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IN THE SUPERIOR COURT OF TOOMBS COUNTY

STATE OF GEORGIA

JAMES CHUPP,

Plaintiff

v. Docket No. 12-CV-1057

PHILLIP FLEXON, M.D.,

Defendant

DEPOSITION OF JOHN BOGDASARIAN, M.D.

Friday, February 7, 2014, 2:29 p.m.

Farmer Arsenault Brock LLC

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Boston, Massachusetts

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P R O C E E D I N G S

JOHN BOGDASARIAN, M.D., sworn

MR. RAY: This will be the deposition of Dr. John Bogdasarian in the matter of James Chupp, plaintiff, versus Phillip Flexon, M.D., defendant, a matter currently pending in the Superior Court of Toombs County, Georgia, Civil Action No. 12-CV-1057. This deposition is being taken pursuant to notice and agreement of counsel for any and all purposes permitted under the Georgia Civil Practice Act.

Consistent with the act, I would propose that we reserve all objections, except as to form and responsiveness, until first use, if that's agreeable.

MR. RICHARDSON: That is agreeable.

EXAMINATION

BY MR. RAY:

Q. Doctor, you have a right under Georgia law to be provided a copy of your transcript and to review it for changes, or in the alternative, you may waive that right. I don't care what your preference is, but I'd like to know what you'd like to do.

A. I'd just as soon reserve the right to read and sign it.

MR. RAY: Dr. Bogdasarian will reserve his right to read and sign his deposition, and I will stipulate that he can sign his errata sheet utilizing a copy of the deposition in the presence of any notary public. If he would then just return it to the court reporter.

Q. At the outset, Dr. Bogdasarian, good afternoon. My name is Chris Ray, and I represent Dr. Phillip Flexon in this case. And as I am sure you have given a deposition before, I know you know the basic ground rules, but I always like to review a few at the outset if I may.

A. All right.

Q. Obviously the purpose of this deposition is for me to ask you a series of questions under oath and for you to answer those questions truthfully and to the best of your ability. As we go through this process today, if at any time I ask you a question which is unclear or you simply do not get my meaning, I would ask that you please stop me and tell me that you do not understand my question and afford me an opportunity to clarify. Is that acceptable?

A. Yes.

Q. And the reason I ask you to do that, sir,

is because if I do ask a question and you do answer the question, I'm going to assume that you understood my question and that the answer you gave was the answer you intended to give. So if I am the least bit unclear, please do let me know.

A. All right.

Q. Also you know this as well, but as you're doing right now, please make sure that all your answers are out loud in a nice clear voice for the benefit of our court reporter. I will try very hard not to speak over you, and I would ask if you would please extend me the same courtesy so she can take down one voice at a time.

A. Yes.

Q. Lastly, if you need a break at any time for any reason, please do not hesitate to ask for one. I'll be happy to call a brief recess to the deposition and we can pick up again when you are ready.

If you could, please, sir, please state your full name for the record.

A. My full name is John Robert Bogdasarian.

Q. What is your current professional address, sir?

A. It's 33 Electric Avenue in Fitchburg,

Massachusetts 01420.

Q. My office was told that you requested prepayment for your deposition today. I brought a check in the amount of $1,750. Is that correct?

A. Yes. Thank you. That's my tough secretary.

Q. Does that represent a particular period of time today, that figure?

A. That represents the time for the deposition this afternoon. It's my fee for a half day deposition.

Q. Okay. Dr. Bogdasarian, do you suffer from any physical or mental impediment or impairment of any kind that would in any way interfere with your ability to hear, understand and respond to my questions?

A. No.

Q. Similarly, have you consumed any medicines or substances that would in any way obtund you?

A. No.

Q. I'm going to mark as Exhibit 1 to your deposition a copy of the deposition notice that was issued in this case.

(Marked, Exhibit 1, deposition notice.)

Q. I just want you to look over to the second

page. Were you supplied with a copy of this notice prior to today?

A. Yes, I was.

Q. Did you see it requested you to bring certain categories of materials which you may or may not have that are responsive to these questions?

A. Yes.

Q. What I'd like to do, if I could briefly, sir, is just run through these topics with you if I may.

A. All right.

Q. Letter a) asked for all material provided to you or reviewed by you in connection with this case, including but not limited to, file records, depositions, reports from other attorneys or individuals and any other materials relevant to this case. I do see that you've brought maybe a four-inch stack of paper with you today. Is that the totality of your file in this case?

A. Yes, it is.

Q. At some point I'm going to ask to have an opportunity to go through that, if I may.

A. Sure.

Q. Some of these topics probably overlap with one another. Letter b) asks for all correspondence,

tapes, memoranda, notes, reports and other documents received or generated by you in connection with this case. Would anything responsive be in that stack?

A. Yes, it would.

Q. Do you have any formal reports that you've generated of any kind other than the affidavit which you signed?

A. No.

Q. Have you maintained any kind of written correspondence with Mr. Cohen's office or Mr. Richardson's office that involved anything more than just cover letters saying, "Here's what I'm sending you"?

A. No, I think that's all that I have.

Q. Have you communicated with Mr. Cohen or Mr. Richardson's office by email at all on this case?

A. No. There may have been an email that just told me where this matter was going to be held, but beyond that nothing.

Q. No substantive communication -- I'm sorry. No communication of substance by email; is that correct?

A. Correct.

Q. Letter c) asks for the results of all

research done by you or for you relative to this case. Have you conducted any specific research in connection with this case?

A. Nothing specific. I have been involved in similar reviews previously, and I perform surgery in this area so that I think I stay current with literature, but I haven't done any specific research with regard to this.

Q. If I hear you correctly, what you're telling me is that you may have in the past as part of your general practice read literature related to this subject, but there's no specific article, text or treatise that you went and consulted as part of your review in this case; is that correct?

A. That's correct.

Q. Letter d) asks for an accurate accounting of the time you've spent in review of this case, including your prep time and your hourly rate. Do you have a written accounting of your time in the case thus far?

A. Yes, I do.

Q. Is that among the materials you have there?

A. Yes.

Q. Why don't we pause for a second and maybe I'll take a look through this stack.

A. Actually, what you just asked for is right on the bottom. I just stopped and picked that up at my office on the way here.

Q. Excellent.

A. That is not inclusive of just the last, for instance, two days, where I had received some additional depositions to review. But I think until that time it should be current.

Q. Is this a set I can mark and keep, Doctor?

A. Yes, you may have that.

MR. RAY: Then I'm going to mark as collective Exhibit 2 a series of invoices. And I'll give you the exact number for the record. One, two, three, four, five invoices, the first dated October 31 of 2011 for $975; the second 11/9/11 for $150; the third February 1 of '02 for $100. The next, March 28 of '02, $125. And the last, February 13 of 2013, $225. Does this represent, Exhibit 2, all of the monies which you have been paid thus far in connection with this case?

A. Frankly, I haven't even paid attention whether they've been paid or not, but those were invoices.

Q. Is this all that you have invoiced for your work in this case thus far?

A. I believe it is, yes.

Q. Have you performed certain additional work in recent days or weeks in preparation for your deposition that's not recounted in Exhibit 2?

A. I have, yes.

Q. How much additional time would you say you have in the case file?

A. I think it was -- I'm going to say around nine and a half hours more of work, just because I received, I think, three depositions and reviewed the records again prior to coming here today.

Q. So nine and a half hours of work within the last few weeks; is that correct?

A. I think within the last two days probably.

Q. These particular invoices have dollar amounts, but they don't happen to reflect total time that was spent. Do you know how much time you had in the case before the nine and a half recent hours?

A. Well, my charge is $300 an hour for record review. So whatever that would total, divided by $300 would give the number of hours I think that I had spent.

Q. All right. Thank you, sir.

Letter e): I think if we go back to Exhibit A of Exhibit 1, letter e) was all invoices,

statements, et cetera. That's what we just marked as Exhibit 2.

A. Yes.

Q. Letter f) asks for a listing of all background sources and other persons, if any, who you have consulted in connection with review of this case. I guess -- let me simplify that question. Other than the materials that are in your stack that you've brought today and any conversations you may have had with Mr. Cohen, Mr. Richardson or anyone else from that office, is there any other source of information that you have concerning this case?

A. No. Again, nothing with respect to this specific matter. That's correct.

Q. Have you consulted with any colleagues, run this fact pattern by anyone, talked to anybody about your review of this case?

A. No, I haven't.

Q. Letter g) asked for an up-to-date copy of your CV. Were you able to bring a CV with you today?

A. Yes. I have one in this pile somewhere. Can I...

Q. Sure.

A. I knew I had one somewhere. (Witness

handing document.)
Q. Thank you, sir.
MR. RAY: I'm going to mark as Exhibit 3 the copy of the CV which you brought today and just handed to me.
(Marked, Exhibit 3, curriculum vitae.)
Q. Let me ask you, does Exhibit 3 to your deposition, Exhibit 3 fairly and accurately set forth your educational background and training as a physician?
A. Yes.
Q. Does it also accurately list your employment history, your licensure, your board certifications?
A. Yes.
Q. Does it accurately list --
A. Let me back up. I don't know that it has my license number and licensure on it. I don't think I ever thought to include that, but -- I will in the future, but I don't believe it has it on it.
Q. Does it include the professional societies in which you hold or have held membership?
A. Yes.
Q. Does it include a list of any and all publications that you've ever done in the

professional literature?
A. Yes.
Q. Is that particular version current and up to date?
A. It is.
Q. Thank you, sir.
Item h) asked for any Rule 26 report which you may have prepared within the last 12 months. I don't know if that term is familiar to you, but if you ever had occasion to serve as an expert witness in a case which pended in a federal court, you would have been required to generate a formal report as an expert, including a list of prior cases in which you had been involved. Have you generated any such reports within the last year?
A. No, I haven't.
Q. Item i) asks for a list of any and all cases in which you have been involved as an expert witness in a ten-year window, from 2004 to the present. Do you maintain any list, whether complete or incomplete, but do you maintain any lists of the work you have done as an expert witness?
A. No, I don't maintain a list. I have done work as an expert witness, but I have not maintained a list of it. Later on if you ask, I can give you

an estimate of the number of times, but I don't have any formal list of it, I'm afraid.
Q. All right. Item j) asks for a copy of the last deposition that you gave as an expert witness. Have you retained copies of your prior depositions as an expert?
A. Actually, if I don't -- after cases have resolved, I don't maintain copies of them. I did do a deposition last week, actually, but I haven't received a copy of that as yet.
Q. Would I be correct in assuming that you probably do have several cases under open review in your office at present?
A. Yes.
Q. How many would you estimate you have that are currently under open review?
A. All together probably within the range of 75, I would think.
Q. Of those 75 that are in your office currently would some of them be instances in which you've given your deposition testimony already?
A. Yes.
Q. Would those depositions be within your possession at your office because those cases are still open?

A. They would be, yes.
Q. Would you be willing to, at my expense, supply me with copies of the deposition transcripts which you do still have in your possession?
A. Yes. I have no idea how many there are, but if you want me to do that, I can do it.
Q. I would make that request, and here's my card.
A. All right.
Q. I'll be happy to cover the copying costs, shipping costs, et cetera, for that.
A. Okay.
Q. Thank you, sir.
Item k) asked for copies of any and all correspondence, emails, faxes, letters, et cetera, between you and Mr. Chupp or his attorneys. Would any of those materials, with I guess the possible exception of emails, but would any other such correspondence be in the stack you brought with you today?
A. Well, I have nothing from Mr. Chupp. There are a couple of cover letters, I believe -- maybe two, I think, all together -- that came from Mr. Chupp's attorneys.
Q. Anything that you do have is in your stack?

A. Yes.
Q. And lastly, item l) asked for copies of all medical records, either generated by you or others, related to your evaluation, care and treatment of Mr. Chupp. Obviously you did not care for and treat him. What I mean is related to your assessment of the evaluation, care and treatment of Mr. Chupp. Do you have all the records that were supplied to you?
A. I have everything here, yes.
Q. I'm going to have to rewrite that question. That's poorly phrased.
MR. RAY: Let's go off the record for a moment.
(Discussion held off the record.)
MR. RAY: Let's go back on the record if we may.
Q. At the break I had the opportunity to pick through the pile of documents you brought with you today, Dr. Bogdasarian, and I just want to read them into the record.
A. All right.
Q. The first is a transmittal letter from paralegal Kathy Agee in Ken Nugent's office just sending Dr. Bogdasarian the depos of James Chupp, Janice Gray and Phillip Flexon. That was dated

February 4 of 2014. So did you just receive these depositions a few days ago?
A. Yes, I did.
Q. And that was the first time you had seen them?
A. Yes.
Q. Did you read all three depositions?
A. I did, yes.
Q. The next item is just a Tiffany Alley confirmation for the deposition today.
The next item is a copy of your affidavit which you executed in this case.
A. Yes.
Q. The next item is Mr. Chupp's deposition transcript. I notice that throughout you've made some purple underlining. Other than this purple underlining, is there any other notation or note taking that you did in any of these depositions?
A. I don't believe I wrote anything in any of them. I think I wrote that there was the word "Kholi," and I think it was misspelled in one deposition. I might have corrected that just so I knew what they were talking about. But beyond that, there's nothing.
Q. Did you generate any notes outside of the

four corners of the depositions themselves?
A. No.
Q. And those passages that you chose to underline, what would lead you to underline a passage as opposed to not?
A. Well, I think the passages that were perhaps most influential in forming an opinion -- there are other things that don't seem to have such importance, and it just makes it easier if I need to go back and review it to review the underlinings rather than read the whole deposition again.
Q. So that includes all three depositions, Mr. Chupp, Dr. Flexon and Ms. Gray?
A. Yes.
Q. The next item was a faxed copy to you of the deposition notice we've already marked as Exhibit 1.
A. Yes.
Q. Then I think we're moving back in time perhaps to when you were first contacted. There's a letter from Mr. Richardson when he and Mr. Cohen were still at McConnell, Sneed & Cohen, dated October 6 of 2011, indicating that, "Enclosed please find the records of Mr. Chupp," and I assume this letter just included the disk.

A. I believe that's what it did, yes.
Q. Then we also have this disk, which then the rest of what's printed out here are medical records that you printed from this disk?
A. Correct.
Q. Is it a complete set of all of the records that were on the disk that are printed out here?
A. I believe so, yes.
Q. All right. The first set of records appear to be a functional capacity evaluation of Mr. Chupp from Coastal Therapy, dated, it looks like, on or about July 21 of 2001.
A. Yes, I believe that's correct.
Q. There's then a subsequent Coastal Therapy note that appears to be July 26 of 2001.
A. Yes.
Q. There's a note from Dr. Howington's office dated April 7 of 2011, a two-page note.
A. If I could just interrupt you. It might help. I think there's stickies with each of the new sets of records. Unfortunately they're not sticking out very well, but I think that --
Q. I'll look for them as I go.
A. Yeah, that might help a little bit.
Q. I don't think we skipped any thus far.

