, again, was the guy who I think spoke to the
9 family and so forth.
10 And I am a big fan of family conferences,
11 you know, when you are trying to figure things out and
12 work them out, to give them informed decision-making
13 and education so forth. So I liked all of that.
14 And then I think he may have even been
15 there at the limited chest autopsy that was done by the
16 hospital. Very impressive again, trying to get to the
17 bottom of what the heck, you know, was happening here.
18 And I think he saw there was not a mass.
19 It was just a pulmonary, organized pulmonary embolism
20 there.
21 So I like to see that in a young doctor,
22 and I think that will be to his credit in the future,
23 you know, when he uses this kind of information he is
24 learning. We learn by mistakes, too. You know, I
25 think he can use it probably pretty well.

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1 In addition, I think he -- there was
2 something else he did that I thought was impressive.
3 Those are most of the things where I felt
4 like, sort of by the -- sort of after he saw the
5 patient on the 30th and then he kind of kicked into
6 action a little bit on the late 30th and early 31st.
7 So I, you know, I respect that and I acknowledge it.
8 I think it was -- in this case it happened,
9 unfortunately, too late for Melissa, so -- when you
10 look back on it.
11 Q. Is the hospitalist's job to sort of manage
12 the care of the patient?
13 A. Yes. The best way to describe that is, in
14 most cases, and I think reading Plost's and Rooks'
15 depos, you know, it seems like they subscribe to this
16 view, too, that is, that, you know, it was -- once
17 Rooks took over the care, once the patient was
18 admitted, you know, into the hospital, you know, it is
19 Rooks's call as the hospitalist.
20 People like Plost are consultants in the
21 case. And I don't like to use sports analogies of
22 everything, but Rooks is the quarterback here. I don't
23 know how to get around that. And that is the role of
24 the hospitalist during that hospital stay.
25 Q. Is one of the roles of the hospitalist

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1 or -- yeah, one of the roles is to know when to involve
2 specialists in a patient's care?
3 A. Yes. Sure.
4 Q. And we talked about the specialist that
5 Dr. Rooks involved in Melissa's care. Was that an
6 appropriate decision, to involve specialists?
7 A. Yes. Yes. And again, involving the --
8 involving appropriate specialists, that is certainly --
9 certainly did that.
10 Q. So if I understand what you are telling me,
11 even though you disagree with his management of this
12 particular patient, based upon some of the things that
13 you have seen in your review of this case, you have no
14 reason to doubt that he is a good physician?
15 A. Yes. My sense is -- my sense is that this
16 guy is a pretty good doc, and he is probably a pretty
17 good doc most of the time, you know. That is my
18 instinct here in looking at all of the files and
19 everything.
20 And now, why in this particular case, you
21 know, I -- why he committed negligence, in my view, you
22 know, maybe only he can answer. I don't know.
23 Q. Well, Doctor, you have been very patient
24 with me as I have asked you questions, and I -- I think
25 I am done. Thank you for your time.

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1 A. Thank you. I appreciate it.
2 MR. BRATCHER: Mr. Fiasco?
3 MR. FIASCO: I don't have any questions.
4 EXAMINATION BY MR. BRATCHER
5 MR. BRATCHER: Q. I just have a couple of
6 real quick questions, Doctor.
7 A. Sure.
8 Q. I believe you have Dr. Rooks' deposition in
9 front of you?
10 A. Yes.
11 Q. And attached to it is a medical record that
12 is Bates stamped?
13 A. Yes.
14 Q. Do you recall you were being asked some
15 questions awhile back in the deposition concerning the
16 July 7, 2002 MEC visit by Ms. Widick?
17 A. Yes.
18 Q. And I believe this would be after the knee
19 injury, I guess, for lack of a better way to put it; is
20 that correct?
21 A. Yes.
22 Q. And I believe you were asked if whether or
23 not those records were, in your opinion, part of the
24 St. John's Hospital system; is that correct?
25 A. Yes, or if I, hypothetically, I thought

