

**In The Matter Of:**  
*Carey vs.*  
*Aspirus Ontonagon Hospital, Inc., et al.*

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*Ira Mehlman, M.D.*  
*June 18, 2015*

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1 STATE OF MICHIGAN  
 2 IN THE CIRCUIT COURT FOR THE COUNTY OF ONTONAGON  
 3 BRENDA CAREY, -----X  
 4 Plaintiff,  
 5 -against-  
 6 ASPIRUS ONTONAGON HOSPITAL, INC.,  
 7 DEPLOYABLE EMERGENCY SERVICES,  
 8 L.L.C., RICHARD CHALTRY, D.O., MAURA  
 9 MANNING, M.D., BRAD GOLDMAN, M.D.,  
 10 DOUGLAS SEGAN, M.D., and  
 11 JOHN AUSTIN, M.D.,  
 12 Defendants.  
 13 Case No.: 13-000079-NH  
 14 -----X  
 15  
 16 126 East 56th Street  
 17 New York, New York  
 18  
 19 June 18, 2015  
 20 10:15 a.m.  
 21  
 22 VIDEOCONFERENCE DEPOSITION of  
 23 IRA MEHLMAN, M.D., taken pursuant to Notice,  
 24 before ALEXIS PEREZ JENIO, a Professional  
 25 Shorthand Reporter and Notary Public of the  
 State of New York.

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 2  
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 22  
 23  
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 25

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1 (Curriculum Vitae of Ira Mehlman, M.D.,  
2 was marked Exhibit 1 for identification.)  
3 (Affidavit of Merit was marked Exhibit  
4 2 for identification.)  
5 (Deposition of Brad S. Goldman, M.D.,  
6 was marked Exhibit 3 for identification.)  
7 (Deposition of Richard Chaltry, M.D.,  
8 was marked Exhibit 4 for identification.)  
9 (Deposition of Maura M. Manning, M.D.,  
10 was marked Exhibit 5 for identification.)  
11 (Deposition of Douglas Segan, M.D., was  
12 marked Exhibit 6 for identification.)  
13 (Deposition of John Austin, M.D., was  
14 marked Exhibit 7 for identification.)  
15 (Deposition of Brenda Carey was marked  
16 Exhibit 8 for identification.)  
17 (Notice of Intent was marked Exhibit 9  
18 for identification.)  
19 (Aspirus Ontanagon Family Practice  
20 Clinic records was marked Exhibit 10 for  
21 identification.)  
22 (Marquette General Health System  
23 records for admission date 10/29/2011 was  
24 marked Exhibit 11 for identification.)  
25

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1 was on workman's comp -- I was still on the  
2 staff, but I was on workman's comp for about 18,  
3 20 months. And then I -- when I came off of it,  
4 I was about to go back to work. I had a contract  
5 to start working with Urgent Care Emergency  
6 Medicine Group in New York City, and just as I  
7 was about -- I was on the schedule, I was about  
8 to begin working, a taxi ran over my foot, a  
9 yellow cab in Manhattan. So that was another  
10 14 months of recovery. I was in one of these cam  
11 walker boots for six months, and I was trying  
12 to -- I've had a number of surgeries in the past,  
13 and I was running out of lives, so I was trying  
14 not to have surgery. So that's about 90 percent  
15 improved, and I'm about to start working again.  
16 Clinically, I've been in conversation  
17 with Cornell New York Hospital about a teaching  
18 position, possibly, and I've got some offers. So  
19 probably in the next two to three months I'm  
20 going to begin one of them.  
21 MR. LaPARL: Doctor, you said, "2010."  
22 Did you mean to say --  
23 THE WITNESS: Let me look at my --  
24 MR. LaPARL: -- July of 2011?  
25 THE WITNESS: -- CV. I think my injury

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1 IRA MEHLMAN, M.D., the witness herein, having  
2 first been duly sworn by a Notary Public of  
3 the State of New York, was examined and  
4 testified as follows:  
5 **EXAMINATION**  
6 **BY MS. MacGREGOR:**  
7 Q. Doctor, will you state your name for  
8 the record, please?  
9 A. **Ira Mehlman. M-E-H-L-M-A-N.**  
10 **MS. MacGREGOR:** I'm getting some  
11 feedback.  
12 (Off the record)  
13 Q. You are currently practicing what  
14 specialty, Doctor?  
15 A. **Well, I'm an emergency medicine**  
16 **physician, and I'm currently not clinically**  
17 **active.**  
18 Q. All right.  
19 Are you currently employed by anybody?  
20 A. **No.**  
21 Q. When did you last practice emergency  
22 medicine?  
23 A. **July -- in late July 2010 I had an**  
24 **injury lifting a 400-pound patient, and I wound**  
25 **up with a herniated C4-5 disc in my neck, and I**

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1 was actually in July -- I think it was  
2 actually July 2010, because then I was about  
3 to start working in 2012 again, and I was  
4 out for about 20 months with my disc and my  
5 neck.  
6 Q. Do you know when it was that the taxi  
7 injury occurred?  
8 A. **Yeah, that was in 2012, as I recall.**  
9 Q. What month?  
10 A. **That was in September 2012.**  
11 **MS. MacGREGOR:** Okay. Let's go off the  
12 record.  
13 (An off-the-record conversation was  
14 held.)  
15 **MS. MacGREGOR:** While we were off the  
16 record, I asked Mr. LaParl whether we needed  
17 to proceed, given that the doctor wasn't  
18 practicing after July 2010, and he said that  
19 we should.  
20 **BY MS. MacGREGOR:**  
21 Q. So what were you doing professionally,  
22 if anything, after -- between July 2010 and,  
23 let's say, May 2011?  
24 A. **I was doing some teaching at Pace.**  
25 **That's a mid level -- it's actually a nurse**

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1 practitioner PA school, and I did some teaching  
2 there.  
3 Q. Tell me about that. What were you  
4 doing and how much time you --  
5 A. Well I gave, probably, in that period,  
6 five or so lectures, possibly to the PA class, of  
7 two hours each, roughly.  
8 Q. Okay. And any other professional  
9 activity during that time frame, July 2010 to  
10 May 2011?  
11 A. Well, that was it. I was on workman's  
12 comp at the time, trying to see when my neck was  
13 going to get better. I was still on the staff,  
14 but I was trying to avoid surgery.  
15 Q. Okay. The Pace school was -- was there  
16 any clinical work there that you were doing?  
17 A. No, it was all classroom.  
18 Q. And that was to PAs, right?  
19 A. Yeah.  
20 Q. Physician assistants?  
21 A. Yes. Yes.  
22 Q. And what was the topics on which you  
23 lectured?  
24 A. General medicine, endocrine  
25 emergencies, presentations to the emergency