A. No.
Q. I said the note of Dr. Howington, 4/7/11; a subsequent note of Dr. Howington -- actually a letter -- of June 7, 2011. Some pages from the Hughston Clinic note for Mr. Chupp. It looks like the date of service is December 14, 2010. This would be Dr. Waldrop's note.
A. Yes.
Q. Then a note from -- well, actually, let me back up. It's a fax cover sheet from Weinstock & Scavo. Is that Scavo [SKAY/VOE] or Scavo [SKA/VOE]?
MR. RICHARDSON: Scavo [SKA/VOE].
Q. Weinstock & Scavo. And it's to Dr. Harvinder Kholi, who's a neurologist in Hilton Head, and it includes in it what appears to be EMG findings of Dr. Kholi dated October 29, 2007.
A. Yes.
Q. Then we have notes from the J.C. Lewis Care Center in Savannah, multiple dates of service.
A. Yes.
Q. Then we have what appear to be some billing records from Memorial Health University Medical Center, including, it looks like, records of medication, testing and other itemized bills of some sort from Memorial.

A. Yes.
Q. And then lastly, the largest single set of records appears to be Mr. Chupp's Memorial chart probably covering -- yes, covering multiple admissions at Memorial, including many subsequent to the events in this case.
A. Correct.
Q. Okay.
A. Just -- I believe there's the admission for the surgery of July 26, and then subsequent a lot of those are emergency department visits, I think, that he made after the surgery.
Q. One thing I did not come across in here and I was going to ask is, have you been provided with a copy of Dr. Flexon's office chart?
A. No, I have not.
Q. Okay. Did you at any time ask to see Dr. Flexon's office chart?
A. No, I didn't.
Q. Did you know it existed?
A. Well, I would assume there would be one that existed, yes.
Q. Is there any particular reason that you didn't ask to see his office chart?
A. No. I think that -- I think the details of

what I needed to know were covered in records that were present otherwise in the deposition, and I had the operative note and the hospital admission, I think, that summarized it well.
Q. Okay. This question is not intended to be facetious. I'm asking it genuinely. You would agree with me, of course not having seen Dr. Flexon's office chart, in fairness you have no idea what may or may not be in it, correct?
A. That's true.
Q. Have we now accurately gone through and recounted all of the materials that you have reviewed in connection with this case and which you have brought with you to the deposition today?
A. Yes, we have.
MR. RAY: I'm going to mark as Exhibit 4 a copy of the affidavit which you prepared in this case. I know there's a copy in the stack, but I'm going to give you that one.
(Marked, Exhibit 4, affidavit.)
Q. Just a few housekeeping questions if I could, Dr. Bogdasarian. Just at first, do you recognize this four-page document to, in fact, be the affidavit which you gave in this case?
A. Yes, I believe that I do.

Q. If you'd go over to the fourth page where there's a signature line for John R. Bogdasarian, M.D. and it's dated the 31st of January 2012, can you verify for me that that is, in fact, your signature?
A. It is, yes.
Q. And it appears that this affidavit has been notarized by a gentleman named Francis Landry. Do you know who Mr. Landry is?
A. Yes.
Q. Who is he?
A. He is the former librarian at HealthAlliance Hospital, who also has a commission as a notary public, and does a lot of notarization for people who need it at that hospital.
Q. Is he --
A. Um --
Q. I'm sorry. Go ahead, sir. I cut you off.
A. He no longer works there, and I'm not certain where he is at this point, but I know he left the hospital about six months ago.
Q. Did Mr. Laundry, in fact, witness your signature and notarize it?
A. He did, yes.
Q. Is he someone who was known to you and you

known to him before the affidavit was executed?
A. Yes.
Q. Let me ask you a few questions about the affidavit, if I may. First, I just wanted to ask how it came into being. What I mean by that is, is this something you typed up yourself, or is this something which came to you in a draft typed-up format from Mr. Cohen and Mr. Richardson, or how did you receive it?
A. You know, I didn't type it up myself, I'm certain of that. I believe that it was sent to me for me to look over and to agree with or disagree with, and my recollection is that I agreed with it.
Q. Was it the product of some telephonic conversations that you had beforehand?
A. I can only say it may have been. I don't recollect specifically if -- I don't keep records of telephonic conversations. So I don't want to say one way or the other whether it may have been. I don't recollect.
MR. RICHARDSON: I believe so, just...
MR. RAY: Thank you.
Q. Doctor, do you know if there were prior working drafts, if you made any revisions of any kind to the first version that was presented to you?

A. I can only say there may have been. I don't recollect specifically. I'm sorry.
Q. I notice that Dr. Flexon's name is misspelled throughout this affidavit. He's listed as Dr. Flexion, F-l-e-x-i-o-n instead of Dr. Flexon.
A. So it is.
Q. Had you noticed that typo before you signed this?
A. I may not have.
Q. Let's go over to the second page, please. Paragraph 4 gives a listing of materials that you had consulted before signing your affidavit. And the first one that's listed there is the medical records of Dr. Flexon. I assume based on what you told me previously, you mean the hospital medical records of Dr. Flexon, not his office chart; is that correct?
A. Correct.
Q. Then you've also seen the records of Dr. Kholi, Dr. Waldrop, Tobin Bone & Joint, Memorial, Myra Pope, the Hughston Clinic and Hilton Head Neurology; is that correct?
A. Yes.
Q. That appears to me to be pretty much the same list of medical records that we just went

through in your stack; is that correct?
A. It is, yes.
Q. Am I correct in understanding that all of the medical records which you have received and reviewed in this case you had available to you at the time you signed the affidavit; is that correct?
A. Yes.
Q. And you have not been supplied with any new, different or additional medical records since the time you signed your affidavit; is that correct?
A. I believe that's correct.
Q. Would you go over, please, sir, to the third page, specifically to paragraph 6, and we will probably get into this in more detail a little later in the deposition, but I wanted to ask you about this. In paragraph 6 you identify two -- you call them deviations or violations of the standard of care that you attribute to Dr. Flexon in this case. Sub 1 says, "Failing to find the spinal accessory nerve and remove the lipoma while in view." And number 2 is, "Failing to separate and protect the nerve." Did I read that correctly?
A. Yes.
Q. As you sit here today, are those the only two violations of the standard of care which you

attribute to Dr. Flexon in connection with his care of Mr. Chupp?
A. I think, as I've had an opportunity to review the depositions since this was put out, I think that there would be two other potential deviations that I was concerned about.
Q. All right. We'll come back to them in a little more detail later, but can you tell me just right now -- so in other words, a third and fourth potential violation of the standard of care?
A. Yes.
Q. What would be the third?
A. The third I think would be the failure to perform a needle aspiration of the right neck mass in Mr. Chupp prior to the open surgery.
Q. And what would be the fourth?
A. And the fourth, I don't want to say that it was a deviation. I think I would just say that I think there are -- that the standard of care prior to and as part of the performance of the surgery that was done by Dr. Flexon would be to inform the patient of the potential complications of the surgery; namely, in this particular surgery, injury to the spinal accessory nerve.
I know there are two sides to the story

as to what happened in the discussion of that complication. So I won't say that it's a deviation on the part of Dr. Flexon, because I know there are different testimonies with regard to that, but I will just say I think the standard of care would include that and it should -- if it wasn't done, it would be a deficiency. If it had been done, it would not be.

Q. Let me, if I may, paraphrase back what I think you've told me. If I misstate it in any respect, please correct me.

You have articulated at least three violations of the standard of care which you attribute to Dr. Flexon in this case, plus a fourth topic which may or may not be a violation of the standard of care; is that correct?

A. Yes.

Q. Let's talk about the first three. The first violation of the standard of care which you attribute to Dr. Flexon in this case is failing to find the spinal accessory nerve and remove the lipoma while in view, correct?

A. Yes. If I can interrupt. I know it wasn't a lipoma that was removed. It appeared to be a different sort of problem.

Q. Even if I separated the word "growth," would that be more accurate?

A. Correct.

Q. Number two, the second violation of the standard of care which you attribute to Dr. Flexon in this case is failing to separate and protect the nerve. Did I read that correctly?

A. Yes.

Q. The third violation of the standard of care in this case is that you believe it was a violation of the standard of care for Dr. Flexon to not perform an FNA or fine needle aspiration biopsy of the mass prior to the excision surgery; is that correct?

A. Yes.

Q. And those are the only violations of the standard of care which you can state to any reasonable degree of medical probability you attribute to Dr. Flexon, correct?

A. Yes.

Q. The fourth topic that you touch on is you believe that the standard of care in a case of this type would require that the patient be taken through an educational process leading up to an informed consent; is that true?

A. Yes.

Q. And you believe such an educational process in a case like this would require that Dr. Flexon or someone at his direction or on his behalf expressly apprise the patient of the risk of injury to the spinal accessory nerve in this type of surgery, correct?

A. Yes.

Q. And you don't know one way or the other whether that happened in this case, correct?

A. Correct.

Q. At this point you're not capable of saying that that was a violation of the standard of care, true?

A. That's correct.

Q. And we'll come back to these in much greater detail, but those are the only violations of the standard of care which you attribute to Dr. Flexon in this case?

A. Yes.

Q. All right. Thank you, sir.

Do you recall when you were first contacted in this case, Dr. Bogdasarian?

A. I think it would have been at a time likely just prior to the date on this cover letter, which

is October 6, 2011. Likely, and, again, I don't have recollection of it, but likely I would have received a telephone call as to whether I'd be willing to review the records.

Q. Do you recall who made initial contact with you?

A. I don't. I'm sorry.

Q. Had you ever had any prior dealings with either Mr. Cohen or Mr. Richardson before this case?

A. I don't recollect that I have.

Q. Had you ever had any prior dealings with the law firms with which they have been associated? They've actually been with three firms, I think, during the pendency of this case, the McConnell --

MR. RICHARDSON: Sneed & Cohen.

Q. -- Sneed & Cohen firm, the Weinstock & Scavo firm and now the Ken Nugent firm. Had you ever had any dealings with any of those law firms before this case?

A. The name Ken Nugent may be familiar to me or it rings a bell, we'll put it that way. But I don't have any specific recollection of a matter that I worked with him on.

Q. Do you know specifically how it is that Mr. Cohen and Mr. Richardson came to find you as an

expert in this case?
A. I don't know.
Q. Have you had occasion to serve as an expert witness in cases in the past involving injury to the spinal accessory nerve?
A. Yes, I have.
Q. Do you know how many cases you've been involved in in the past in which you've been consulted where one of the issues at issue was an injury to the spinal accessory nerve?
A. I haven't counted them, but I'm certain it's more than five.
Q. In all of the cases in which you have been involved as an expert in which one of the medical issues was the spinal accessory nerve, have you ever been an expert on behalf of the defendant physician?
A. I believe that on one occasion I -- and I may be confusing the nerve, but I believe on one occasion I may have been asked to serve as an expert on behalf of a physician.
Q. Have you ever given testimony under oath, either at a deposition or at a trial, where you offered an opinion that a physician's inadvertent injury to the spinal accessory nerve was not a violation of the standard of care?

A. No. The matter that I recollect that I was involved in or was asked to review the matter on by the firm representing the physician, I believe that the situation was one of a so-called schwannoma or a tumor itself of the --
Q. Of the neural sheath?
A. Yes, of the spinal accessory nerve. And I think it was not so much inadvertent removal as necessary removal of the tumor, which then, of course, compromised the function of the nerve.
Q. That would be a very factually different case than the one we're here talking about, correct?
A. Yes.
Q. Because in the case of a schwannoma, the growth that needed to come out would be so intermixed and interlocked with the nerve that it may be impossible to remove the schwannoma without also sacrificing the nerve?
A. Correct.
Q. Would I be correct in assuming then all of the rest of the time that you have offered testimony involving an inadvertent injury to the spinal accessory nerve, you have offered a sworn opinion that the healthcare provider fell below the standard of care?

MR. RICHARDSON: I'll object to form, but you can answer.
A. I think in all the situations in which I've been asked to render testimony, that has been the situation, I believe.
Q. What I said is correct?
A. Yes.
Q. Would I also be correct in assuming that most of the cases in which you have been involved which have involved an inadvertent injury to the spinal accessory nerve arose in the context of lymph node removal in the posterior triangle?
A. I would think yes, in one fashion or another, one type of surgery or another, yes.
Q. Have you ever served as an expert witness involving the specific fact pattern in this case of a growth, a hemangioma or other growth, completely encapsulated within the sternocleidomastoid muscle?
A. I don't believe that I have, no.
Q. In your own practice as a physician have you ever personally encountered a hemangioma fully encapsulated within the sternocleidomastoid muscle?
A. I don't believe that I have.
Q. Have you ever -- well, strike that. Then you would not have performed surgery on one either,

true?
A. That's correct.
Q. Dr. Bogdasarian, would you agree with me that it's a very serious matter for a physician to testify as an expert witness in a medical malpractice case?
A. Yes.
Q. Would you also agree with me that it's a very serious matter for a physician to testify in a medical malpractice case that another physician has violated the standard of care and committed malpractice?
A. Yes.
Q. Would you agree with me that an expert witness in a medical malpractice case owes a duty of thoroughness, fairness and objectivity to the plaintiff patient, the defendant physician, the court and the jury no matter who may be paying that expert for his time?
A. I would, yes.
Q. Do you agree that an expert witness in a medical malpractice case should have current hands-on experience concerning the matter to which he is testifying?
A. Yes.

Q. Would you agree with me that physicians do not guarantee perfect outcomes to their patients?
A. Yes.
Q. Would you agree with me that patients can and do have bad outcomes while under a physician's care, absent any negligence on the part of that physician?
A. That can happen, yes.
Q. Would you agree with me that the best physician in the world -- let's be more specific. Would you agree with me that the best head and neck surgeon in the world, if we could agree who that person was, that the best head and neck surgeon in the world could provide what appears to be a near perfect course of care to a patient and the patient still could have a bad outcome?
MR. RICHARDSON: I'll object to form. You can answer.
A. I'm not certain I can understand that question. I'm not sure what "near perfect" is. I'm not sure I can answer that.
Q. Let me ask a different question. Would you agree with me that the best head and neck surgeon in the world could provide a course of care to a patient that fully complies with the standard of

care and yet that patient still have a bad outcome?
A. Yes, I would.
Q. Do you agree with me that an expert witness in a medical malpractice case should be fully informed as to the facts of the case?
A. Yes.
Q. Do you believe that you have taken all of the time needed to become fully informed in connection with this case and to provide full and complete opinions here today?
A. I believe I have, yes.
Q. I guess phrased differently, have you done everything you think you need to do in order to be ready to testify today?
A. Yes.
Q. Are you confident in the opinions you intend to express here today?
A. Yes.
Q. Have you had adequate time to prepare for your deposition today?
A. Yes.
Q. Did you at any time in the course of your review of this case request any materials for review that were not provided to you?
A. No.