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1 they might not be.
2 Q. Would you turn to the Bates stamp marked
3 Paul 003 and 004? When you go to the exhibit, it is
4 towards the front. Not the very back. Keep going
5 forward.
6 A. I don't see it in this one. I know I have
7 seen it before.
8 Q. It should be. I brought the original of
9 it, but if you want to, you can look at the original.
10 If you would look on page three, do you
11 remember reviewing that document at some point as part
12 of the July 7 medical record for MEC?
13 A. Yes.
14 Q. Would you turn to the page behind it, which
15 is Paul 004?
16 A. Sure.
17 Q. Would you tell me who --
18 MS. CALLAHAN: Kelly, I -- you are -- I
19 can't hear as well.
20 MR. BRATCHER: I am -- kind of moved out of
21 the sunlight. Let me move over here a little bit.
22 MS. CALLAHAN: Are you -- are you
23 representing to this witness that 003 and 004 are the
24 MEC records?
25 MR. BRATCHER: No.

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1 MS. CALLAHAN: Okay. That is what it
2 sounds like you are saying.
3 MR. BRATCHER: No. It's not my
4 representation at all. I want to ask him if, one, he
5 looked at it in relation to the July 7 visit, and then,
6 two, if he would, please, tell me who signed off on
7 those phone calls that were made on July 7.
8 THE WITNESS: Yes, I did see this before.
9 And the on-call physician was Dr. Milner. And does the
10 caller agree with the action taken, yes. And then the
11 patient was instructed to notify their primary care
12 physician the next business day, yes.
13 MR. BRATCHER: Q. And at some point was
14 Dr. Paulsen, based on the record on No. 4, made aware
15 of that visit?
16 A. Yes. They have signatures and
17 co-signatures, and Dr. Robert Paulsen is a co-signator.
18 Q. Okay. Now, I wanted to ask you as well,
19 you were asked a question, if you want to turn back
20 here, about a July 31 date on your handwritten notes in
21 relation to Dr. Rooks. I believe the notation was
22 OCP-July 31st?
23 A. Yes.
24 Q. That page in front of you, what does it say
25 at the bottom? Is it an SMJ record?

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1 A. SMJC 0041.
2 Q. Is that the notation by Dr. Rooks you are
3 referring to in your notes?
4 A. Yes.
5 Q. Okay. In that note does Dr. Rooks mention
6 that Melissa had a knee injury and also was on birth
7 control pills?
8 A. Yes. He reports starting on -- she started
9 on the birth control pills in June and had swelling in
10 the left knee something like six weeks ago without
11 apparent injury.
12 Q. Also, there is one more notation I would
13 have you look at, just to kind of be clear on some of
14 these earlier questions, and it has to do with -- since
15 we are using the original, I will show you -- I believe
16 you discussed with Ms. Callahan the Doppler record; is
17 that correct?
18 A. Yes.
19 Q. Is that page that is in front of you a
20 portion of the Doppler record?
21 A. Yes.
22 Q. And was the Doppler completed on July 30th?
23 A. It looks like it was completed on the 30th,
24 yes.
25 Q. And from reading that page in the record,

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1 does the Doppler notation and report show that Melissa
2 Widick had a knee injury?
3 A. Let me just go over it again with detail.
4 It has leg trauma, yes.
5 Q. Does that Doppler record also say that
6 Melissa Widick was on birth control pills?
7 A. As I recall, it does. Let me find the spot
8 again. Oral contraceptives. Yes.
9 MR. BRATCHER: Are you still there? Karen?
10 I think that was her getting cut out.
11 THE VIDEOGRAPHER: We are off the record at
12 7:18 p.m.
13 (Short recess.)
14 THE VIDEOGRAPHER: We are back on the
15 record at 7:19 p.m.
16 MR. BRATCHER: I have nothing further,
17 Karen. I just wanted to ask some factual questions.
18 MS. CALLAHAN: I lost you there for about a
19 minute or so. Was your ultrasound Doppler question
20 your last one?
21 MR. BRATCHER: Yes. Yes. I heard that
22 noise and I figured you were probably dropped.
23 MS. CALLAHAN: I didn't know if you heard
24 the noise like I did.
25 MR. BRATCHER: No, I did, and so that's