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1 department; a variety of subjects like that for  
2 the class.  
3 Q. How much of it would you say was  
4 related to emergency medicine as opposed to maybe  
5 general medicine or internal medicine or, you  
6 know?  
7 A. It was all -- it was all surrounding  
8 emergency medicine.  
9 Q. Okay. All right.  
10 And then you indicated that there's a  
11 letter to Mr. McKeen. Is that indicating --  
12 telling him what your status was?  
13 MR. LaPARL: No, I don't want you to --  
14 I haven't seen the letter, so I don't even  
15 know what he's referring to.  
16 MS. MacGREGOR: Well, I can ask him.  
17 You can state your objection on the record,  
18 but it's not attorney-client privilege or  
19 anything.  
20 Q. Go ahead.  
21 A. I don't recollect precisely, but I  
22 think I may have sent him a letter around that  
23 time, but I don't recollect exactly. That's a  
24 very vague -- it's a number of years ago. I  
25 don't even remember the dates at this point

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1 precisely, and I don't know that I sent one, but  
2 I think I may have.  
3 Q. Was that something that you were doing  
4 with the attorneys who routinely hired you, just  
5 let them know that you had to leave the practice  
6 of medicine for a while?  
7 A. That's why I wrote the letter. And I  
8 know I sent it to the State of Maryland, because  
9 it was an issue. And, again, I'm not sure if I  
10 sent it, but I recall that I sent out a number of  
11 letters to appropriate states.  
12 Q. While you were practicing emergency  
13 medicine, did you have -- were you ever called on  
14 to be -- well, let me start here: While you were  
15 practicing emergency medicine, did you have  
16 admitting privileges?  
17 A. Well, that's very dependent on the  
18 hospitals, what the policy is. Certainly in  
19 community hospitals -- in teaching hospitals, are  
20 house staff. I generally would have admitting  
21 privileges. In community hospitals, it would  
22 almost always be through an admitting attending  
23 or a hospitalist.  
24 Q. So, to be clear, in the community  
25 hospital setting, typically you would not be

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1 admitting the patient, rather the patient would  
2 be admitted to an attending?  
3 A. Yes, you would contact an attending or  
4 a hospitalist, or both, often, to admit a  
5 patient.  
6 Q. Okay.  
7 A. In teaching hospitals you could admit,  
8 generally, and then call house staff.  
9 Q. Okay. All right.  
10 When you were practicing -- last  
11 practicing emergency medicine, who was your  
12 employer?  
13 A. That would be -- I am going to look at  
14 my CV, but that would have been Saint Joseph's in  
15 Yonkers Medical Center, and that would have been  
16 through Med Excel, a contracting group called Med  
17 Excel. M-E-D, E-X-C-E-L.  
18 Q. So your employer was Med Excel, or were  
19 they just the -- kind of the local tenants'  
20 group, or something, that assigned you there?  
21 A. No, that would be the people who paid  
22 me and my employer. They had a contract with the  
23 hospital.  
24 Q. All right. And how big a hospital is  
25 Saint Joseph's?

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1 A. It's probably --  
2 Q. How many beds?  
3 A. Probably about 180 beds, 200 beds. The  
4 emergency department had some probably 25 bays,  
5 beds, and volume of about 30,000 patients a year.  
6 Q. And how many shifts a month were you  
7 working for Saint Joseph's when you last --  
8 A. I was --  
9 Q. Go ahead.  
10 A. I was working about two -- at the  
11 beginning of my employment with them, I was also  
12 working with a hospital, North General, in Harlem  
13 in Manhattan. So I would work a shift a week  
14 there, and then I would work two, two and a half  
15 shifts at Yonkers. So I worked -- but that was  
16 for two years.  
17 And then the last two years of my  
18 working with Saint Joseph's in Yonkers, I was  
19 working probably, roughly, 2.5 shifts, roughly 36  
20 or so hours per week, probably, on the average.  
21 Q. So were you at Yonkers for  
22 approximately four years?  
23 A. Roughly, yeah. I believe so, yeah.  
24 Q. All right. And the time frame for that  
25 would be what, 2010 to 2006?

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1 A. No, it would be 2007 to -- I was on the  
2 staff until 2012 but clinically working from 2007  
3 until, basically, August of 2010, clinically.  
4 Q. All right. You're looking at your-  
5 A. CV.  
6 Q. -- your CV there? It doesn't reflect  
7 the August 2010 date, correct?  
8 A. Well, no. It has me on the staff -- I  
9 was on workman's comp, so I was on the staff in  
10 January of 2012.  
11 Q. Okay. Yeah, no, I was just making sure  
12 that my copy of your CV is the same as the one  
13 you're looking at. Okay?  
14 A. Yes.  
15 Q. All right. And for purposes of the  
16 record, we had marked your CV as Exhibit I. And  
17 that's two pages, correct?  
18 A. Yes. It's two pages plus a page of  
19 articles published, some 20 articles that are  
20 attached to it.  
21 Q. Oh, there's a third page?  
22 A. Yes. Well, it's -- I don't consider it  
23 part of my CV, but I -- people ask if I've  
24 published, so I staple it to the record -- to the  
25 CV, the résumé now, the three pages that I have

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1 here.  
2 Q. Okay. In the list of articles, are  
3 there any articles that deal with emergency  
4 medicine?  
5 A. There's no article that deals with the  
6 subject at hand here. There's a -- one or two  
7 articles that deal with, very tangentially,  
8 emergency medicine, but nothing that's at all  
9 involved to the case at hand.  
10 Q. Very good. Thank you.  
11 Then also on your CV for the time frame  
12 I'm most interested in, and on the CV it reflects  
13 5 -- May 2009 to the present time, senior  
14 consultant emergency medicine for the VA?  
15 A. Yes.  
16 Q. Tell me what that is and what your role  
17 is.  
18 A. That's -- I'm not sure how they  
19 contacted me, but I've been in -- I was contacted  
20 and involved in doing peer review. It had  
21 nothing to do with any litigation that might have  
22 any monetary concern. It was mainly about peer  
23 review. And so it was a peer-review panel that  
24 the VA had, and I would be asked -- I haven't  
25 been asked in the last -- I haven't heard from