Q. And all of the materials that have been provided to you in this case were provided to you by Mr. Cohen and Mr. Richardson, correct?
A. I believe so, yes.
Q. I assume I know the answer to this question, but I need to ask it anyway. Would I be correct in assuming that you have never had a physician/patient relationship with Mr. James Chupp?
A. That's correct. I have not.
Q. Would I also be correct in assuming that you've never met the man?
A. Correct.
Q. Have you ever communicated with any of Mr. Chupp's treating physicians about his condition?
A. No.
Q. Where do you currently hold licensure as a physician, Dr. Bogdasarian?
A. In Massachusetts.
Q. How long has it been since you have held licensure anywhere else, if ever?
A. I've not held licensure anywhere else.
Q. You did all of your training as a physician in Massachusetts?
A. I did, yes. Well, except for medical school, but all of my post medical graduate has been

here, yes.
Q. Where do you currently hold hospital privileges?
A. I hold privileges at HealthAlliance Hospital, which is a combination of two campuses, Burbank and Leominster Hospital, and at the Nashoba Valley Medical Center in Ayer, Massachusetts.
Q. And your office is in Fitchburg; is that correct?
A. Yes.
Q. I told the folks before we started today, I was grateful you agreed to come to Boston, but my wife, who has friends in Hubbardston, was very disappointed we didn't get to go to Fitchburg.
A. It's about 20 miles west of Fitchburg, yes, nice little town.
Q. Can you give me sort of a thumbnail sketch of your practice, which I think is Central Massachusetts Otolaryngology. Tell me, who are the physicians in that group? Is it a solo practice? Let me start with that.
A. Currently it's a solo practice. I'm the only physician in the practice, and it's -- I practice general otolaryngology. Shall I continue?
Q. Please.

A. I take care of both sexes and all ages of patients. I perform surgery related to the ear, nose and throat, head and neck area, ordinarily two to three mornings a week in the operating room and two mornings and five afternoons in my office setting. I see consultations at the hospital and provide emergency department coverage at the two hospitals.

Q. I had used the term "head and neck surgeon" a little while ago. I wanted to make sure that for purposes of your qualification and your profession and also Dr. Flexon's qualification and his profession, if I refer to someone as either an otolaryngologist or an ENT or a head and neck surgeon, within the context of Mr. Chupp's case, are those all appropriately interchangeable terms?

A. I think, yes.

Q. I asked you also a little while ago if you ever encountered and operated upon a hemangioma fully encapsulated within the sternocleidomastoid and you told me you had not. I want to ask a slightly broader question.

Have you ever encountered a tumor of any type, which is to say it could be a lipoma, it could be a sarcoma fully encapsulated in the

sternocleidomastoid?

A. I'm going to have to answer that fairly by saying I may have. Certainly I've done many surgeries that involve dissection of the spinal accessory nerve through the sternocleidomastoid muscle. I've been in practice for 35 years and had two residencies before that. I can only say I can't remember a specific instance. I can only say I may or may not have.

Q. Certainly as you sit here today, there's no specific recollection of a specific case that comes to mind?

A. That's correct.

Q. Other than the hospitals which you have already identified, have you ever held privileges at any other hospital facility since the time of your completion of your training?

A. Yes.

Q. Where else have you held privileges in the past?

A. I've had courtesy staff privileges at the Heywood Hospital in Gardner, Massachusetts; the Athol Hospital in Athol, Massachusetts; Clinton Hospital in Clinton, Massachusetts; Cutler Army Hospital in Devens, Massachusetts now. I think that

would represent all of the hospitals that I've worked at.

Q. Have your hospital privileges at any institution ever been revoked, denied, restricted or suspended?

A. No.

Q. Have you ever had an application for privileges rejected?

A. No.

Q. Has your medical license in the State of Massachusetts ever been revoked, censured, disciplined or received any other kind of negative treatment?

A. No.

Q. Have you ever voluntarily withdrawn an application for either licensure or privileges before action?

A. No.

Q. Do you consider any particular journals to be standard and authoritative in the field of head and neck surgery?

A. Well, when you say "standard and authoritative," I think that there are journals within ear, nose and throat, or otolaryngology, head and neck surgery, that are read frequently. Whether

everybody always agrees with everything in them, I'm not certain, but they are journals we all read.

Q. Let me ask a different question then. Are there any journals in the field of otolaryngology that you know of to be widely read and widely relied upon and which you yourself consider to be leading journals?

A. Yes. There would be Otolaryngology: Head and Neck Surgery.

Q. Is that one or two?

A. That's one. Some people term it the White Journal because of its color. Laryngoscope; the Archives of Otolaryngology. I think those would the three main ones that I think many otolaryngologists receive. The Otolaryngologic Clinics of North America is a quarterly hardbound journal that comes out. There's a non-peer-reviewed journal called ENT, which I think most of us get.

Q. And all of the ones that you've listed, are those widely read in your field?

A. Yes.

Q. In a similar vein, I'd like to talk to you about textbooks, if I may.

A. All right.

Q. Are there any particular textbooks which

you consider to be widely read and widely relied upon concerning the subjects of the anatomy and surgery of the neck?

A. Concerning anatomy and surgery?

Q. Of the neck.

A. Well, I think John Lore's, L-o-r-e, Atlas of Head and Neck Surgery is the one I like.

Q. How about Cummings's text?

A. Yeah, Cummings is not so much an anatomy and surgery text as a large multi-volume textbook about laryngology, so I have that. Frankly, I don't get textbooks too much anymore because they seem to outdate pretty quickly and there's so much available online now to look up. But that's one. Paparella is another textbook. And then there are many kind of subspecialty texts as well.

Q. I had a physician tell me recently that it takes five years to put a textbook together and it's outdated the day they roll off the printing press.

A. In all truth I don't buy textbooks anymore for that reason, because -- unless there's some very special topic that I'm interested in, but by and large through many of the member search engines now, I think you get very up-to-date information and it clutters your office a lot less and it's less

expensive too.

Q. Doctor, have you ever published professional literature on any of the subjects that are at issue in this particular case?

A. No.

Q. Have you ever submitted an article for publication in the professional literature that was rejected?

A. No.

Q. I don't know if I saw it on your CV, but have you from time to time held clinical academic appointments?

A. Yes.

Q. Do you currently hold a clinical academic appointment?

A. Yes. I believe that I'm still listed in two medical schools as -- one is now termed clinical associate professor. The other is called a clinical affiliate. I have not, though -- at Boston University, which was the clinical associate professorship, I used to teach in the operating room setting, but I have not done that for about ten years or so. And the clinical affiliate through the University of Massachusetts has been inactive probably for four or five years, somewhere in that

range.

Q. These clinical academic appointments, you were not part of the full-time academic faculty of these institutions?

A. That's correct.

Q. And you were also, I assume, not remunerated for your service?

A. You know, I think initially I might have been on a very kind of token remuneration. I believe it was -- I've forgotten even which one it was. I think it might have been Boston University. But for most of the time I was not, that's correct.

Q. Mostly an unpaid position?

A. Yes.

Q. In what fields are you board-certified?

A. Well, I'm board-certified in otolaryngology head and neck surgery and I've been so since 1978. I was board-certified in general surgery from 1976 to '86. It required recertification in '86, but I was -- I wasn't a general surgeon. I didn't practice that specialty. So I didn't really think it was necessary to take that examination again.

Q. Did you complete a full general surgery residency?

A. I did, yes.

Q. Is that common or uncommon for otolaryngology?

A. It's uncommon.

Q. Tell me a little bit about that career pathway if you would.

A. Well, after graduating from medical school, I determined that I wanted to be a general surgeon. I did my training in Boston. My father was an otolaryngologist. I have a brother who's an otolaryngologist. And they pestered me, I guess, constantly about it being a better career path.

And I finally did make -- and based on need, too, I think at the time there was kind of a surplus of general surgeons and a need for otolaryngologists. Actually, the part of general surgery I enjoyed the most was head and neck surgery. So I thought I'd make the change. Because of some personal commitments, I wanted to stay in the Boston area. And when I made the decision, I was going to be through with four years of general surgery, so I thought since I'd gone that far, I might as well do the good year, the chief residency year. So I completed that and then switched over in 1975 to otolaryngology and completed that residency.

Q. If a medical student at that time had

wanted to go straight into an otolaryngology residency, was that an option?

A. Yes.

Q. With an intern year?

A. I think at the time there the requirement was a year of internship and I think one year of residency and then a three-year otolaryngology residency.

Q. So you got the full constructive credit of your surgery years and you just had to do the three years of otolaryngology to complete the training?

A. Yes.

Q. Do you have to recertify periodically for your otolaryngology board, or are you grandfathered?

A. I'm grandfathered. I don't have to recertify.

Q. When did you first start doing medical legal case review work?

A. I don't recollect specifically the year, but when I'm asked that question, I say 1981 because that's the one I think I started in. I think it was about then.

Q. Do you know how many cases in toto you have been consulted in since 1981 as a medical legal expert?

A. I think in that 35 years or so, I think that -- well, it's not 35, is it? It's 33 years. I think somewhere -- I haven't counted them, I will say. I'll estimate probably 400 to 500 that I've been asked to review in that period of time.

Q. Do you know how many depositions in toto you have given over the course of your career?

A. Again, I haven't counted them, but I would estimate around 150. It may be more; it may be less.

Q. Do you know how many trial appearances you have made?

A. I think a similar number.

Q. So about 150 depositions, give or take, about 150 trial appearances, give or take?

A. I think so.

Q. In some of your prior depositions you've indicated that your review work has broken down somewhere in the vicinity of 90 to 95 percent of the plaintiff and five to 10 percent to the defendant. Does that hold true?

A. Yes.

Q. My preliminary research suggests that you've been involved in medical legal cases that have originated in a number of states. What I'd

like to do, if I could, I'm just going to run through the list and I'm going to read off the states. If you could just say yes, no or I don't know with regard to each state whether you have been involved in a case which originated there.

A. When you say "involved," do you mean have I reviewed a matter?

Q. That's right.

A. Okay.

Q. Maryland?

A. Yes.

Q. New York?

A. Yes.

Q. Pennsylvania?

A. Yes.

Q. Florida?

A. Yes.

Q. Michigan?

A. Yes.

Q. Illinois?

A. Yes.

Q. North Carolina?

A. Yes.

Q. Rhode Island?

A. Yes.

Q. Texas?
A. Yes.
Q. Iowa?
A. Yes.
Q. Delaware?
A. Yes.
Q. Ohio?
A. Yes.
Q. Virginia?
A. Yes.
Q. South Carolina?
A. Yes.
Q. Connecticut?
A. Yes.
Q. New Jersey?
A. Yes.
Q. Minnesota?
A. Yes.
Q. Georgia?
A. Yes.
Q. The District of Columbia?
A. Yes.
Q. Louisiana?
A. Yes.
Q. Massachusetts?

A. Yes.
Q. Missouri?
A. Yes.
Q. Vermont?
A. Yes.
Q. West Virginia?
A. Yes.
Q. Mississippi?
A. I don't recollect Mississippi, but I may have.
Q. Colorado?
A. Yes.
Q. Kentucky?
A. Yes.
Q. Nevada?
A. Yes.
Q. The State of Washington?
A. Again, I may have reviewed a matter there. I don't recollect specifically, but I may have.
Q. Utah?
A. Again, I don't remember specifically. I may have. If you found it, I probably did, but I don't remember specifically.
Q. Have you ever reviewed a case in California?

A. I don't believe that I have.
Q. Now, I know that was a lengthy list. But are there any other states off the top of your head that you recall that you have been consulted in a case that arose there that we haven't talked about?
A. I can't -- I don't think so. I think you've covered them.
Q. Have you ever been consulted as an expert --
A. Wait a minute. I think North Dakota perhaps.
Q. As far as you know then, including North Dakota, would that be a complete list?
A. As far as I know, yes.
Q. Have you ever been consulted as an expert witness for a case pending in Canada?
A. I have been consulted I think on one occasion, yes.
Q. Any other foreign countries?
A. No, I don't think so.
Q. It also appears to me that you have been engaged in cases in which a variety of different medical conditions and subjects were at issue in the case. I apologize for the length of this list, but I'd like you to do the same thing, if you could, as

we did with the states. I want to read through a list of medical topics, and I want you to confirm yes, no or I don't know whether you've ever been involved in a case that included that particular medical issue. Nasal polyps?
A. Yes.
Q. Sinus surgery?
A. Yes.
Q. Suffocation during tracheostomy reversal?
A. Yes.
Q. Hearing loss?
A. Yes.
Q. Meningitis?
A. Yes.
Q. A belated breast cancer diagnosis?
A. Breast cancer?
Q. Yes.
A. Gee, I don't recollect that.
Q. Seizures following tonsillectomy?
A. Again, I don't recollect specifically. I may have.
Q. Cervical fracture and decubitus ulcer?
A. I don't recall that either.
Q. Mantle cell lymphoma?
A. Yes.

Q. Facial paralysis?
A. Yes.
Q. Loss of vision?
A. Yes.
Q. Myocardial infarction?
A. I don't remember that specifically. Some of those that I'm not sure of may have been --
Q. Incidental?
A. Well, incidental, or I may have been asked to look at some otolaryngologic consequence of the problem, but I don't think that I would have been the specific expert with regard to some of those subjects.
Q. Mercury chloride overdose?
A. Again, I don't remember that.
Q. Esophageal perforation during discectomy?
A. Yes.
Q. Vocal chord paralysis?
A. Yes.
Q. Failure to perform a pre-op cardiac work-up?
A. I may have been.
Q. Operating room fire?
A. Yes.
Q. Facial fractures?

A. Again, I don't remember specifically, but I may have been.
Q. Failure to diagnose diabetes?
A. Yes.
Q. Blepharoplasty, eyelid surgery?
A. Again, I may have been.
Q. Misdiagnosis of lung cancer?
A. Again, I don't recollect specifically. I may have been.
Q. Anoxic brain injury?
A. Yes.
Q. Damages to blood vessels?
A. Yes.
Q. Proper ascent and descent in a hyperbaric chamber?
A. Yes. Again, I think I was tangentially involved in that. But yes, I think I was asked to look at a portion of that.
Q. Retained objects or retained foreign bodies?
A. Yes.
Q. Horner's syndrome?
A. Well, again, I think that would have been one of the symptoms someone may have had, yes.
Q. Diagnosis and treatment of squamous cell

cancer?
A. Yes.
Q. Failure to diagnose aneurysm?
A. Yes.
Q. Negligent prescription of narcotics following sinus surgery?
A. I believe so, yes.
Q. Failure to diagnose osteomyelitis?
A. I believe so.
Q. A case involving the prescription of Beconase to a pregnant woman causing birth defect?
A. I don't recollect that, but it's possible.
Q. Is Beconase a nasal agent?
A. Yes, a steroid nasal spray.
Q. Diphtheria?
A. I believe that I may have been involved in one matter such as that -- regarding that some years ago.
Q. Fungal infections?
A. Yes.
Q. Intraoperative burns to the patient from an electrocautery device?
A. Yes.
Q. Brachial plexus birthing injury?
A. I don't recollect that. I'm sorry.