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1 when I said -- we went off the record for a minute, but
2 that was it. I have no further questions and will pass
3 the witness.
4 MS. CALLAHAN: Okay. Bill, did you have
5 anything?
6 MR. FIASCO: No, thanks.
7 MS. CALLAHAN: Okay.
8 FURTHER EXAMINATION BY MS. CALLAHAN
9 MS. CALLAHAN: Q. Doctor, earlier in my
10 question to you about the MEC record, did you
11 understand that the MEC record was a different record
12 than Paulsen pages three and four?
13 A. Yes.
14 Q. Okay.
15 A. Yes. I --
16 Q. Do you ask a patient, as part of your
17 history, for the patient to identify the medications
18 that they are taking, after the patient has provided
19 you with that information, then do you take it upon
20 yourself to try and determine whether or not the
21 patient has been honest with you?
22 A. I think you better repeat that one. I got
23 caught up in two parts of it.
24 Q. When you ask a patient, for instance, to
25 identify for you the medications that he or she is

1 taking as part of your evaluation of the patient.
2 A. Yes.
3 Q. And the patient gives you that list of
4 medications, or tells you they are not taking any
5 medications, do you trust the information that they
6 provide to you?
7 MR. BRATCHER: Object to the form.
8 THE WITNESS: Well, I mean, I, first of
9 all, if a patient submits a medication list to you, you
10 know, that has been updated and they say, that is my
11 medication list, we tend to verify it, but, you know,
12 we trust and verify.
13 Now, if upon asking them about medications,
14 if they divulge their medications as part of a
15 medication history, we usually go back and talk about
16 over-the-counter medicines, contraceptives, you know,
17 or other kinds of medicines, just to make sure they
18 understand we all mean all medicines. But I mean, we
19 typically do that.
20 Now, in this case, again, with -- Melissa's
21 had a bit of health care background, a more recent
22 health care background, I would expect her -- I think I
23 would likewise, like the family, expect her to
24 understand that birth control pills are a medicine.
25 Q. So when a patient who is not medically

1 naive is giving you that information regarding their
2 medications, you are not going to take it upon yourself
3 to then start looking through records to see whether or
4 not the patient is being truthful with you --
5 MR. BRATCHER: Objection as to form.
6 MS. CALLAHAN: Q. -- or complete with you?
7 A. No. I mean, I think if you are dealing
8 with a compliant, good faith patient, as I feel like we
9 were in this particular case, I mean, there is no
10 reason to doubt what she is saying.
11 Now, as far as medication history, now, as
12 part of going through, you know, the record and being
13 thorough, I mean, we usually have multiple
14 opportunities to sort of get at that kind of
15 information, you know, through just comprehensive
16 evaluating somebody.
17 So it may come up at other points in the
18 interview, but, you know, there is no reason to doubt
19 what they are telling you. It just may come out at
20 different times during the interview. That's all.
21 MS. CALLAHAN: All right. That's all I
22 have.
23 MR. BRATCHER: Karen, so, I guess we can do
24 this off the record as far as filling out the check.
25 MS. CALLAHAN: You want to read and sign?

1 MR. BRATCHER: He will read and sign.
2 THE WITNESS: I would love to read and
3 sign, yes.
4 MR. BRATCHER: Okay. I'm going to go off
5 the record.
6 THE VIDEOGRAPHER: This is the end of the
7 tape No. 3 and the end of this deposition of John H.
8 Fullerton, M.D., on July 31, 2006. We are off the
9 record at 7:23 p.m.
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1 STATE OF_____)
) ss.
2 COUNTY OF_____)
3
4
5
6
7 I, the undersigned, declare under penalty of
8 Perjury that I have read the foregoing transcript, and
9 I have made any corrections, additions or deletions
10 that I was desirous of making; that the foregoing is a
11 true and correct transcript of my testimony contained
12 therein.
13 EXECUTED this_____day
14 of_____,
15 200____, at _____,
_____.
16 (City) (State)
17
18
19
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22
_____
23 JOHN FULLERTON, M.D.
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