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1 them in the last year or so, but for a number of  
2 years I would be sent probably an average of a  
3 case every month or two, and I'd be probably one  
4 of a half a dozen doctors who would look at it.  
5 And then we'd have a -- a telephone conference  
6 call, where we would discuss the issues.  
7 And it was all related to -- I'd be  
8 involved in cases that were related to emergency  
9 medicine issues in VA hospitals. And so then we  
10 would come to a conclusion about whether standard  
11 of care and appropriate care was met. And then  
12 the VA would do what -- I'm not sure what they  
13 did with it after. I think they probably --  
14 there would be some action that would be in terms  
15 of quality improvement, I guess, afterwards.  
16 Q. Okay --  
17 A. But I would be a part of a group of  
18 doctors who would just do a peer-review analysis  
19 and then have a conference call and discussions.  
20 And then they would write up a report and you  
21 would see it after, about actions they were going  
22 to recommend. If that is clear.  
23 Q. That is. I understand that process  
24 entirely.  
25 So was there -- did there come a time

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1 where those cases began to taper off or did it  
2 just suddenly stop?  
3 **A. It probably tapered over the last year**  
4 **and a half or so to the point now, that I've had**  
5 **maybe one in the past year.**  
6 Q. Okay. And so in the months immediately  
7 following your car -- or, I'm sorry, your --  
8 **A. Lifting a patient.**  
9 Q. -- accident at work --  
10 **A. Yeah, work accident.**  
11 Q. Right. So in July 2010, how many,  
12 would you say, cases you reviewed for the VA  
13 between let's say July 2010 and May 2011?  
14 **A. Possibly a half a dozen. Maybe four to**  
15 **six, probably.**  
16 Q. And how many hours would you say each  
17 case would require of your time?  
18 **A. Probably, in total, including the calls**  
19 **and reviewing stuff, it would probably be 8 to**  
20 **10 hours total over the period that they would be**  
21 **discussed.**  
22 Q. Okay. So each case would require you  
23 to review the record and then have this phone  
24 call, and that would take potentially 8 to  
25 10 hours --

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1 **A. Yeah.**  
2 Q. -- per case?  
3 **A. Yeah. Sometimes it would include, you**  
4 **know, a review of x-rays and cardiograms and**  
5 **et cetera, and then there would be a two-hour**  
6 **conference calls often. And then there would be**  
7 **some reports sent out about the cases with**  
8 **some -- some actions included that they were**  
9 **going to do.**  
10 Q. All right. Okay.  
11 Other professional activity during that  
12 time frame of August 2010 to, you know, the  
13 summer, really, of 2011, anything else you were  
14 doing professionally?  
15 **A. I was attending grand rounds and**  
16 **reading medical journals, and I mentioned some**  
17 **degree of teaching at Pace PA school.**  
18 Q. Medical literature...  
19 So how often would you attend grand  
20 rounds?  
21 **A. Probably one to two times a month.**  
22 Q. I take it during that first month or  
23 two following the injury, were you -- what, were  
24 you hospitalized or were you bedridden or --  
25 **A. I was bed ridden pretty much for three**

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1 **weeks --**  
2 Q. Okay.  
3 **A. -- with radicular -- radicular symptoms**  
4 **from the root, and then that gradually improved**  
5 **over time.**  
6 Q. Okay.  
7 **A. There was discussions of surgery, but I**  
8 **didn't want to have surgery at that point.**  
9 Q. So was there a period of months when  
10 you would not have performed any professional  
11 activity?  
12 **A. No, I was -- probably the first three**  
13 **weeks, certainly no.**  
14 Q. Okay. All right.  
15 Were you also doing expert witness work  
16 that summer --  
17 **A. What I could do --**  
18 Q. -- of that year --  
19 **A. What I could do, from home generally.**  
20 **I was pretty much home bound for three weeks.**  
21 Q. Right. And then between July 2011  
22 and -- I'm sorry, July 2010 and May, June,  
23 July 2011, so for that year period, were you  
24 doing expert witness work?  
25 **A. Yes.**

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1 Q. All right. Let's talk about that for a  
2 minute.  
3 So -- well, let's talk just kind of  
4 generally. What -- how much -- how many cases  
5 are you offered on average a year? A month?  
6 Whatever works for you.  
7 **A. Well, it's decreased over the years --**  
8 **well, it decreased over the last probably five to**  
9 **eight years, but I get called probably -- I get**  
10 **contacted possibly on 10 to 12 cases a year now,**  
11 **and it's probably been roughly that for the last**  
12 **few years, of which I probably accept 80 percent**  
13 **after an initial contact, because it seems like**  
14 **it -- there could be merit to them.**  
15 Q. So between July 2010 and May 2011, do  
16 you have any way of estimating how many cases you  
17 looked at that you reviewed during that time?  
18 **A. Possibly eight cases. I don't know.**  
19 **I'm not sure precisely.**  
20 Q. All right. And do you have any way of  
21 estimating how much time -- when a new case is  
22 sent to you, how much time you generally tell  
23 folks you're going to need to review that?  
24 **A. Well, an initial review is usually two**  
25 **to three hours.**

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1 Q. All right. Do you remember whether you  
2 had some cases that were pending during that time  
3 frame as well as more mature cases?  
4 A. I don't recall precisely. I mean, I'd  
5 be guessing -- I'm not sure I understand. You  
6 mean how many cases were active during that time?  
7 Q. Right. Right.  
8 A. It's hard to know, because attorneys  
9 don't contact you unless they need you for  
10 something. And so cases, probably four out of  
11 the five cases that I might have laying around  
12 are probably resolved eventually, and only if I  
13 make a call to find out if I can throw out the  
14 records that I'm stubbing my toe on do I find out  
15 if it's active or not. So I -- it's hard for, I  
16 think, people who are reviewing cases for  
17 attorneys to know what's active until they  
18 contact you.  
19 Q. Right. Okay.  
20 A. I'm trying to attempt to answer your  
21 question.  
22 Q. Right. So that --  
23 A. I probably --  
24 Q. -- let me just make sure --  
25 A. I probably -- I probably had five to

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1 eight cases certainly active, at least, probably.  
2 Q. All right. So --  
3 A. But I wouldn't know that.  
4 Q. Right. Yeah.  
5 The eight cases we were talking about  
6 earlier, what I thought you were telling me, and  
7 this is what I want to make sure of, was that  
8 those might have been -- those are cases that  
9 you're offered. Those are new cases that you  
10 review?  
11 A. I might have.  
12 Q. And then --  
13 A. I probably got called for maybe 10 to  
14 12 cases, possibly.  
15 Q. Okay.  
16 A. During a year.  
17 Q. Right.  
18 A. During that year of that -- because,  
19 typically, 75 to 80 percent of what I'm called  
20 for do I wind up taking, that seem they could  
21 have merit or -- and they're not all plaintiff  
22 cases; they're also defense cases.  
23 So maybe 75 percent of them can I be of  
24 assistance. So if I might have gotten 10 to  
25 12 cases, there may be 7 or 8 that I might have