Q. No, no. Trust me, I just want to know what you do recall.
Failure to treat infected dental work?
A. I don't recollect that one either.
Q. Failure to diagnose Hodgkin's?
A. I may have.
MR. RAY: We've probably been going about an hour. Why don't we take a short break and we'll pick up again, if that's all right.
THE WITNESS: All right. Sure.
(A recess was taken.)
MR. RAY: Let's go back on the record.
Q. Dr. Bogdasarian, I understand that over the years you have had relationships or encounters with several referral businesses which are in the business of helping lawyers find experts. Is that correct?
A. Yes.
Q. You have had cases sent to you by Medical Advisors in Philadelphia; is that right?
A. Yes.
Q. You've had cases sent to you by MedQuest in New York City; is that true?
A. Actually, Medical Advisors is now in I think Bala Cynwyd, Pennsylvania. They used to be in

Philadelphia.
Q. You've had cases from MedQuest in New York?
A. Yes.
Q. From Technical Assistance Bureau in Pittsburgh?
A. Many years ago. I think two or three matters, perhaps.
Q. ExpertNet in Chicago?
A. Again, years ago.
Q. Are there any other agencies of that type that you've had dealings with that you can recall?
A. There's one called Caseworks, which is in Newtown, Pennsylvania. I'm sorry. Newtown, Connecticut, I'm sorry. It's some years ago. They sent me a few matters for review. And one called Saponaro, I think in -- I believe they're in Pennsylvania, who had asked me to look at two or three matters as well.
Q. Do you advertise your services as an expert witness in any manner?
A. No.
Q. Have you ever?
A. No.
Q. What portion of your professional time would you estimate is dedicated to medical legal

case review?
A. I think of the time that I work, about fifteen percent.
Q. Last year for 2013, do you know how much money you made from medical legal case review work?
A. No. I don't really keep specific track of it.
Q. You have no idea at all?
A. I think I could just tell you that probably about 15 percent of my income is related to medical/ legal work because I think that the time that I spend in terms of charge is commensurate with the medical work that I do, but I don't -- I can't give you specific figures.
Q. What's your billing structure, your charges for medical legal case review work?
A. I charge $300 an hour for record reviews, and meetings, reports, that sort of thing. $1,750 for a half day deposition. I don't think I've ever done a full day's deposition. I think my charge for that is $2,500, but, again, I don't think I've ever done one. And for a trial appearance it's $3,500 for a day away from the office and reasonable charges for expenses.
Q. So for example -- I'm sorry. I didn't mean

to interrupt you.
A. Go ahead.
Q. So for example, this case pends in rural Georgia. You'd probably have to have an airline flight and drive for some distance. Would you bill for expense attendant to air fare, car, hotel, that sort of thing?
A. Yes.
Q. What about your time in transit, do you bill for that?
A. I don't ordinarily unless it means taking a day -- if it meant taking a day off from my office work, then I probably would, but if I could travel without impacting that, then I would not.
Q. How many depositions do you give in a typical year?
A. I think somewhere around ten on average.
Q. Has that held true say over the last three or four years?
A. I think so.
Q. How many trial appearances in a typical year over the last three or four years?
A. I think probably five to ten.
Q. Doctor, have you yourself ever been sued for malpractice?

A. No.
Q. That takes out a whole page.
A. Glad about that, both parts of that.
Q. Have you ever been party to any other kind of lawsuit, that is, suing someone or being sued over money, a business dispute, anything like that?
A. No.
Q. Dr. Bogdasarian, this next series of questions is not intended to offend you. I ask it of almost every witness in every case.
Have you ever been arrested, sir?
A. No.
Q. Have you ever been charged with any crimes?
A. No.
Q. Have you ever been convicted of any crimes or pled guilty to any crimes?
A. No.
Q. Have you ever been treated for substance abuse?
A. No.
Q. Have you ever participated in an impaired physician program as an impaired physician?
A. No.
Q. Have you ever filed a bankruptcy petition?
A. No.

Q. Since 1978 when you completed your training as a physician, has there ever been a period of longer than 30 days when you have not been actively engaged in the practice of medicine?
A. Yes.
Q. Okay. Can you tell me about that, please.
A. I had a surgery in 2012.
Q. Stop right there. Is it a personal medical issue?
A. Yes.
Q. Does it have any bearing on your ability to be a witness in this case?
A. No.
Q. I don't need to ask you about that, and I'm not going to.
A. All right.
Q. Other than a personal medical leave that you needed, have you ever had an interruption of longer than a month in your practice?
A. No.
Q. As far as you know, have any negative reports concerning you ever been made to the Massachusetts medical licensing authorities?
A. I'm not aware of any.
Q. As far as you know, have any negative

reports concerning you ever been made to the National Practitioner Databank?

A. Not that I'm aware of.

Q. I believe you told me earlier that you have never personally encountered the particular type of mass -- at least you could not recall the specific instance of when you encountered the particular type of mass with which Mr. Chupp presented to Dr. Flexon, correct?

MR. RICHARDSON: I'll object to form.

A. I don't believe that I -- again, I'll say I don't recollect having a hemangioma of the sternocleidomastoid muscle or certainly one that was completely encapsulated or contained within that muscle.

Q. Have you ever heard of such a lesion from one of your colleagues who may have encountered that?

A. I don't believe that I've heard of one through a colleague. I believe I may have read of them, but I have not heard of it.

Q. Are you under the impression that it's a rare presentation?

A. I think it's pretty unusual, yes.

Q. Do you have an opinion in this particular

case as to what caused the hemangioma to grow in Mr. Chupp's sternocleidomastoid?

A. Well, I don't. Hemangiomas are benign tumors of blood vessels. So I don't know if anyone knows why those occur.

He had had certainly some incidences of trauma to his neck and some surgery to his neck. Whether that had any influence or not, I'm not certain, but I think the fair answer would be I don't know why it started.

Q. Would I be correct in saying that it is possibly post traumatic in origin?

A. I would say it's possible, yes.

Q. Would you agree with me that the preferred course of treatment for a growth of this type in the muscle would be complete excision?

A. No. I don't think I'd agree with that.

Q. What do you believe would be the preferred course of treatment for a growth of this type in the sternocleidomastoid muscle?

A. I think the preferred course of treatment would be thorough evaluation of the nature of the mass and then a discussion with the patient as to the pros and cons of surgical removal or of some other treatment.

Q. Have you ever seen any photographs of the mass on Mr. Chupp before it was removed?

A. No.

Q. Have you been provided with and reviewed any radiographic studies that might depict the mass?

A. Not the images themselves. I've seen, of course, reports regarding imaging studies, but have not seen the studies themselves.

Q. But, for example, the ultrasound and the CT that were taken preoperatively, you have not reviewed those images?

A. No, I haven't.

Q. That's correct?

A. Correct.

Q. Would you agree from your review of the written record that this was a large growth in the sternocleidomastoid muscle?

A. Well, I think the greatest extent of it was five centimeters in a vertical dimension. That's a good size, yes.

Q. Did you understand from your review of the records that it had had a recent rapid increase in size according to the patient?

A. Yes.

Q. Did you understand from the record that

according to the patient it was a painful mass?

A. Yes.

Q. Adding that data to the question I asked you earlier, you've told me that you do not believe that a wide and complete excision was the preferred course. Would you agree with me that a wide and complete excision was a reasonable treatment choice --

A. Yes.

Q. -- for a patient in that condition?

A. Yes. Just to clarify. I think certainly it was an option. I just wasn't certain about the word "preferred." I think that comes down to a decision between patient and doctor.

Q. I guess what I'm getting at is it was a reasonable treatment choice and not a violation of the standard of care to recommend complete excision, correct?

A. Correct. As one of the options, yes.

Q. I'd like to talk to you about your personal experience with injury to the spinal accessory nerve, and I'm not talking about in your testimonial capacity. I'm talking about your capacity as a surgeon.

A. Yes.

Q. Would I be correct in assuming that you have on many occasions in your career intentionally severed and removed the spinal accessory nerve as part of a radical neck dissection?

A. Yes.

Q. Can you estimate for me the number of times you've treated a patient where the course of care required the deliberate transection of the spinal accessory nerve?

A. Well, when I was a resident in general surgery and otolaryngology, the standard surgery for removal of lymph nodes in the neck was a so-called radical neck dissection, and as part of that, removal of the spinal accessory nerve was the standard treatment.

At some point after I went into practice, we started doing different sorts of neck dissections, but I would say during the residency and the early part of my training, I probably did over 100 neck dissections in which we sacrificed the spinal accessory nerve purposely.

Q. Let's use that round number of approximately 100, if I may. So then it would be fair to say that you also had an opportunity to follow and be involved in the care of many of those

patients post-operatively; is that correct?

A. Definitely, yes.

Q. So in the approximate hundred occasions in which you deliberately cut and removed the spinal accessory nerve, I presume that you or someone working with you explained to those patients in advance of the procedure the role of the spinal accessory blade in innervating the sternocleidomastoid and the trapezius.

A. Correct.

Q. You would have explained to those patients the expected or anticipated effect of no longer having innervation of the SCM and trapezius; is that correct?

A. Just as a little quibble, actually, as part of the radical neck dissection, the sternocleidomastoid muscle got taken out --

Q. Is taken out.

A. -- so that really had no --

Q. I noticed the weakness in my question. I'm sorry.

A. No, not a problem. But yes, it was important to discuss that.

Q. Let's just focus on the trapezius for a moment. You would have expressed and explained to

these patients that they were going to have a functional change in their shoulder as a result of no longer having a functional trapezius muscle; is that correct?

A. Correct.

Q. Of those approximately 100 patients upon whom you deliberately removed the SAN, spinal accessory nerve, did all of those patients go on to develop pain in the neck and shoulder on that side?

A. Boy, I don't know if I would want to say all. Obviously I can't remember every specific patient. Without getting too far afield on your question, I think that what always struck me about radical neck dissections was -- in conjunction with other major resections in the head and neck area, people complained about their shoulders more than the other things. That was what seemed to strike them or hurt the most. But I don't think I could say every one. I just can't recollect every specific case.

Q. Would it be fair to say most of the patients in whom you removed the spinal accessory nerve suffered some form of atrophy of the trapezius muscle?

A. I think almost all of them, yes.

Q. To varying degrees, correct?

A. Yes.

Q. Would you agree with me that that process of atrophy was not typically an immediate change in the appearance of the muscle right after the surgery, but a change that could be chronicled over a period of months?

A. Yes.

Q. Would you also agree with me that typically the pain that was associated with the removal of the spinal accessory nerve was not always present immediately following the surgery either?

A. I think that's true, yes.

Q. Rather the pain usually would come about as a result of the muscle atrophy and the consequent shoulder droop stretching and straining on the other muscles and ligaments, correct?

A. I believe that's what happens, yes.

Q. And the pain comes in basically insofar as the other muscle groups are having to work to replace the function of the trapezius as best they can; is that correct?

A. The pain comes from that. I think that's a lot of it. I think probably some ligament stretch has other components or adds other components.

Q. In the patients whom you treated where you deliberately cut the spinal accessory nerve, were those patients routinely referred for physical therapy?

A. Yes.

Q. In your experience as a head and neck surgeon, do you believe that physical therapy conferred a benefit on most of those patients?

A. I think it conferred some benefit. It certainly didn't completely relieve their symptoms. So I think it was a slight benefit. I'll put it that way.

Q. Would you agree that in your experience the patients who successfully completed their physical therapy regimen on the whole did better than those patients who did not?

A. That's probably fair to say.

Q. Have you yourself ever had an inadvertent, unintentional injury to the spinal accessory nerve during a surgical procedure which you have performed?

A. Not that I recollect.

Q. Have you ever had any of your professional colleagues, either folks who used to be in practice with you or other members of the same service at a

hospital where you practice, have an inadvertent, unintentional injury to the spinal accessory nerve?

A. I really -- among those who have practiced with me before, I can't -- nothing comes to mind of anyone mentioning that to me. I'm not -- sometimes we did surgeries together. I never -- I don't recollect having seen it. When we're not together, I don't recollect anyone telling me about it. And I really can't speak for other otolaryngologists or surgeons in the community. Nothing comes to mind.

Q. In your capacity as a member of the clinical faculty at either B.U. or the University of Massachusetts, did you ever have occasion to supervise the training of surgeons in head and neck procedures in the vicinity of the spinal accessory nerve?

A. Quite -- that was probably the most common operation that I did with them, was some neck dissection in association with another head and neck resection of some sort.

Q. Were these typically general surgery residents or were they typically otolaryngology residents?

A. At Boston University otolaryngology residents.

Q. Did any of the residents who were ever under your supervision, as far as you know, ever have an unintentional or inadvertent injury to the spinal accessory nerve during a surgery on the neck?

A. Again, I don't recollect that. I can recollect a hypoglossal nerve injury some years ago, but not -- actually, it wasn't under my supervision. I was just observing a different -- another surgeon with a resident. But I've not -- I don't recollect a spinal accessory nerve injury.

Q. Dr. Bogdasarian, would you agree that injury to the spinal accessory nerve is a recognized risk and complication of surgery in the vicinity of the sternocleidomastoid muscle and the posterior triangle of the neck?

A. I know that I've been asked this question before and sometimes attorneys mean different things by that than what physicians do, but I think from a medical standpoint, without stating whether it's -- by what means it occurs or for what reason it occurs, yes, I would agree that it's a recognized complication.

Q. Well let's move on to the more precise questions then. Would you agree that as such, an injury to the spinal accessory nerve during surgery

in the region of the sternocleidomastoid muscle can occur without any negligence on the part of the operating surgeon?

A. Yes.

Q. So, in other words, surgery in the neck can be carried out by a surgeon in a manner which fully complies with the standard of care and yet the patient can still have an injury to the spinal accessory nerve?

A. Under certain circumstances, yes.

Q. Let's talk about which circumstances in your view would constitute such an example.

A. Go ahead.

Q. I'm asking you.

A. All right. Well, I think that certainly with revision surgery, if someone had operated in an area before in that vicinity and caused scar tissue that made it difficult to isolate or find the nerve or to protect the nerve appropriately, that would be one situation. We've talked about schwannoma before, which certainly would be another situation that that could happen. Malignant tumors that are intimately associated with the nerve so that removal of the malignant tumor required removal of the spinal accessory nerve or resulted in removal of the

spinal accessory nerve in an attempt to remove cancer.

I think those would be the main situations in which I think it would happen with a surgeon doing things properly.

Q. What about a patient with a spinal accessory nerve with a particularly unusual or eccentric course out of the anatomical norm?

MR. RICHARDSON: I'll object to form, but you can answer.

A. Well, I'm not -- I think that's very hypothetical because I don't -- aside from some neoplasm or something causing it to happen, I don't think that there's that kind of variation in the course of the spinal accessory nerve. But -- so I think I'd just have to say I'd have to consider any individual presentation individually with respect to that.

Q. Am I to understand then that the only circumstances under which you believe it would not be a violation of the standard of care for a surgeon operating in the vicinity of the sternocleidomastoid and posterior triangle of the neck to injure the spinal accessory nerve would be in the presence of either scarring, a schwannoma or a malignant tumor?

A. Well, I don't think that's completely fair, because I think obviously there might be situations that I'm not thinking of where that could happen and I'd have to consider those if I was asked about them.

Q. As -- I'm sorry. Go ahead.

A. No. I was just going to say obviously I'm concentrating on this particular case and the circumstances that existed when I made my decision as to whether or not the standard of care was complied with.

Q. Would I be correct in stating that as you sit here right now, however, there's no other specific condition other than scar, schwannoma or malignant tumor that you would point to as a specific circumstance in which injuring the spinal accessory nerve during surgery in the vicinity of the sternocleidomastoid muscle and the posterior triangle of the neck would not be a violation of the standard of care?