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1 accepted and spent a couple of hours on each  
2 initially.  
3 Q. Okay.  
4 A. Just from my experience with how it --  
5 how it plays out.  
6 Q. Right. And, again, so I'm clear, those  
7 are new cases during that time frame. And you  
8 also think you may have had some existing files  
9 that we're just not sure what's active and what's  
10 not?  
11 A. Yes.  
12 Q. Okay. All right.  
13 How does your expert witness work break  
14 down percentage-wise as between plaintiff and  
15 defendant work?  
16 A. Well, initially, when I retired from  
17 the Army in 1992, it was mostly plaintiff based,  
18 probably 90-plus percent. The last five to  
19 eight years, it's probably 80 -- 80, 85 percent  
20 plaintiff, and 15, 20 percent defense.  
21 Q. When was the last time you gave a  
22 deposition or testified in any way on behalf of a  
23 defendant?  
24 A. Um, um, probably in the... I'm trying  
25 to see. In the last, um... probably a

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1 deposition -- I've reviewed cases, a lot of times  
2 when I review cases for the deposition it winds  
3 up with a recommendation to settle with -- I get  
4 contacted from attorneys, particularly who have  
5 been on the other side of a case I may have been  
6 in, so -- that have me review it.  
7 And after discussions, most of the time  
8 it's just my opinions on the case and where  
9 there's failure to meet standards of care for  
10 them, so they're educated. So the last  
11 deposition, in fact was probably two or  
12 three years ago for a deposition case.  
13 Q. Okay.  
14 A. It's not rare for me to review a case  
15 for defense, but they -- after I review it, I  
16 tell them I can't do what they might like me to  
17 do in the courtroom to support it, and I show  
18 them the weaknesses.  
19 Q. All right. So more often than not  
20 you're finding that there are concerns and it  
21 would be difficult for you to defend the care of  
22 the provider?  
23 A. Not difficult. If there's concerns, it  
24 would be impossible. But I tell them what and  
25 how -- why they might want to settle it.

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1 Q. Okay. Great, thanks.  
2 **A. When I said "not difficult," I mean**  
3 **impossible for me to go to court.**  
4 Q. Right. You're not going to go in and  
5 try to support care that you don't believe in.  
6 **A. Right. Exactly.**  
7 Q. Thank you.  
8 In what are you board certified?  
9 **A. Well, I'm board certified currently in**  
10 **internal medicine and in endocrinology**  
11 **metabolism. After my neck injury, I let my**  
12 **boards expire at the end of 2011. I am what's**  
13 **called a past diplomat of the American -- College**  
14 **of Emergency -- Emergency Physicians. And I was**  
15 **board certified up until December 31, 2011.**  
16 **After that, I elected not to sit for**  
17 **those boards, because I wasn't going to work in**  
18 **an inner city or the kind of ED where I need**  
19 **them, and I'm board certified in medicine and**  
20 **endocrinology for life.**  
21 **I'm still a fellow of the American**  
22 **College of Emergency Physicians and a fellow of**  
23 **the American College of Physicians for the**  
24 **internal medicine group.**  
25 Q. Did you do an emergency medicine

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1 residency or fellowship?  
2 **A. No. I'm of the age -- those didn't**  
3 **exist when I began my training, so I was boarded**  
4 **and did a residency and fellowship in**  
5 **endocrinology and internal medicine.**  
6 Q. Have you ever worked internal medicine  
7 or endocrinology, let's say, in the last  
8 20 years?  
9 **A. 20 years?**  
10 Q. Yes.  
11 **A. Well, I was in the Army for 20 --**  
12 **almost 23 years, and during up --**  
13 Q. All right.  
14 **A. -- up until 1992. And during that**  
15 **time, when I was director of the emergency**  
16 **department at Walter Reed for 11 of those years,**  
17 **although a large part of my time was spent**  
18 **developing and creating and running the emergency**  
19 **department, I still attended in probably three**  
20 **months of the year I would -- besides still**  
21 **running the emergency department and working it,**  
22 **I would also be an attending on a ward, an**  
23 **internal medicine ward, and also attend in**  
24 **thyroid and endocrine clinic.**  
25 Q. Okay?

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1 **A. So that would be up to 1992, where I**  
2 **would spend at least a few months of the year**  
3 **involved in the emergency medicine but also**  
4 **involved, to a degree, in internal medicine and**  
5 **endocrinology metabolism.**  
6 Q. And since that time, your -- the  
7 primary focus of your practice as been in the ED,  
8 correct?  
9 **A. Yeah. I was the director of emergency**  
10 **departments for probably 15 or so years after**  
11 **that, or more, probably. And my time was all**  
12 **committed pretty much to emergency medicine.**  
13 Q. Have you ever had any issues with your  
14 license or with staff privileges? Ever have  
15 anything been called into question in either of  
16 those areas?  
17 **A. No, and no mal --**  
18 Q. No reprimand --  
19 **A. No malpractice either. I'm knocking on**  
20 **the table here, because it's unusual.**  
21 Q. For sure, yeah.  
22 **A. Yeah.**  
23 Q. Any reprimands of any kind from  
24 hospitals with whom you've worked or employers  
25 with whom you've worked?

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1 **A. No.**  
2 Q. And have you ever been terminated from  
3 a contract because of quality-of-care issues?  
4 **A. No.**  
5 Q. Are you familiar with the expert  
6 witness affirmation from the American College of  
7 Emergency Physicians?  
8 **A. Yeah. I don't carry it around in my**  
9 **wallet, but I'm familiar that it exists, yeah.**  
10 Q. Have you signed it --  
11 **A. No.**  
12 Q. -- signed onto it?  
13 **A. No. I wouldn't sign it, no.**  
14 Q. Why not?  
15 **A. You know, I went to college at**  
16 **Princeton, where we had an honor system; I was a**  
17 **Boy Scout, and I was an Army officer for**  
18 **23 years, including colonel; I was an escort**  
19 **physician with the U.S. Congress and prominent**  
20 **members of the country to bring them back alive**  
21 **from crazy places. I don't need to sign an**  
22 **affidavit or some sort of a piece of paper from**  
23 **the American College of Emergency Physicians,**  
24 **even though I'm a fellow, to state that my**  
25 **behavior, my practice, and my testifying is**

1 **ethical. I don't -- I mean, that's obvious.**  
 2 **It's never come into question.**  
 3 Q. So nobody has ever questioned the merit  
 4 or the ethical basis for your testimony as an  
 5 expert witness?  
 6 A. **No, nobody.**  
 7 Q. Has there been any challenges to your  
 8 testimony through the American College of  
 9 Emergency Physicians --  
 10 A. **No, no.**  
 11 Q. -- let me put it that way.  
 12 A. **No.**  
 13 Q. And have you ever been stricken as a  
 14 witness or denied -- your testimony denied as  
 15 unreliable or inadmissible, that you know of?  
 16 A. **Well, in 2006 there was a Daubert**  
 17 **process in Michigan on TPA, tissue plasminogen**  
 18 **activator, and a patient with a stroke and the --**  
 19 **with, I think, an attorney, Sam Mackler (phon), a**  
 20 **case that was -- that came -- with a Daubert**  
 21 **process, where I appeared and the attorneys**  
 22 **appeared and the defense expert appeared, and the**  
 23 **case was thrown out because it was felt that the**  
 24 **attorney and I didn't bring enough literature to**  
 25 **the court to support that TPA was the standard of**

1 you're aware of in which your testimony was  
 2 called into question and actually found to be  
 3 inadmissible?  
 4 A. **Yeah. There was a conversation in a**  
 5 **journal that was unethical and inappropriate, and**  
 6 **that was, again, about TPA, because there was a**  
 7 **big movement for defense attorneys to try to get**  
 8 **around TPA use, which is the standard of care**  
 9 **worldwide, with a much bigger window. There was**  
 10 **another issue about that. But that was nobody**  
 11 **that had any ability to call my testimony in --**  
 12 **and it was an unethical thing, and they stopped**  
 13 **doing what they were trying to do, which was just**  
 14 **to intimidate doctors from standing up for**  
 15 **patients that were injured or maimed or not**  
 16 **treated correctly.**  
 17 Q. Right. Have you ever prepped --  
 18 prepared a list for the federal court, or  
 19 otherwise, of the cases on which you've acted as  
 20 a consultant?  
 21 A. **I've appeared in federal court, and**  
 22 **they ask for that. And I don't keep a record of**  
 23 **these things, and so attorneys -- I mean, there's**  
 24 **all sorts of websites, or sites that could be**  
 25 **gathered. And I know some attorneys, when --**

1 care in that case.  
 2 **The defense expert had testified that**  
 3 **he gave TPA three times, but somehow the judge**  
 4 **concluded that TPA wasn't the standard of care.**  
 5 **In fact, TPA is nationally and internally the**  
 6 **standard of care. The judge made a lame**  
 7 **decision. It was held up by appeals, but it was**  
 8 **a lame decision. And in the New England Journal**  
 9 **of Medicine, in June of 2011, there was an**  
 10 **article, basically, that said the -- that TPA was**  
 11 **the standard of care, that places that consider**  
 12 **it not are doing a disservice to stroke patients,**  
 13 **and TPA is used much more with a much bigger**  
 14 **window. So that was an issue that was -- the**  
 15 **court made -- I mean, our system --**  
 16 Q. Right.  
 17 A. -- is imperfect. That was one of the  
 18 imperfect decisions. It was found that we didn't  
 19 bring enough material to the court to make that  
 20 judge conclude that -- I've appeared and  
 21 testified since in Michigan, and it's the only  
 22 time that a case didn't go forward because the  
 23 literature didn't convince that judge, who new  
 24 nothing about medicine.  
 25 Q. Okay. So that's the only case that

1 **I've probably been involved in several federal**  
 2 **cases over the years, and the attorneys have put**  
 3 **that list together. I know -- but I don't have a**  
 4 **copy of it, and I've never tried to do that.**  
 5 Q. Okay. All right.  
 6 In the last couple of years, can you  
 7 give me an idea of the percentage of your income  
 8 is attributable to expert witness work?  
 9 A. **Probably 20 percent, maybe.**  
 10 Q. Okay and --  
 11 A. **18, 20 percent, possibly. Less lately**  
 12 **because I'm doing less, but probably about that.**  
 13 Q. So the income -- other income you have  
 14 is what, workers' compensation?  
 15 A. **Well, my Army retirement,**  
 16 **investments --**  
 17 Q. Oh, okay.  
 18 A. -- **financial things.**  
 19 Q. Okay, got it. All right.  
 20 So the -- and then, are you paid for  
 21 the peer-review work?  
 22 A. **What?**  
 23 Q. For the VA.  
 24 A. **For the VA, it's around \$600 for the**  
 25 **total of it. It's sort of almost pro bono,**

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1 really.  
2 Q. Per case?  
3 A. **Yeah, \$600 per case, period. And it's**  
4 **8 to 10 hours, so it's very minimal.**  
5 Q. Yeah.  
6 A. **But it's the VA, and I was a soldier**  
7 **for 22 years, 23 years, so I do it, if asked.**  
8 Q. Do you remember ever reviewing a case  
9 in which the allegation was similar to this? And  
10 I'll just characterize it as failure to  
11 investigate blank back or neck pain or symptoms.  
12 A. **As I sit here, I don't remember a**  
13 **specific case, no.**  
14 Q. How about one involving a delayed or  
15 misdiagnosis of a spinal lesion or a cord  
16 compression?  
17 A. **Well, I'm sure I've -- I know I've**  
18 **reviewed cases of epidural abscesses and such**  
19 **things, but I -- as I sit here, I don't recall**  
20 **it. And I'm sure if you -- even, most likely if**  
21 **you gave me the name of the case I probably**  
22 **wouldn't recall it, but I know I've had cases**  
23 **like that, certainly.**  
24 Q. How about a case in which the patient's  
25 complaints were pain and it turned out that the

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1 patient had something very life threatening,  
2 specifically, let's just say, cancer?  
3 A. **Well, I -- it's in the category of**  
4 **space-occupying lesions, which could be hematomas**  
5 **from a spinal tap, for example, or a misadventure**  
6 **like that, or a dissection of blood through an**  
7 **aortic aneurism into bone and -- or an abscess.**  
8 **I've certainly had cases where those**  
9 **have occurred. They're part of the differential**  
10 **diagnosis of people with severe back pain, and**  
11 **who then ultimately go on to having neurologic**  
12 **deficits. So I know I've had cases like that in**  
13 **the past, certainly, yes.**  
14 Q. Okay. All right.  
15 All right. So let me just review what  
16 it is you told me before we went on the record,  
17 that you have there in front of you what we've  
18 marked as exhibits for the purpose of the record.  
19 So we have your CV marked as one,  
20 Exhibit 1; your Affidavit of Merit is marked as  
21 Exhibit 2. There are six depositions marked as  
22 Exhibits 3 through 8, and those include  
23 Dr. Goldman, Dr. Chaltry, Dr. Manning, Dr. Segan,  
24 Dr. Austin, and Brenda Carey?  
25 A. **That's correct. So far, yeah.**