A. I might add some other kind of tumor that somehow was involving the nerve that required the nerve to be removed in order to remove that tumor. Again, that would require the judgment of the surgeon at the time whether the sacrifice of the

nerve was warranted given the problem that he was dealing with. And, of course, it involves knowing where the nerve is and dealing with it prospectively. But, again, those circumstances I gave you are the ones that come to mind. There may be others I'm just not thinking of right now.

Q. In this particular case, based upon your full understanding of the medical records and the history of the patient, do you have any reason to believe he had a schwannoma?

A. No.

Q. Do you have any reason to believe Mr. Chupp was suffering from a malignant tumor in the vicinity of the spinal accessory nerve?

A. No.

Q. Let me ask you this question: Did you understand that Mr. Chupp did have a history of repeated traumas to the neck and right shoulder?

A. Yes.

Q. Do you have an opinion as to whether any of those traumas to the neck and to the right shoulder which Mr. Chupp had suffered prior to his surgery may have resulted in any scarring or anatomical alteration of the spinal accessory nerve in him?

A. I don't believe that it did. I know he had

a cervical fusion procedure. I'm not -- I believe it was likely done from a posterior approach. I say that because certainly in Dr. Flexon's operative note there's no mention of any scarring or any aberrant course to the spinal accessory nerve.

Q. Let's talk a little bit about -- since you bring it up, let's talk a little bit about the spinal accessory nerve in general. Not so much in Mr. Chupp. Can you and I agree that in general from the point the spinal accessory nerve exits the skull, it moves generally in a posterior and caudal direction?

A. Posterior and caudal being inferior, yes.

Q. Let me use plainer English. Can we agree that it is generally moving from a more frontward position in the body to a more backward position in the body and also moving from a higher position in the body to a lower position in the body?

A. Yes.

Q. Until it terminates in the trapezius muscle, correct?

A. Correct.

Q. Now, is it true that in some patients the spinal accessory nerve will run along the underside of the sternocleidomastoid without actually being

enmeshed in the fibers of the sternocleidomastoid?
A. Yes.
Q. Do you know if that is the more common or less common presentation?
A. I think that's probably the less common -- well, I'm sorry. Well, in my experience, I would say it's the less common presentation.
Q. Another sizable portion of the population, and probably the more common portion of the population are those in which the spinal accessory nerve actually passes through the body of the sternocleidomastoid before entering the posterior triangle and moving downward towards the trapezius, correct?
A. Correct.
Q. Even the ones that don't actually pass through the sternocleidomastoid still throw off some motor branches into the sternocleidomastoid?
A. Yes.
Q. Based upon everything you know about this case, can you state within a reasonable degree of medical probability one way or the other what the course of Mr. Chupp's spinal accessory nerve was?
A. My recollection is that Dr. Flexon said that it went through the body or at least partway

through. I think he was talking about the posterior third of the muscle was pierced by the spinal accessory, if I'm recollecting. I think that's what he said.
Q. Where do you believe you saw that?
A. I believe he referenced it in his deposition, and I think he did -- I'm not certain it's mentioned in the operative report. I'd have to look again, but I'm quite sure it was in his deposition.
Q. I'd like you to assume that Dr. Flexon testified that he visualized the spinal accessory nerve at the posterior margin of the sternocleidomastoid muscle.
A. I recollect that, yes.
Q. Just so I make sure we're speaking the same English here. His use of "posterior" in that context is not -- correct me if I'm wrong -- it's not used to refer to the underside of the sternocleidomastoid muscle. It's meant to refer to the side of the muscle closer to the back of the patient, correct?
A. Yes. And I think that would be the only proper way to interpret that. I think deep or medial would be the other term that -- it refers to

deep to the sternocleidomastoid muscle.
Q. Well, do you know if Dr. Flexon is describing a spinal accessory nerve which is emerging out of the sternocleidomastoid or emerging from under the sternocleidomastoid when he said he saw it along the posterior margin?
A. My understanding was that -- I recollect that he said in his deposition, and I'd have to look at his operative report briefly to recollect what he said there, but my recollection about his deposition was that it did go through and come through the muscle fibers of the back third of the posterior third of the sternocleidomastoid muscle.
Q. And, again, just so we have our language clear, your use of the term "posterior" in that context is a little different than the use of the "posterior" I was using a moment ago from posterior edge, correct?
A. No, no. I'm talking about the same thing. I think -- my understanding was that the nerve went deep to the sternocleidomastoid muscle and then entered the sternocleidomastoid muscle about two-thirds of the way back or posterior so that there was one-third of the posterior margin left, and the nerve went through that last third.

Q. Can I ask you to take out that depo and just tell me what language you're relying on, if you would.
A. Sure.
Q. We can go off the record for a minute if you want.
A. Yeah, I might just need a minute.
(Discussion held off the record.)
Q. If you'd tell us what page and line you're looking at, Doctor.
A. Just give me one more second. Well, I may not have found the best part of it, but I can give you some areas where I think he at least is saying that it did do that. So it would be page 71.
Q. Okay.
A. Do you want me to read it?
Q. Let me take a peek and I may ask you to read it.
A. (Witness handing document.)
Q. We'll go back to your transcript in a moment. Was there anything in the operative note that helped illuminate your opinion on the subject of whether the spinal accessory nerve actually passed through the muscle fibers of the sternocleidomastoid?

A. No. I don't think that it does. I think he's referring to dividing the sternocleidomastoid muscle over the mass that was in it, but he doesn't really mention the spinal accessory nerve, other than posteriorly material, which, again, I take to mean at the back edge of the sternocleidomastoid muscle.

Q. Again, when you say "back edge," are we talking about back in the sense of deep or are we talking about back in the sense of anterior, more towards the back of the body?

A. Posterior, more towards the back of the body.

Q. Posterior, more towards the back of the body?

A. Yes.

Q. I'll take the operative report back. I still have pages 70 and 71 of Dr. Flexon's deposition. I think what you may have been pointing to was a question posed to him at line 11 which said, quote, "And were you able to determine whether or not the spinal accessory nerve was running through the muscle?"

"ANSWER: In the way I cut to the muscle I believe I was. In the way I go through the muscle

I believe I was. Let me explain."

Then Mr. Cohen asked a question. "I don't understand. I'm sorry." I interposed an objection. And then Dr. Flexon picked up again.

"In the manner in which I go through the muscle, I believe that you can. Now, let me explain up to."

Mr. Cohen said, "And again you can determine where the spinal accessory nerve is?

"ANSWER: Yes. Let me just say you visualize and see the mass. You then go up and you identify on the posterior border where the nerve comes out. So you get an approximate level of where you believe it would be in the muscle."

A. Yes.

Q. Now, would you agree with me that -- and I realize you're interpreting what he said here. But when it says, "The posterior border where the nerve comes out," that could refer either to where the nerve actually emerges from muscle tissue or it could also refer to where the nerve emerges into visualization but deep to or underneath the sternocleidomastoid?

A. Yes.

Q. As you sit here right now do you really

know one way or the other whether this spinal accessory nerve was or was not in the sternocleidomastoid?

A. Well, as I say, I just received this deposition I think it was a couple of days ago. So I read it yesterday, and my recollection is that -- at least my understanding, what I came away with was the sense that it went through the muscle. You've asked me to go through a 150-page deposition now and pick that out, and I'm happy to do it, but I don't think it's fair to ask me to do it in two minutes to find the passages. But if you want me to do it, I'll look again and I will admit that I could be wrong. I think the important point is not so much where it comes out but knowing where it is, wherever it comes out or wherever it goes. So to me it's not hugely important, but if you want me to look --

Q. The transcript is what the transcript is. It says what it says.

A. Exactly.

Q. But if I'm hearing your testimony correctly, your sense or takeaway from reading the transcript, your perception is that the nerve was in the sternocleidomastoid muscle?

A. For a part. Again, it's not terribly

important to my opinion, but that's the recollection I have.

Q. You acknowledge that it is possible that Dr. Flexon saw it to be otherwise, though, correct?

A. It's possible, yes.

Q. Let's talk about the -- were you supplied with any of the exhibits to Dr. Flexon's deposition?

A. No.

Q. Mr. Cohen provided Dr. Flexon with a drawing, a human anatomical drawing that he was asked to mark upon. Have you ever seen that?

A. No.

Q. You saw it described, though, in the testimony?

A. Yes.

Q. Did you ever ask to see that drawing?

A. No.

Q. I will tell you that in the drawing Dr. Flexon was asked to mark the point where the spinal accessory nerve came out past the posterior margin of the sternocleidomastoid, and my recollection is it was perhaps marked in the context of being asked where he had placed his stimulator, but there's an X that's marked on the nerve there.

A. Yes.

Q. He was also asked to draw crudely a circle to depict where the mass was. Do you have any reason -- I know you haven't seen the drawing, but insofar as you were not at the surgery that day and Dr. Flexon was, I would assume you would have no reason to disagree with his recollection and the depiction of the relative positions of the mass and the nerve, would you?

A. No.

Q. In a typical patient --

(Telephone interruption.)

Q. I wanted to speak just generally, and I realize that the course of the spinal accessory nerve can vary, just as any structure can vary anatomically from person to person. But am I correct in my understanding that generally the point at which the spinal accessory nerve passes the posterior border of the sternocleidomastoid is usually at the more superior end of the sternocleidomastoid in level 2 or maybe the high end of level 3 of the neck?

A. Yes.

Q. Do you know where the mass was located in terms of level of the neck in this case?

A. My recollection of the description of the

drawing was that it was below that. That's my recollection.

Q. Do you know what the actual physical distance would have been between the mass and the visible portion of the spinal accessory nerve at the posterior margin during the case?

A. I'm sorry. The difference between --

Q. Do you know what the actual distance would have been between, say, the nearest edge of the mass and the visible portion of the spinal accessory nerve where it sat at the posterior border during the case?

A. I seem to recollect, just having looked, that there was something like two centimeters difference, but I could be wrong about that.

Q. Would you, again, agree that Dr. Flexon as the person who was actually present there that day is in the best position to opine about the relative distance of those structures?

A. Yes.

Q. Let's, as I said we would, circle back to your standard of care violation opinions, which we touched on briefly early in the deposition, and I'd like to go back to in a little more detail. I believe we have established that there are three

violations of the standard of care which you have attributed to Dr. Flexon in this case and a fourth topic which we need to speak of perhaps separately.

A. All right.

Q. Let's talk about the fourth topic first if we could. The fourth topic, as I understand it, is something which you have a suspicion could or could not have been a violation of the standard of care in this case, but it depends upon the facts of what transpired. Is that correct?

A. Exactly, yes.

Q. As you sit here right now, based on all of the evidence which has been made available to you, including the medical records and the testimony of Dr. Flexon and the testimony of Mr. Chupp, you're incapable of coming down on one side or the other on that topic; is that correct?

A. Yeah. I would add testimony of Ms. Gray as well.

Q. Ms. Gray as well.

A. She had some comments about that, but that's correct. I wasn't there. So I'm not willing to say who said what at the time.

Q. So if we were before the jury today trying this case and you were under oath, you would not be

capable of raising your right hand and swearing to within a reasonable degree of medical probability that there is, in fact, this fourth violation of the standard of care for failure to get -- I guess it's proper informed consent; is that correct?

A. Correct.

Q. I know that you have not seen Dr. Flexon's office chart, but I do want to show you a note from a preoperative visit, if you'll bear with me just a moment.

A. It's good to see somebody else looking through records for once.

Q. I'm going to show you the second page of a two-page note dated July 13 of 2010 from Mr. Chupp's preoperative office visit with Dr. Flexon in this case. And specifically, I would point your attention to the next to the last sentence, which begins with the words "I also." Could I ask you to just read the rest of that paragraph aloud into the record, please.

A. "I also explained to him that his spinal accessory nerve is at risk, but hopefully that should not be a problem." Actually, okay. "He has a shrug at the present and hopefully this could be maintained." You know, I actually have this in my

records as well.
Q. Okay.
A. Now that you show it to me.
Q. Would you agree with me that if Dr. Flexon did specifically warn Mr. Chupp about the potential risk to the spinal accessory nerve during -- I'm sorry -- before the surgery, then there would not be a basis for this hypothetical fourth violation of the standard of care?
A. I think that's correct. I think -- obviously the patient has to understand a little bit what spinal accessory nerve means and what it does, but if he did that, then I think there would be no violation or deviation from the standard of care.
Q. Let's talk about the three topics which you have articulated as violation of the standard of care. Actually, before we do that, your comment that you thought you had seen that before, I did not see Dr. Flexon's office chart in your materials. Had a page of it perhaps been contained in another chart?
A. I know I've seen that note. And so it's in here somewhere. It might be -- I can look toward the bottom if you want me to help.
Q. I can tell you the note was discussed in

the deposition. Is it possible you saw it in that context?
A. I'm quite sure I've seen it. I looked through the records this morning, and I'm quite sure I saw it in there.
Q. All right.
A. Now that you've shown it to me, I'm pretty sure. I think it would be -- I can look for you too. I'm pretty sure it would be toward the bottom.
Q. Let's do this...
MR. RAY: Matt, I'd like to mark the disk if you could and ask the court reporter to have a copy of the disk made -- printed out and marked as an exhibit.
Q. Doctor, I'll split the file with you.
A. Yeah. I'll take the lower half.
Q. Sure. Let me find a breaking point. I don't want to break on one of your stickies.
MR. RAY: I'm going to mark the disk as Exhibit 5.
(Marked, Exhibit 5, disk containing medial records.)
Q. Doctor, there are no medical records in the paper stack that would not be on the disk, correct?
A. No...?