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1 Q. And then we've marked as 9 the Notice  
2 of Intent to File Claim.  
3 We marked as 10 a set of records from  
4 Aspirus Ontonagon, which includes clinic and  
5 emergency department records for the time frame  
6 of March 16, 2011, through the hospitalization in  
7 October 2011, correct?  
8 A. **Yes.**  
9 Q. Okay. And then 11, Exhibit 11, was, I  
10 assume, select records from the Marquette General  
11 hospitalization that started October 29, 2011. I  
12 don't think -- you have the entire record there  
13 for that or just parts of it?  
14 A. **I have close to a half inch. I don't**  
15 **know if there's nurses or lab missing, but it**  
16 **looks -- well, it could be more than a half inch,**  
17 **but a half inch sounds right, that's what I have,**  
18 **yeah.**  
19 Q. Now, she was there for 15 days, so I  
20 think that record is probably a couple of inches  
21 thick?  
22 A. **I massage, yeah.**  
23 Q. Okay. So you also have there in front  
24 of you some selected other medical records. It  
25 sounds like selected records from the Marquet

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1 General Hospital for the bariatric surgery in  
2 January 2011; Northern Orthotics; the  
3 psychologist, Tribiano (phon); and the  
4 Cardiovascular Group there in Marquette.  
5 A. **That's correct.**  
6 Q. All right.  
7 A. **And I'm sure you're right about the**  
8 **10/29 to 11/14, because it doesn't have the --**  
9 **obviously it doesn't have all the labs, by any**  
10 **stretch, or the nurses' notes, or physical**  
11 **therapy, yes.**  
12 Q. Do you remember seeing any of the other  
13 Marquette General records? And specifically I'm  
14 interested in the bariatric service, the  
15 weight-loss service.  
16 A. **Well, that's part of the selected**  
17 **records of the 11/19/2011 bariatric admission. I**  
18 **don't know if it includes -- I have no stickies**  
19 **on that. I went through it very, very quickly.**  
20 **I don't know if it includes bariatric records**  
21 **subsequent to 10/29.**  
22 Q. Okay. No, what I was interested in was  
23 there were a number of encounters, outpatient  
24 encounters, with the providers in that clinic  
25 prior to the January 19th procedure, and then

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1 also after that procedure, during the summer of  
2 2011, leading up to the paniclectomy, and then  
3 maybe even after that.  
4 **A. I know I've seen some pieces that were**  
5 **preoperative bariatric service records, namely**  
6 **prior to 1/19/2011. And possibly I may have seen**  
7 **some stuff pre-pannus surgical removal. I don't**  
8 **recall specifically. There may be some in there.**  
9 Q. Do you have the records from the pannus  
10 removal? That would have been September --  
11 **A. September --**  
12 Q. -- 2011?  
13 **A. -- 2011, yeah... I'm not sure, as I**  
14 **sit here.**  
15 **(Pause)**  
16 **That would have been September of 2011,**  
17 **I think, as I recall it. Right?**  
18 Q. Correct.  
19 **A. Yeah. In brief, looking through those**  
20 **pieces of paper -- oh, here's some others.**  
21 **I thought I might have seen some, but**  
22 **I'm not quickly finding it.**  
23 Q. Okay.  
24 **A. But I can keep looking, if you would**  
25 **like, while you ask me questions.**

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1 Q. Oh, that's all right. We're going to  
2 get copies of nearly all of that.  
3 Other than the last group of records I  
4 mentioned starting with the MGH record of  
5 January 19, 2011, all the rest of them are marked  
6 as exhibits, so...  
7 Okay. So have you seen any photographs  
8 of Mrs. Carey?  
9 **A. Not that I recall.**  
10 Q. Have you seen any of the actual films?  
11 **A. As I sit here, not that I can recall.**  
12 Q. Have you seen any medical records from  
13 pre 2011?  
14 **A. Pre 2011, yes, I have, yeah.**  
15 Q. What have you seen from prior to 2011?  
16 **A. I know I've seen some things that -- I**  
17 **know I have seen some things that were twenty --**  
18 **have "2010" on them, I'm pretty sure. I don't**  
19 **recall specifically, and, obviously, I didn't**  
20 **think they were too relevant to what I was asked**  
21 **to do.**  
22 Q. All right. Have you seen any records  
23 for treatment of back pain that pre-existed 2011?  
24 **A. Not as I sit here, nor did I ever see**  
25 **it memorialized in the records from -- that I**

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1 **was -- that I thought was a primary thrust. I**  
2 **didn't see it memorialized in the 2011 records**  
3 **either.**  
4 Q. And you have not seen any affidavits of  
5 meritorious defense, that would be affidavits by  
6 the experts that we've identified?  
7 **A. No, I haven't.**  
8 Q. Have you reviewed any summaries or  
9 lists or any sort of timelines concerning the  
10 case?  
11 **A. Not -- no, I haven't.**  
12 Q. Okay. Have you discussed the case with  
13 anyone other than the plaintiff's counsel?  
14 **A. No.**  
15 Q. Do you have a document that sets out  
16 your fee structure?  
17 **A. Do I have a document about that --**  
18 Q. Yes.  
19 **A. -- no.**  
20 Q. No?  
21 **A. I don't have a document about that.**  
22 **But what is, I mean, I can tell you. It's \$400**  
23 **an hour for any review work. And for a**  
24 **deposition, like today, \$1,400, minimum, and if**  
25 **it goes beyond three and a half hours, it would**

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1 **be greater than \$1,400. And for trial**  
2 **appearance, \$3,000 plus appropriate expenses,**  
3 **like travel and food.**  
4 Q. Sure. Thank you.  
5 And as far as billing records, you did  
6 not bring those with you here today?  
7 **A. I don't keep them. I submit an**  
8 **invoice, and if it's paid, I destroy it and I get**  
9 **a 1099 at the end of the year and pay my taxes,**  
10 **like hopefully most Americans.**  
11 Q. All right. So you're saying you don't  
12 have any billing records for your work on the  
13 case to date?  
14 **A. That's correct.**  
15 Q. Can you estimate how much time you have  
16 spent on the case and/or billed to Mr. LaParl to  
17 this point?  
18 **A. Well, I billed your firm, I assume,**  
19 **\$1,400 for the deposition today, and I billed the**  
20 **McKeen firm \$2,000 for the preparation for today.**  
21 **And prior to this, I've probably billed \$1,500,**  
22 **roughly. I'm pretty -- that's probably what I**  
23 **billed them.**  
24 Q. Okay.  
25 **A. Give or, maybe, possibly another few**

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1 **hundred dollars, but less than \$2,000 up till my**  
2 **commencement for the review for today.**  
3 Q. Right, okay. And that time is billed  
4 on an hourly basis at \$400 an hour?  
5 A. **Yes.**  
6 Q. And before we went on the record, you  
7 told me you don't make any independent notes,  
8 although you do make record and you do notate the  
9 records that you review, and you also have sticky  
10 notes on them, the records that we've marked as  
11 exhibits, correct?  
12 A. **That's correct.**  
13 Q. Have you done any research relative to  
14 this case, specific to this case?  
15 A. **No.**  
16 Q. Have you reviewed anything else as you  
17 sit here today that comes to mind beyond what  
18 we've talked about specific to this case?  
19 A. **No.**  
20 Q. And at this point, have you completed  
21 your review to the extent that you feel  
22 comfortable telling me your opinions as you  
23 expect them to be, come time of trial?  
24 A. **Yes.**  
25 Q. Do you know any of the other -- any of

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1 the defendants?  
2 A. **No.**  
3 Q. Do you know -- well, do you know any of  
4 the experts that have been named? And you may  
5 not even know who they are.  
6 A. **I don't know who they are. Whom they**  
7 **are.**  
8 Q. Okay.  
9 A. **Who.**  
10 Q. All right. So I have your Affidavit of  
11 Merit here, but I guess -- so that's where I want  
12 to go next, just to your criticisms of the  
13 defendants. Probably the best way for me to  
14 handle that is for you to look -- to go to each  
15 encounter and tell me what it is that you think  
16 should have been done, or that was done that  
17 shouldn't have been, and talk about the standards  
18 of care for each encounter with that. Is that an  
19 okay to go --  
20 A. **Yeah.**  
21 Q. -- as far as you're concerned?  
22 A. **Yeah, that's fine.**  
23 Q. So let me have you identify -- tell us,  
24 or tell me, how you define the standard of care.  
25 A. **Well, the standard of care is the**

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1 **minimum that a physician practicing in his or her**  
2 **specialty is required to do all the time with**  
3 **respect to the case they're treating.**  
4 Q. Under that, those circumstances?  
5 A. **Well, under any circumstances. And if**  
6 **they can't do what they need to do because of**  
7 **restrictions of where they are, like a hospital**  
8 **without an MRI or a CAT scan or a neurosurgeon,**  
9 **then, to stabilize a patient and transfer to the**  
10 **appropriate hospital.**  
11 **Obviously, if a patient needs a dive**  
12 **chamber or a hyperbaric chamber for carbon**  
13 **monoxide poisoning or a burn unit, and they're**  
14 **not in a burn unit or a Level 1 trauma center,**  
15 **then they need to stabilize a patient, do what**  
16 **would be expected for them to do, and then to**  
17 **transfer safely to an appropriate place --**  
18 Q. Right.  
19 A. -- **assuming it's not the middle of**  
20 **winter and the worst storm of the century in the**  
21 **middle of Alaska or something.**  
22 Q. Ontonagon has those storms too. But,  
23 okay, I got it.  
24 All right. Let's go to the first  
25 encounter that you as an expert in emergency

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1 medicine anticipate testifying about.  
2 A. **Well, my looking which way would be --**  
3 **I mean the first encounter I have is 5/17/11 in**  
4 **the chart that relates to the case, but that's**  
5 **not in an emergency department.**  
6 Q. Right.  
7 **MR. LaPARL:** She wants you to focus on  
8 the emergency department visits --  
9 **THE WITNESS:** Yeah.  
10 **MR. LaPARL:** -- I believe. Is that  
11 correct?  
12 A. **So the first visit --**  
13 **MS. MacGREGOR:** Well, let me just --  
14 Q. You know, I was interested in hearing  
15 from you which ones you anticipate testifying  
16 about, and apparently you haven't -- plaintiff's  
17 counsel hasn't talked about which ones you  
18 actually qualify to testify about, correct?  
19 A. **Well, I can tell you --**  
20 **MR. LaPARL:** No, wait, wait, wait.  
21 He's going to be offering testimony  
22 regarding emergency medicine, so...  
23 **MS. MacGREGOR:** Okay. All right.  
24 A. **I can tell you the visits, and I'm**  
25 **going to try to put them in order. How about if**

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1 I do that?  
 2 Q. Okay. Okay, that would be great.  
 3 A. I think the first ER visit from the  
 4 notes I made on the pages that we talked about,  
 5 would be -- it looks like 8/9/2011, August 9th,  
 6 which would be Dr. Chaltry's visit where he saw  
 7 the patient in the emergency department.  
 8 Q. Right.  
 9 A. And let me preface my remarks --  
 10 MR. LaPARL: Just -- just tell her  
 11 which -- you don't have to preface anything.  
 12 She just wants to know which visit --  
 13 MS. MacGREGOR: Excuse me, Mr. LaParl,  
 14 it is not appropriate for you to coach your  
 15 witness.  
 16 MR. LaPARL: Well, I'm not coaching  
 17 him, but he doesn't have to preface  
 18 anything.  
 19 MS. MacGREGOR: You may make an  
 20 objection to a question.  
 21 Q. But, Doctor, go ahead and tell me how  
 22 you want to preface your comments.  
 23 A. Well, all of my remarks are about the  
 24 egregious deviations from the failures of the  
 25 group of doctors who were working both in the ER