Q. Medical records.
A. That's correct. Everything on the disk is here.
MR. RAY: Why don't we take a short break while he looks for that.
(Discussion held off the record.)
Q. Doctor, we've taken about five or ten minutes to afford you an opportunity to look through the paper printed out chart. Up to this point you have not been able to locate a copy of Dr. Flexon's office notes concerning Mr. Chupp, true?
A. Correct.
Q. All right. I also understand, as Mr. Richardson, suggested, that we can look at what's on this disk that I've asked the court reporter to print out. It should be a complete copy of the records supplied to you. If the records were on there, you may have seen it. If they're not, you would not have?
A. Correct.
Q. All right. We were in the midst of discussing the three standard of care violations that you have in this case. The first was failing to find the spinal accessory nerve and remove the lipoma, which we've already agreed was actually a

hemangioma, while in view. I'd like you to, if I could ask you to, put a little more meat on the bone, so to speak, of that first violation of the standard of care. What specifically is it that you contend that Dr. Flexon should have done in the course of the surgery that he did not do?
A. Well, you know, I think frankly the two standard of care criticisms that are there outside of the needle aspiration one are very much intertwined, and essentially I think basically the obligation of the surgeon in this particular surgery is to locate, protect and preserve the spinal accessory nerve in the course of the procedure. How would he have done that? I think that he would have done that by finding the nerve on the posterior margin of the sternocleidomastoid muscle, and then there are different techniques, but you follow the nerve from posterior to anterior through the muscle or behind the muscle, wherever it goes, keeping the nerve in view the entire time and essentially divide the fibers of the sternocleidomastoid muscle and remove the tumor away from the nerve keeping the nerve in view at all times. I believe that if one does that, that the function of the spinal accessory nerve will be

preserved.
Q. Can we agree that Dr. Flexon did locate the spinal accessory nerve during the surgery?
A. He saw it in one location, I think at the back edge or the posterior edge of the SCM muscle.
Q. Explain to me how if the patient presents with a spinal accessory nerve that does not, in fact, run through the sternocleidomastoid but only runs deep to it, how does one gain visual access to that nerve on the reverse side of the intact sternocleidomastoid muscle?
A. Well, you have to find the nerve either in front of the muscle, anterior to it or posterior to it, usually easier to find it posterior to it, because it's usually more superficial and there's less anatomy in the way. And I think that's what he did. He said he saw it there and stimulated it.
Once you have that, then the easiest way to do it is take a hemostat or forceps and slide it over the nerve, keep sliding it and spreading it open. If you need to, you can cut through. As you look at the nerve underneath your forceps, you can cut through the muscle fibers, knowing that they're away from that, from the nerve, and just visualize it as you go forward through the muscle. If the

muscle is small enough, you could lift the whole muscle up off of the nerve without cutting through it and just look at it through a tunnel from front and from back, but in most people, especially males, the muscle is pretty big and you're likely going to have to cut through it.
Q. In a 6-foot-2, 200-plus-pound weight lifter and construction worker, would you expect it to be a thin sternocleidomastoid that could be easily lifted?
A. No. I think you would have to go through it.
Q. Again, I may not be visualizing the anatomy properly here. If the muscle is in your field and you can only see a piece of the nerve where it emerges from behind the muscle, how do you get to visualize the nerve which is behind the muscle and deep to your field of view without cutting into the muscle?
A. Well, you may not be able to. You may have to cut into the muscle or cut through it in order to follow the nerve through and underneath it. Then you have to be very careful when you come to where the nerve branches to send a branch to the sternocleidomastoid. Otherwise you can cut that.

You can either do that, or as I said, in a thinner person, female, you might be able to lift the whole muscle up and look under it.
Q. In this case since we're talking about Mr. Chupp, let's leave that option off the table, if we may.
A. Right.
Q. So what happens in the circumstance where you have the sternocleidomastoid muscle in your field of view, you're able to visualize where the nerve emerges at the posterior margin, but that nerve is completely deep to the sternocleidomastoid. It does not involve it or run through it at all.
A. Mm-hmm.
Q. Are you suggesting that you should completely transect the sternocleidomastoid to get down to the nerve beneath it?
A. If that's the situation, yes. Yeah, you can do it and just sew it back together at the end. I mean, it's not -- we do that a lot in exposing structures in the neck. Muscles can be taken apart and put back together. I think it's better than guessing as to where the nerve might be, and especially if there's a tumor that could potentially distort the anatomy and just trusting to luck that

you're not going to injure it.
Q. Did you understand in this case that Dr. Flexon felt that he was able to keep the deep wall of the sternocleidomastoid muscle completely intact at the close of his case?
A. Mm-hmm.
Q. Is that a yes?
A. Yes. Yes. I'm sorry. Yes.
Q. Did you also understand that Dr. Flexon is of the view that he did not encounter the nerve at any point in the body of the sternocleidomastoid muscle while he was excising the tumor?
A. I believe that was his impression, yes.
Q. If that's true, if it is true that Dr. Flexon was able to fully excise the hemangioma leaving some layer of thickness on the back wall of the sternocleidomastoid muscle intact and he did not encounter the spinal accessory nerve at any time in that excision, would he be correct then that the spinal accessory nerve either passed completely deep to the muscle or passed in a layer of the muscle that still had not been reached?
A. No. I don't think he can make that assumption, because he didn't see the nerve anyplace else other than at the very posterior or back margin

of the muscle. So I don't think he knew where it was. I think -- frankly I think the results of the procedure speaks for itself. I think the nerve was injured in the course of moving it, and...

Q. Let's talk a little bit about that then. Perhaps that will help with this first topic. I guess in fairness you said this. Topics 1 and 2 really do sort of collapse in on one another.

A. They're essentially the same thing, yes.

Q. So the first violation of standard of care and the second violation of the standard of care are really related to the same process in the surgery; is that fair?

A. Correct.

Q. And that process is one of finding the nerve, identifying it and protecting it from injury?

A. Yes.

Q. That's what 1 and 2 encompass, and that's what you say Dr. Flexon failed to do?

A. Right.

Q. You had an interesting word choice in your affidavit that I wanted to ask you about. I don't need to look it up. I remember it. You said the nerve was "diminished," which is an interesting word choice, and I assume was a deliberate word choice.

Let me ask you this: Can you tell me the precise form of mechanism of injury which this nerve suffered? For example, can you tell me if it was stretched? Can you tell me if it was stunned? Can you tell me if it was burned? Can you tell me if it was partially transected? Can you tell me if it was completely transected? Can you tell me if its blood supply was cut off? Of course that's compound, but can you tell me specifically what the mechanism of injury is in this case?

A. Let me back up and say I don't think the word "diminished" was actually my choice of words, but I didn't strongly disagree with it, so I didn't -- again, I don't recollect specific conversations about this, but obviously I didn't change it if it weren't mine to begin with. I think "diminished" can mean anything from a little bit to no function at all. So I think I didn't argue with that. Specifically can I say what happened? I think I could say more likely than not what happened, but I cannot say, based on the fact that Dr. Flexon didn't tell us all the instruments were used, every manipulation that he did and also didn't see the nerve anywhere other than the posterior border of the sternocleidomastoid muscle, specifically what

happened to it. But I think I can say more likely than not, just based on how we did the operation what it would have been.

Q. And what is that?

A. I think it would have been damaged with the cautery instrument or the harmonic scalpel that he was using.

Let me just say, I think stretch injuries are -- unless they're extremely violent, are not prone to give permanent injuries such as this. Blood supply, I am very doubtful, cutting off the blood supply would be harmful because it wasn't really along that kind of stretch of nerve, and Dr. Flexon didn't discuss or describe dissecting off the -- dissecting the nerve out and stripping its vascular supply. So I think, I would say more likely than not, it would be the cautery instrument, the cutting instrument that was utilized to go through the muscle.

Q. You said cautery, and you also said a harmonic scalpel. Are those two different things?

A. They are different, yes. The harmonic scalpel I think works more of a different kind of energy than heat.

Q. At what stages in the case did Dr. Flexon

use electrocautery?

A. I'm not certain he used it much at all. I think the harmonic scalpel, I think he referred to as being what he used the most. They might have used cautery to stop bleeding, raising flaps and so on, but I'm not certain.

Q. Forgive me because a moment ago you just told me that you could say to a reasonable degree of medical probability, which is to say more likely than not, that the damage was done either by cautery or harmonic scalpel; is that correct?

A. Yeah, I think that -- perhaps I misspoke. He was quite clear, I think, in stating that he used the harmonic scalpel to cut the CM muscle and didn't use cautery in that area.

Q. So does that change your opinion? Don't take my word for it. You change it if I'm wrong. Is your opinion then that you believe more likely than not, which is to say within a reasonable degree of medical probability, that was the use of the harmonic scalpel in this case that caused the injury to the nerve?

A. I think I would say that, because I don't think there were other instruments utilized, at least according to his description of the procedure

in the area that would cause that kind of damage, and that is dysfunction or diminished function, if you want to call it that, of the spinal accessory nerve.

Q. Can you -- I'm sorry. I didn't mean to cut you off. Go ahead.

A. And I don't think stretch injury or cutting off the blood supply would be reasonable assumptions with regard to that.

Q. What about a crushing injury of the nerve? Could this have been a crushing injury of the nerve?

A. It could be. It's a possibility. I think it's less likely. Usually crush means you would use a hemostat or a clamp to crush it. Again, I don't think that would represent very good technique. It's a possibility, but I don't think it's the most likely.

Q. Can you tell me, to within a reasonable degree of medical probability, specifically what type of injury you believe the harmonic scalpel did to the spinal accessory nerve in Mr. Chupp?

A. I think I can only say that whatever injury it was, it was enough to cause Mr. Chupp to experience symptoms of dysfunction of his trapezius muscle, fairly classic symptoms of denervation or

significantly diminished function of the trapezius. Also, findings on the EMGs that were done by Dr. Kholi, if I'm saying his name right.

Q. I think it's Kholi, but...

A. Kholi, I'm sorry. So it was something to the extent that it interfered with the conduction of electrical impulses down the nerve.

Q. But to be clear, you don't know if it rendered the nerve in two or if the nerve was still intact but simply lost the ability to transmit; is that correct?

A. Right. I think the bottom line is the same. The patient ends up in the same way. But whether it was actually transected or cut in two or heat energy or energy from the scalpel injured it to the extent that it didn't cut in two but couldn't function anymore I don't know.

Q. Can you state within a reasonable degree of medical probability if you believe the harmonic scalpel that was manipulated by Dr. Flexon actually came into direct contact with the spinal accessory nerve?

A. I couldn't rule that out certainly because he didn't really see the nerve, other than at the posterior edge of the SCM muscle, but I can only go

by what he said he did in the operation and how the patient ended up to know that something interfered with the function.

Q. I'm going to object to the responsiveness. Let me ask that question again if I may.

Can you state to within a reasonable degree of medical probability, which is to say can you say more likely than not, that Dr. Flexon's harmonic scalpel, in fact, actually came into physical contact with the spinal accessory nerve?

A. No. I don't think I can say that to a reasonable degree of medical certainty.

Q. If the harmonic scalpel did not come into direct contact with the spinal accessory nerve, by what mechanism do you believe the energy from the scalpel would have or could have caused injury to the spinal accessory nerve?

A. Well, I think that it can be -- without absolutely contacting it, my understanding is that it can contact -- I mean, come close enough, that there's still a little diffusion of energy. It doesn't go very far, but my understanding is it doesn't have to touch the structure absolutely. And I've said also that I keep in mind that there could be other potential causes of injury to the nerve. I

only know that the nerve was injured and...

Q. But all of the other potential causes that you point to, you have already said you cannot say more likely than not that they happen to be true?

A. I think those are less likely, yes.

Q. So the only cause you can say more likely than not you believe did happen is the use of the harmonic scalpel, true?

A. I think that is the most likely of the causes. So I think more likely than not it was that. Whether it was by specific actual contact with the nerve or coming very close to it, I can't say.

Q. Can you tell me at what stage in the procedure and at what firing of the harmonic scalpel you believe this injury occurred to the spinal accessory nerve?

A. No, I couldn't say that.

Q. Do you know the particular make and model of the harmonic scalpel that was employed by Dr. Flexon in this case?

A. I think he called it an ACI, but beyond that I'm not familiar with it.

Q. Do you use harmonic scalpels in your own performance of head and neck insuring?

A. No, I don't.
Q. Have you ever used a harmonic scalpel in the course of your career?
A. I don't think I have.
Q. Have you ever done any research or published any papers on harmonic scalpels and their potential for injury intraoperatively?
A. I've read certainly the fliers. I've been shown the instruments. I happen to like what I use. I'm happy with the way I do it, so I haven't chosen to make a change. But beyond that, in terms of -- I've read about the instrument, and certainly companies who sell them have sent me literature on them and asked me to use them. But beyond that, I haven't --
Q. If you had been performing this surgery or a surgery similar to this surgery, what device would you have used for the primary excision and separation of the muscle nerve fibers?
A. I ordinarily do it -- we utilize this a lot in various neck dissections. I ordinarily do it by putting a hemostat -- just a clamp over the nerve and lifting anything above it that I want to cut, and I tend to use a cautery.
Q. Can you tell me where along the course of

the spinal accessory nerve you believe more likely than not this injury occurred?
A. Well, my understanding is that both the sternocleidomastoid muscle and the trapezius muscle were denervated. I looked at that quite a bit. Not everybody talked about the SCM muscle. But I think -- it seemed to me the nerve conduction studies seemed to indicate that both those muscles were not functioning. And so it would be on the upside or proximal side or cephalic side of the nerve.
Q. At some point proximal to where it could be visualized leaving the posterior margin of the spinal accessory nerve?
A. Yes.
Q. I'm sorry. Of the sternocleidomastoid muscle?
A. Yes.
Q. Now, you know that Dr. Flexon stimulated the spinal accessory nerve intraoperatively at or about the point where it passed the posterior margin of the sternocleidomastoid, correct?
A. Yes.
Q. And you know that as of the end of the year when he did that stimulation, that he did see a shrug before closing, correct?

A. Yes.
Q. And I assume your point or position on that would be that to the extent the lesion or injury was more proximal, a distal stimulation doesn't tell you anything about what the condition of the nerve may have been proximal to the point of stimulation.
A. At that point, that's correct, yes.
Q. The portion of the spinal accessory nerve which you believe was injured intraoperatively, do you believe it was a portion that was either inside the sternocleidomastoid or deep to the sternocleidomastoid, depending upon what its pathway was?
A. I think more likely than not, yes.
Q. I think we established earlier, you don't know one way or the other whether this particular spinal accessory nerve in Mr. Chupp either runs through the sternocleidomastoid or deep to it, true?
A. I'd have to look through the records again. I think at most only the -- the nerve only went through the posterior part of the muscle. So anterior to that or in front of that, it apparently was deep to the muscle.
Q. Is it possible that Dr. Flexon -- strike that. Let me ask it a different way.

I asked you a little earlier about Dr. Flexon's description of how he was able to maintain the continuity of a partial thickness of the back wall of the sternocleidomastoid. You recall that discussion?
A. Yes.
Q. Is it possible in your view that the spinal accessory nerve could have passed through the posterior -- strike that -- the back wall of the spinal accessory? Strike that. I'm a little tired.
Is it possible that the spinal accessory nerve could have passed through the back wall of the sternocleidomastoid muscle at a depth that Dr. Flexon never actually reached it visually, but it was close enough to it that when the harmonic scalpel was being used that it could pass through those muscle fibers and cause injury to the spinal accessory nerve?
MR. RICHARDSON: I'll object to form. You can answer.
A. I just want to understand. You're talking about now -- we're assuming that the nerve is medial to or deep to on the inside of the muscle?
Q. Yes, sir. I guess what I'm saying is that we know that Dr. Flexon carved out a portion of the

sternocleidomastoid, but the back wall was left intact.

My question is, is it possible that the spinal accessory nerve could have passed through that thinned-out back wall, that that's where it engaged the muscle, would still, therefore, not be visualized by Dr. Flexon as he got as deep as he did, but he could still injure it with a scalpel unwittingly because of the thinness of the wall that was left between it and the nerve? Does that question make sense?

A. I think it does. And I'll say yes, I think that's possible. And that's really where my criticism is. You shouldn't cut anything in this location without having the nerve in direct view. So I think your question is assuming that he doesn't see it and he's just cutting somewhere and he happens to get the nerve. I think the important part of this procedure is that you see the nerve at all times and anything that you cut or get close to is not the nerve. That's my point.

Q. Not to beat a dead horse, but to circle back to a question I asked you earlier then. Are you saying that the standard of care would require in a patient like Mr. Chupp with a large, thick,

sternocleidomastoid muscle, that in every instance in a surgery like that, you would have to cut entirely through that muscle to make sure you visualize the nerve?

A. No, not in every instance. I think you have to go as far as where you have to go in any particular person to see the nerve. If the nerve goes straight halfway through in terms of the depth of the muscle, then you only have to go halfway through. If it goes all the way through, then you either have to go all the way through and see it -- as I said, you can put it back together -- or if it's thin enough, you can lift it up and look under it.

Q. Maybe I'm dense, and I apologize.

A. You're not.

Q. Let me try to get at this a different way.

So are you telling me that if a surgeon like Dr. Flexon approaches a case like this and he is able to slowly and carefully dissect the muscle fibers down around this lesion as he goes, going through careful slow planes with careful slow dissections, and at no layer or level does he encounter the spinal accessory nerve as he progresses and he gets even to the point where he

has gotten beneath the lesion and he's able to fully excise the lesion and he still has not encountered the spinal accessory nerve at any point, are you saying that the standard of care requires him to keep excising below that level until he finds the spinal accessory nerve?

A. No. But I think your question is assuming something that probably isn't true, and that is that he didn't encounter the spinal accessory nerve. I think if you can be absolutely sure that you are not encountering it, then it probably is a reasonable way to do the operation. But I don't think that was accomplished in this case. So I think the nerve was encountered. I think he just didn't recognize it.

Q. But the only way in which you are able to have that opinion, I assume, is because you know the outcome, by which I mean you know the end state condition in which Mr. Chupp found himself, true?

A. No. I mean, I think that -- in this particular type of surgery and in many types of surgeries that otolaryngologists do, carotid surgery with the facial nerve, thyroid surgery with the recurrent laryngeal nerve, you have to see the nerve at all times when you're removing tissue. You have to start in a place where you can see it, find it

without injuring things and follow it through there through places where you can't see it by exposing and removing things so that you can see it. So you have to have it in view at all times. I think that's really the key to any kind of nerve preservation in surgery in the head and neck. If you don't do that, then injuries come about.

Q. What specifically -- well, strike that. Let's do this two ways. Let's assume for purposes of this question that somehow you as the operating surgeon on a case like Mr. Chupp's could simply know that the spinal accessory nerve was deep to the sternocleidomastoid. If you could just know that going into the case.

A. Mm-hmm.

Q. How would you approach Mr. Chupp's case so as to protect the nerve?

A. Well, I mean, if I had some -- I don't think it's feasible, but if I had some God-given guarantee that the nerve was nowhere near where I was working, then I suppose I wouldn't have to worry about it. I could just carve out the mass, but I wish it were that way.

Q. Let's ask the question a second way. Let's assume that you knew -- again, with certainty --

that the spinal accessory nerve passed through the sternocleidomastoid muscle in this patient like Mr. Chupp. And you even have some sense at what level or depth that passage takes place. What steps would you as the operating surgeon have to take consistent with the standard of care to protect that nerve?

A. I think one has to start usually at the posterior or back edge of the muscle where you can see the nerve, and then you -- again, the way -- there may be other techniques that people use that are different than mine, but the one I do and the one I've seen most people do is slide a hemostat over the nerve and spread it so that you can see the nerve underneath where you are and then cut everything above it knowing that your instruments aren't touching the nerve or damaging it.

Q. And this is a nerve in the body of the sternocleidomastoid muscle that you're talking about?

A. Yes. You know, in neck dissections, at least my experience, is that that's what it is most of the time.

Q. You and I had a conversation earlier about the general course of the spinal accessory nerve and

we agreed that its movement generally from the skull is that it moves to a more anterior and inferior position as it leaves the skull -- I'm sorry -- a more posterior and more inferior position as it leaves the skull, correct?

A. Yes.

Q. I know you have not seen the drawing that was attached to Dr. Flexon's deposition, but I'd like you to assume that in that drawing there is a substantial distance along the sternocleidomastoid from interior to superior between where the mass is drawn and where the spinal accessory nerve is visible at the posterior margin of the sternocleidomastoid.

A. At the posterior margin?

Q. At the posterior margin. Where it's visible at the posterior margin. In your experience, at the point at which the spinal accessory nerve becomes visible at the posterior margin of the sternocleidomastoid, isn't it true that the spinal accessory nerve's course through the sternocleidomastoid is generally more superior to that point?

A. Yes. In other words, it's directed upward from that point, and it tends to kind of flatten out

or plateau out as it goes more posteriorly, yes.

Q. That being the case, when a surgeon feels that he's operating on a mass that is measurably inferior or lower along the sternocleidomastoid, does that surgeon have a reasonable expectation that the spinal accessory nerve's pathway is above or beyond the surgical field?

A. Well, I think, you know, generally that could be an expectation, but I don't think anything can replace actual visualization of the nerve. I don't think that one can make assumptions.

Q. Bear with me a moment, if you would. Did you see any signs of nerve tissue being present on the pathology specimen?

A. No.

Q. If Dr. Flexon had actually cut or taken away a piece of the spinal accessory nerve during the surgery, would you have expected the pathology department to have identified that?

A. Well, if a section were taken out of the nerve and it was attached to the specimen and sent with the specimen, I would expect the pathology department to mention that. The nerve is a good size nerve, about the size of that rubber band there, the smaller rubber band.

Q. About the size of a thin piece of spaghetti?

A. Yes, about that size.

Q. About that color too?

A. Maybe a little whiter, but similar.

Q. The color of spaghetti.

A. Oh, yes, the color of spaghetti, yes.

MR. RAY: Off the record.

(Discussion held off the record.)

Q. Have we fully explored the first and second violations of the standard of care which you attribute to Dr. Flexon in this case?

A. I think we have, yes.

Q. Let's turn our attention then to the third violation of the standard of care which you attribute to Dr. Flexon. And I know I wrote it down somewhere. Hold on.

A. Needle aspiration.

Q. So the third violation of the standard of care that you attribute to Dr. Flexon in this case is failure to perform a fine needle aspiration on the mass, I guess, before proceeding with his surgery; is that correct?

A. Yes.

Q. All right. Let's talk a little bit about

FNAs and FNA technique and that sort of thing. First off, would you agree with me that an FNA involves sticking a hypodermic needle into a mass drawing off a comparatively small quantity of cells and making those available for a smear cytology type examination?

A. Yes.

Q. Would you agree with me that FNAs in all masses of all types carry with them known rates of false negative results?

A. Yes.

Q. Would you agree with me that FNAs as applied to sarcomas -- strike that.

Do you happen to know what the false negative error rate is for FNA testing in sarcomas?

A. I don't think I could give you a percent. I don't know the answer to that.

Q. Would you know if FNA sensitivity is lesser in sarcomas than other lesions?

A. Well, I don't know it as a fact, but I would assume that it is, because the more solid a tumor, the harder it is to draw cells out. So the more liquid a tumor is, the more cells one can usually get. But there's no question with any needle aspiration there is a rate of false

negativity.

Q. You believe Dr. Flexon should have done an FNA as an intermediate step in this case; is that correct?

A. As a preoperative step, yes.

Q. All right. Is that an FNA that you would have expected him to perform himself?

A. Well, I do them myself unless I can't palpate a mass, in which case I ask a radiologist to do it. But radiologists do it or surgeons do it.

Q. Is this an FNA that you would envision being transdermal or an FNA in which you would envision a surgical excision being made and then the cells taken off?

A. No. One could do this right in the office setting, put a little xylocaine or Novocain in. Apparently this was a very easily and palpable and visible mass. So I think it would be very easy to get a needle into it.

Q. Would you agree with me that neither you nor I have any way of knowing for certain what the pathological interpretation of that FNA biopsy would have been had one been done?

A. Correct. I mean, I think you would have had to do it to see for certain what it was going to

be, but that's correct.

Q. Can you and I agree that one of the working suspicions that Dr. Flexon had when he first met with Mr. Chupp and assessed this mass was the possibility that it was a sarcoma?

A. Yes.

Q. I think in fairness we could also agree that it was probably fairly low in Dr. Flexon's differential based on his dictation at the time?

A. Yes.

Q. Is that also true?

A. Yes. But it was even mentioned in the differential diagnosis by the radiologist who did the CT scan of the neck.

Q. Would you agree with me that even if something has a low index of suspicion in the differential, if it is something as potentially life-threatening as sarcoma, that it is still entitled to serious consideration and work?

A. Yes.

Q. In this case, we know that the mass eventually turned out to be a hemangioma, correct?

A. Yes.

Q. Do you have an opinion, to a reasonable degree of medical probability, as to if an FNA had

been done as to what you think the pathological findings would have been?

A. Yes.

Q. And what is that?

A. I think they would have found blood primarily in this. But -- well, yes, they would have found blood.

Q. Would you agree with me that an FNA finding of blood would not completely rule out the possibility of sarcoma or other tumor cells still being present in the balance of the body of that mass?

A. I think that -- I think it would -- if the needle aspiration were done properly, I think on one pass or I think on one section, I think it would be fair to say that it would not one hundred percent or completely rule out the presence of a more ominous problem.

Q. That being the case, if Dr. Flexon had performed an FNA as an intermediate step and those FNA results had come back, as you suggest, perhaps with principally being blood cells, it would still be within his professional judgment as a surgeon at that point to recommend additional surgical exploration of the mass; would it not?

A. That would be within his judgment, yes.
Q. And it would not be a violation of the standard of care for him to offer that as a treatment option to the patient, true?
A. Correct. No, I don't think at any time it would have been a violation of a standard of care to offer it as an option.
Without going beyond your question, I think the reason I'm stating that this is a violation of a standard of care is I think it is what a reasonably trained physician in these circumstances would have done as a first test.
Q. Can you and I agree that even if it is a violation of the standard of care in your view for the FNA not to have been done, that if it was still Dr. Flexon's recommendation that the surgery go forward and Mr. Chupp were still willing to go forward with the surgery, then would you agree that the failure to do the FNA, in fact, caused no harm to Mr. Chupp?
A. If the results came back as blood, you mean, or indeterminate?
Q. Yes, sir.
MR. RICHARDSON: I'll object to the form, but you can answer.

A. I'm just trying to think how to answer that. I think that a reasonable approach, if that had been done, and if that had been the case, would have been to repeat it. I think if it had been done on a second occasion and it was benign, I think you could say to a reasonable degree of medical certainty that you were dealing with benign disease. In fact, the original diagnosis of the radiologist who read the CT scan was that it was bleeding into the muscle or hemangioma.
Q. Let's --
A. I'm sorry to be carrying on, but I think in that situation one sits down with a patient, tells him percentages and pros and cons of what you're dealing with, and you let the patient by informed consent make a decision with you.
Q. Well, let me ask it this way then: Would you agree with me that although you -- strike that.
Let's assume just hypothetically that on some date between when Dr. Flexon first met Mr. Chupp and the day on which he performed the surgery the two of them got together and had an FNA done on some intervening date. Let's just assume hypothetically that that happened.
A. All right.

Q. And let's further assume that after that FNA it came back with an inconclusive negative or non-frightening finding. Let's even assume there was a second pass with the same result. And even after both of those it was still Dr. Flexon's recommendation that Mr. Chupp proceed with the surgery and Mr. Chupp were willing to proceed with the surgery.
Assuming all of that to be true, would you agree with me that in that hypothetical scenario, whether the FNA happened or didn't happen, did not cause any harm to Mr. Chupp?
A. The end point would be the same, I think, that he would have gone through with the surgery.
Q. And I understand that you're saying it's possible that the FNA would have resulted in new data that might have led to new decision-making between the provider and the patient, correct?
A. I'll go farther than say "possible." I think it's probable, but with that small change.
Q. But just to be clear here, you think you can have an opinion more likely than not as to what the surgeon's recommendation would have been and what the patient's decision-making process would have been?

A. Well, I think -- and I'm putting myself in Dr. Flexon's shoes here -- I think given the fact this mass had been present for a year and a half, granted it did increase in size, given the findings on CT scan, given the diagnosis of the radiologist who read the CT scan as favoring blood, given the rarity of sarcomas, and given a discussion of potential complications of this surgery, I think it's very reasonable that a patient would have said, "Let's wait a few weeks and see what happens with this. Is there some other way to treat it?"
Q. You would agree with me, though, in fairness, because you're dealing with the mental process of a human being who isn't you, anything you offer about what you think they might do is somewhat speculative on your part, true?
A. I think that's always the case. But just to finish that, I've dealt with thousands and thousands of patients in my career, and I think I've learned something in that time about how people think, and I don't think it's unreasonable that he would have said "Let's wait," with an understanding of what the situation was.
Q. Again, you would agree with me, though, that surgical excision of a, say, roughly two-inch

by two-and-somewhat-inch painful hemangioma in a large muscle of the neck is not an unreasonable treatment recommendation, true?

A. No. Another fact was that he was told he had cancer. Maybe they changed it to say 50/50 chance you have cancer, he's sent to a cancer center to talk to a surgeon to get surgery, I think very few people in that situation are going to refuse to have something done. I mean, I think if you think you have cancer, then obviously you're not going to let it sit there. Frankly, I think the chance that he had cancer based on all of the history, physical findings and if a needle aspiration had been done, the radiographic studies, I think it was much less than 50/50 chance that he had cancer.

Q. We'll move on from this subject in just a minute. Let me ask one capstone question if I may. I think you answered this implicitly.

Would you agree with me that it's entirely possible, even if the FNA testing had been done, that the surgery may have proceeded and the outcome still have been the same?

A. I think it's possible, yes.

Q. Have we fully and fairly explored this third violation of the standard of care which you

attribute to Dr. Flexon in this case which you captioned as failure to perform an FNA, fine needle aspiration, biopsy?

A. Yes, sir, I think we have.

Q. Dr. Bogdasarian, would you agree with me that Mr. Chupp suffers from a large number of serious neck and right shoulder problems which are completely unrelated to the claimed injury to the spinal accessory nerve on July 26 of 2010?

A. Well, I know that he had had apparently a fracture of his neck from an accident when he was a teenager. He'd had surgery. I think Ms. Gray indicates that at times he would twist his neck or stretch it. So I think he had some discomfort there. He had a fracture of his right scapula, I think, in an altercation. I don't know that that had been a problem, but I think he did have certainly some injuries before that may have caused him some difficulties.

Q. You've mentioned some. Let's run through a few of them in detail, if we could. You would agree he had a neck fracture in the 1980s which led to a fusion at C4-5?

A. Yes.

Q. Were you aware that as of January 10, 2007,

about three years before the events in this case, he was also found to have spondylosis at C5-6 and C6-7?

A. I believe so, yes.

Q. Were you aware that in October of 2009 -- strike that. Were you ever provided with any of Mr. Chupp's medical records from the Gwinnett Medical Center? I did not see them in your file.

A. I think they were referred to, but I did not see them.

Q. I'd like you to assume then in October of 2009 he had a presentation to the emergency department at that facility, which is an Atlanta area hospital, and told them that he had chronic pain in both shoulders at that time. Keep that fact in mind if you would. You were aware that he had a fracture of his right scapula in 1996?

A. Yes.

Q. And you were aware that he had -- well, strike that.

Let me come at it this way: Were you aware or are you of the opinion -- well, strike that.

You have not seen any of Dr. Flexon's post-operative office visits with the patient, have you?

A. No. I've only seen them referenced in the various depositions.

Q. Okay. Do you have an opinion as to whether the scope of the pain and the weakness and the limitations which Mr. Chupp presented with to Dr. Flexon in some of the post-operative visits represented dysfunction or incapacity that was broader than what one would expect from loss of trapezius and sternocleidomastoid function?

A. Because of his previous problems?

Q. Yes, sir.

A. I'm going to plead that I don't know the answer to that. I probably am going to need him to testify to that. I'm sorry.

Q. Okay. Have you ever seen the MRI findings of October 24, 2010 where Mr. Chupp was found to have a partial thickness tear of the supraspinatus tendon?

A. I saw that report, yes.

Q. Can you and I agree that the partial thickness tear to the supraspinatus tendon is in no way related to the surgery that Dr. Flexon performed?

A. I would agree.

Q. Did you see an assessment that was made by

Dr. Tobin on October 29 of 2010 where he detected atrophy of Mr. Chupp's supraspinatus and infraspinatus muscle?

A. Yes.

Q. Would you agree with me that any denervation or atrophy of the supraspinatus and infraspinatus are not in any way related to Dr. Flexon's surgery?

A. I looked at that, and I -- the spinal accessory, as far as I know, has nothing to do with those muscles. So I don't know how I could explain that unless it was some disuse atrophy just from not using them because of discomfort. To that extent it could be related, I suppose, but I don't know of any other way.

Q. Let me phrase it this way: You cannot say more likely than not that the infraspinatus or supraspinatus atrophy was related to Dr. Flexon's surgery, true?

A. That's true.

Q. Dr. Tobin believed in his note that this was actually related to a suprascapular nerve injury. Are you familiar with the function and pathway of the suprascapular nerve?

A. I've looked it up before, because it's come

up before in other reviews that I've done, but beyond looking it up, I don't have any personal experience with it.

Q. Well, if I told you I looked it up and here's what I found: If I told you that the innervation of the supraspinatus and the infraspinatus arises through the suprascapular nerve through the upper trunk of the brachial plexus deriving from C5 and C6, does that sound reasonable to you?

A. Yes, I think that's correct.

Q. Any lack of nerve function along that pathway would not be in any way related to Dr. Flexon's surgery, true?

A. That's true. The spinal accessory nerve is called that because there's the accessory branch that comes from the brain and then the spinal parts that come I think through C2, 3 and 4, if I have that correct, but I don't think that there was any sign of injury to those, as far as I know, to those branches.

Q. In fact, just so we're clear, you believe the injury site -- the only injury site that's related to Dr. Flexon's care is you believe there was a harmonic scalpel injury to the spinal

accessory nerve proximate to or in the sternocleidomastoid, correct?

A. Yes.

Q. And these other neural pathways and muscles that I've mentioned do not relate to that anatomy?

A. Correct.

Q. Did you see the MRI finding of the November 28, 2010 visit to Memorial where the radiologists found severe diffuse fatty atrophy of the entirety of the right teres minor and infraspinatus consistent with chronic denervation?

A. I believe I did see that as well, yes.

Q. All of these muscles I mentioned, the infraspinatus, the supraspinatus, the teres minor, these are part of the rotator cuff, are they not?

A. I think so.

Q. Injury in those muscles and the rotator cuff would not bear any relationship to the surgery of Dr. Flexon, correct?

A. Correct.

Q. Do you know if Mr. Chupp had ever had a rotator cuff injury on the opposite side?

A. I believe he did.

Q. Do you know if rotator cuff injuries of this type are common in weight lifters?

A. I'm not an orthopedist. So I could not say how common they are. I do believe they happen, though.

Q. In light of all of these other limitations on Mr. Chupp's ability to make use of his right arm and shoulder, wouldn't you agree with me that it's entirely possible that a significant portion of the functional limitations and the pain from which he suffers are attributable to these conditions other than the surgery?

A. I don't think so, because he -- I think he had all of those things prior to -- I know they weren't all documented by MRI, but I believe he had those conditions and injuries well prior to the surgery by Dr. Flexon, and I think he's testified that his symptoms got a lot worse and it was witnessed by Ms. Gray as well. I know that -- well, I'll leave it at that.

Q. If I were to tell you that the Social Security Administration had made a determination that Mr. Chupp --

A. That's why I left it at that.

Q. -- was already completely disabled two weeks before the surgery, I assume you would have no basis to disagree with their determination?

A. Correct. And that was something I was going to mention, but I think up until then he had been working, so...

Q. You believe he was still working up until 2009 -- I'm sorry -- 2010?

A. No, I think he stopped around 2008, 2009, something like that.

Q. Do you know if it was any of these physical limitations that he was suffering in the neck and right arm and shoulder that pre-existed the surgery of July 26, 2010 that had led to his stopping work?

A. I can't remember specifically if there was something there that caused it. I'm sorry, I'm just not recollecting, but I do agree I think he stopped working around 2008 or so.

MR. RAY: Matt, are you going to offer Dr. Bogdasarian on issues of damages, long-term prognosis? It would seem to be out of his area of expertise, but I just want to find out before I --

MR. RICHARDSON: I don't believe so at this time. I'd have to...

MR. RAY: Let me ask a few questions, if I may.

Q. You do not routinely, in the course of your practice, treat patients who have suffered a spinal

accessory nerve injury for that injury, correct?

A. That's correct. I mean, I might refer them to an appropriate place.

Q. So someone like a neurologist or a neurosurgeon or an orthopedist might be a person in a better discipline to talk about issues of what the future might hold for Mr. Chupp; is that fair?

A. Well, I mean, I followed many patients with spinal accessory nerve injuries and watched their courses because, again, we used to remove a lot of those nerves with radical neck dissections, but in terms of appropriate treatments and remedies and perhaps specific disabilities, I would defer to those specialists.

Q. At present would I be correct in assuming that the expert testimony that you would envision yourself coming to Toombs County, Lyons and Vidalia, Georgia, to testify about would be those violations of the standard of care that we have already talked about concerning Dr. Flexon; is that correct?

A. That's correct. And I will say that there were certain problems that Ms. Gray, for instance, observed and Mr. Chupp's, you know, inability to reach -- you know, lift a bag of flour above his head and that sort of thing, I guess as an

otolaryngologist, from an otolaryngologist's perspective, I would agree that those are certainly things that can happen with spinal accessory nerve injuries, but to get more specific than that, probably I wouldn't.

Q. This is an appallingly obvious question, but I need to ask it anyway.

What is the evidence that you rely on in this case to support the conclusion that Mr. Chupp, in fact, did suffer a spinal accessory nerve injury? What is it about his current condition? What evidence do you rely on to support that conclusion?

A. Gee, after you preface that, I think I'm going to be the person who misses the question who's buried in Grant's Tomb.

I think that I would rely on the medical records, which includes certainly the EMG studies, the findings of the numerous physicians, the emergency department physicians and orthopedists, neurologists who followed him afterwards and on deposition testimony.

Q. Specifically with regard to the EMG testing that was done by Dr. Kholi in this case, are you an expert in reading and interpreting that EMG report data?

A. No. I would have to rely on the conclusions of Dr. Kholi.

Q. So you would defer to a neurologist in the interpretation of that data?

A. If I were asked to read that study with someone else interpreting it, yes.

Q. Have we fully and fairly explored all of the criticisms and violations of the standard of care which you intend to attribute to Dr. Flexon and testify to at the trial of this case?

A. Yes, I believe we have.

Q. So it would be an accurate statement then for me to say that in all other aspects of his care, evaluation and treatment of Mr. Chupp, you would agree that Dr. Flexon met the standard of care?

A. I guess that's the converse of what you asked me.

Q. It is.

A. I think that would be -- yes, I think that would be fair to say.

Q. Doctor, would you agree with me that two prudent well-trained physicians in the same discipline could have a good faith difference of opinion as to what the standard of care may require in a given case?

A. Yes.
Q. I assume you would not contend that a colleague who disagrees with you on a matter of professional judgment is necessarily wrong simply because they disagree with you?
A. Correct.
Q. You may, in fact, think they're mistaken on a principle reason.
A. I understand, yes.
Q. I assume that you're not suggesting that Dr. Flexon is a poor physician and surgeon in general, true?
A. No, not at all.
Q. You're not suggesting and won't tell the ladies and gentlemen of this jury that he was inadequately or improperly trained, true?
A. No. He trained at a very good place.
Q. And you won't tell the jury that he shouldn't be practicing medicine, correct?
A. Correct.
Q. You just believe in the context of this particular case that he made an error?
A. Correct.
Q. Have you ever had a patient come into your office and make a surreptitious audio recording of

that patient's office visit with you?
A. I'll say not to my knowledge. I've never -- if it's been done, I've not ever had that happen.
Q. You saw the testimony about that in the deposition?
A. I did.
Q. Did that strike you as at all odd?
A. Yes. I think -- I mean, as I look at this as a completely objective observer, I would say if I was the doctor, I would want to know. Patients often come in with someone else who takes notes about what you say, and I think it's just so they can remember and understand and perhaps look things up. I think that's what was contended here, but I think it's different.
Q. You would agree with me that having a tape recorder hidden in a foldover magazine is not quite the same thing as having a note taker with you, true?
A. That's true, I think.
Q. As a physician if that were to happen to you, how would you feel about it?
A. Well, I'm sure I wouldn't like it. I think it would say something about my relationship with the patient, I think. Hopefully I would not say

anything that would bother me, but on the other hand, I would prefer -- I would agree that if someone were doing that, that he tells me. I wouldn't object to it if someone wants to record what I said, but it would be nice to know.
Q. Have you ever been supplied with a copy of the audio recording from that encounter between Ms. Gray, Mr. Chupp and Dr. Flexon?
A. No. I only learned of it within the last 24 hours when I read these depositions. Obviously I'm curious about it, but I have not gotten a copy.
Q. Have you ever been to Lyons, Georgia or Vidalia, Georgia?
A. No.
Q. Do you know where those cities are located?
A. No. I've been to Georgia to other parts, but not to those particular areas.
Q. Have you ever been to Savannah, Georgia where the care in this particular case was rendered?
A. No.
Q. Do you know Dr. Phillip Flexon or have you ever heard of him?
A. No, I don't think so.
Q. It's possible you and he may attend the same meetings, I assume?

A. It's possible.
Q. National meetings?
A. Yes, it's possible.
Q. But he's not someone you've ever come across, correct?
A. Correct.
Q. In reviewing the medical records and the depositions, you have likely seen the names of other doctors and providers who were involved in the patient's care. Did you recognize any of those other healthcare providers?
A. No, I don't know any of them.
Q. As you sit here right now, do you intend to do any additional specific work in connection with this case prior to trial?
A. No, I don't have any intent. It probably would be nice if I got the records of Dr. Flexon, just to look at them. They were so referred to in the depositions that I would be very doubtful they're going to change anything, but for completeness' sake, I think it would be nice to have those.
Q. I recognize this is difficult to predict as you're sitting here right now, but do you anticipate forming any new opinions concerning Dr. Flexon's

care in connection with this case?
A. I don't anticipate that.
Q. Would you agree with me that fairness would dictate that if you review new or different materials, or if you develop any new or different opinions that arise from those materials that are different from what you told me here today that you would alert Mr. Cohen and Mr. Richardson to that fact and perhaps afford me an opportunity to come back and ask some follow-up questions?
A. Yes.
MR. RAY: Let's take a short break. I'm probably finished. I just want to look through my notes.
THE WITNESS: Sure.
(Discussion held off the record.)
Q. Dr. Bogdasarian mentioned he had something he wanted to add. So go ahead, sir.
A. Just that you had mentioned in the beginning that you wanted copies of all the depositions that I could find amongst my records. I'm willing to do that, but...
Q. Yes, sir. All the depositions which you have given. Obviously I don't want other depositions in your possession, but any deposition

transcripts that you have that you've given. I'll be happy to pay for the copying costs.
A. I understand that. I'm just -- you've obviously been very thorough. You've gone through pretty much everything that's going to be said in those. I'm happy to do it, but I'm just trying to save you some money.
Q. I appreciate it, but if you don't mind, I would like to get it.
A. All right. I'd be happy to do it.
Q. You do have my contact information?
A. I do.
Q. Dr. Bogdasarian, have you understood all my questions as I put them to you today? And on those occasions where I was not clear, did you give me an opportunity to clarify?
A. Unless you've confused me to the point that I don't know I'm confused, then I have understood them.
Q. Have we fully and fairly explored all of your opinions in this case?
A. Yes.
Q. Have I treated you professionally and courteously in your deposition today?
A. You have, yes.

MR. RAY: All right. I believe that's all I have, sir. Thank you for your time.
MR. RICHARDSON: No questions.
(Discussion held off the record.)
MR. RAY: We had said on the record earlier that Exhibit 5, a copy of the disk would be printed. I think it would be easier if we just ask for the CD to be copied, and we'll have a copy of the CD attached to the exhibits and I guess the original should go back to Dr. Bogdasarian.
(5:52 p.m.)

CERTIFICATE OF COURT REPORTER

I, Kathleen Mullen Silva, Registered Professional Reporter, do certify that the deposition of JOHN BOGDASARIAN, M.D., in the matter of James Chupp v. Phillip Flexon, M.D., on February 7, 2014, was stenographically recorded by me; that the witness provided satisfactory evidence of identification, as prescribed by Executive Order 455 (03-13) issued by the Governor of the Commonwealth of Massachusetts, before being sworn by me, a Notary Public in and for the Commonwealth of Massachusetts; that the transcript produced by me is a true and accurate record of the proceedings to the best of my ability; that I am neither counsel for, related to, nor employed by any of the parties to the above action; and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action. Transcript review was requested of the reporter.

February 18, 2014
Kathleen Mullen Silva, RPR, CRR

TO: Matthew Richardson
Re: Signature of Deponent John Bogdasarian, M.D.
Date Errata due back at our offices: 03/20/2014

Greetings:
The deponent has reserved the right to read and sign. Please have the deponent review the attached PDF transcript, noting any changes or corrections on the attached PDF Errata. The deponent may fill out the Errata electronically or print and fill out manually.

Once the Errata is signed by the deponent and notarized, please mail it to the offices of Tiffany Alley (below).

When the signed Errata is returned to us, we will seal and forward to the taking attorney to file with the original transcript. We will also send copies of the Errata to all ordering parties.

If the signed Errata is not returned within the time above, the original transcript may be filed with the court without the signature of the deponent.

Please send completed Errata to:
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3348 Peachtree Rd NE, Tower 200, Ste 700
Atlanta, GA 30326
(770) 343-9696

ERRATA

I, the undersigned, do hereby certify that I have read the transcript of my testimony, and that

___ There are no changes noted.
___ The following changes are noted:

Pursuant to Rule 30(7)(e) of the Federal Rules of Civil Procedure and/or OCGA 9-11-30(e), any changes in form or substance which you desire to make to your testimony shall be entered upon the deposition with a statement of the reasons given for making them. To assist you in making any such corrections, please use the form below. If additional pages are necessary, please furnish same and attach.

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DEPONENT'S SIGNATURE

Sworn to and subscribed before me this ___ day of _____, _____.

_____
NOTARY PUBLIC
My Commission Expires:_____