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1 and the family practice clinic, failures to take  
 2 an appropriate and thorough history and  
 3 appreciate the clinical significance of it;  
 4 failure to perform an appropriate and complete  
 5 physical examination, and certainly to include an  
 6 appropriate neurologic examination and appreciate  
 7 the clinical significance of it; and a failure to  
 8 utilize ancillary testing to include imaging,  
 9 namely CT or MRI and x-rays, and use of  
 10 laboratory tests, such as C-reactive protein,  
 11 sedimentation rates, and basic labs, including  
 12 chemistries and CBC, and appreciate their  
 13 clinical significance; and the absence of using  
 14 available or obtainable consultations to include  
 15 orthopedics, neurology, neurosurgery, in the  
 16 evaluation of their patient; and then the failure  
 17 to timely initiate -- after doing appropriate  
 18 history, physical, ancillary testing,  
 19 consultation, the failure to timely initiate  
 20 treatment, both for -- well, for space -- to  
 21 diagnosis the space-occupying mass that I was  
 22 believe was present as far back as May; and to  
 23 initiate specific treatment after diagnoses were  
 24 made, which would have included enlarged lymph  
 25 glands from the non-Hodgkin's diffuse B-cell

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1 lymphoma; and to initiate the appropriate  
 2 treatment for the lymphoma, because all of -- all  
 3 of medical problems do better when early  
 4 diagnosis is done, performed, and timely, early  
 5 treatment. So all of them boil down to that.  
 6 And then the big -- the big elephant in  
 7 the room, too, is that the failure of this small  
 8 group in this three- to four-bed emergency  
 9 department who were interfacing in -- both in the  
 10 ER, working with one another, and in a clinic,  
 11 despite them all taking care of this patient so  
 12 many times over six months, none of them in the  
 13 Aspirus Ontonagon Medical Hospital, and their  
 14 clinics, none of them apparently communicated  
 15 with each other to any significance or, if at  
 16 all, about this same patient they were all  
 17 touching and examining and responsible for, and  
 18 this patient went under -- went seriously treated  
 19 with serious and potentially harmful medications  
 20 for over six months without any effort or attempt  
 21 at an appropriate diagnosis.  
 22 So that's the sort of -- the cover  
 23 paragraph of what happened. And then I can get  
 24 into, if you'd like, the first --  
 25 Q. Yeah?

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1 A. -- what appears to be the first visit  
 2 of August 9, 2011.  
 3 Q. Okay. Let me just take you back,  
 4 though, first, to July 28th.  
 5 A. To July 28th --  
 6 Q. Right. So --  
 7 A. -- when the patient was seen in the  
 8 clinic --  
 9 Q. Correct.  
 10 A. -- attended by Dr. Goldman?  
 11 Q. Right. And Dr. Goldman is board  
 12 certified in emergency medicine, and so I don't  
 13 know for sure that you would be permitted to  
 14 testify to his standards of care when he's acting  
 15 in a family practice role, but, if you would, why  
 16 don't you look at that note and tell me what you  
 17 consider to be a breach of standard of care from  
 18 an emergency medicine standpoint.  
 19 A. There's an adage in emergency --  
 20 there's an adage in medicine, particularly in  
 21 emergency medicine: If somebody is seen two  
 22 times, you better -- if somebody is seen two  
 23 times -- and that means two times in any clinical  
 24 setting -- if somebody -- if you're evaluating  
 25 somebody who's been seen two times, you better

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1 make sure you're not missing something. And if  
 2 they've been seen three times, you'd better have  
 3 a reason not to admit them, because you are  
 4 missing something. So that's an axiom about if  
 5 somebody is seen in whatever setting three times  
 6 you better admit them, because you're missing  
 7 something, if they're coming with serious  
 8 complaints.  
 9 Q. Okay.  
 10 A. So Brenda Carey was in this very small  
 11 hospital and being treated, really, by the same  
 12 set of physicians in either the family practice  
 13 or the ER setting, and also by a nurse  
 14 practitioner, Jennifer Weaver.  
 15 And so the first complaint I would have  
 16 about Dr. Brad Goldman is that when he sees this  
 17 patient on 7/28/11, she has now had, since  
 18 May 17th, new severe onset back pain and symptoms  
 19 for a lot more than three times when she came in  
 20 to see him in the clinic setting and as an  
 21 emergency medicine physician practicing in the  
 22 clinic setting.  
 23 And she also, when she presented, was  
 24 having the complaints of back pain, which go back  
 25 to May 17th, and had lost a significant amount of

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1 weight. She had bariatric surgery in January, I  
 2 think 18th, of 2011, roughly, and she had had  
 3 somewhere around a 100-pound weight loss.  
 4 That's -- that's either a heck of a great  
 5 response to her bariatric surgery, or I think,  
 6 actually, probably a little more than one would  
 7 have anticipated her weight loss to be, because I  
 8 think there was actually -- she had the bariatric  
 9 surgery, but I think she also had a very  
 10 significant weight loss. I would have been sort  
 11 of struck by that, and if she has any other  
 12 complaints and is not doing well, I would wonder  
 13 if her weight loss would be a result of the  
 14 bariatric surgery plus something else going on.  
 15 And, in fact, it's very common for patients with  
 16 non-Hodgkin's lymphoma or other serious,  
 17 malignancies or diseases to lose weight with  
 18 anorexia and weight loss.  
 19 So I don't -- I don't think I can just  
 20 pat the surgeons who did the bariatric surgery on  
 21 the back, although they did well. I think the  
 22 fact that she's got pain is emblematic of the  
 23 fact that her back pain is related to something  
 24 absolutely separate from her bariatric surgery,  
 25 which turned out to be the case. So that would

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1 be --  
 2 Q. So if --  
 3 A. That would be Point 1 in her history  
 4 and findings that this weight loss was not just  
 5 from bariatric surgery, but also from a serious  
 6 underlying illness unrelated to that. So.  
 7 Q. Okay.  
 8 A. And she's been taking -- she's being  
 9 medicated with significant doses of Lortab and  
 10 Flexeril, but she's still having pain, and simple  
 11 musculoskeletal pain is -- thank goodness, most  
 12 patients who have back pain, it's 90 percent,  
 13 probably, musculoskeletal. But you know what?  
 14 They start getting better in 72 hours. Even if  
 15 it's a partially herniated disc, they start  
 16 eventually getting better.  
 17 So the benign musculoskeletal causes of  
 18 back pain are almost always getting better within  
 19 a week or two. This is now many visits to a  
 20 number of doctors in a number of venues over two  
 21 months into her back pain, many medications, and  
 22 she's clearly not getting better and has striking  
 23 back pain, which is uncontrolled by strong  
 24 medications.  
 25 Also in the history is that she's not

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1 getting sleep at night because things get worse  
 2 at night. Typically, simple benign  
 3 musculoskeletal pain is better in bed unless you  
 4 happen to have the worst bed in the world. But  
 5 usually, musculoskeletal pain is worse when  
 6 you're up and about, standing prolonged, lifting,  
 7 moving things. But it's generally relieved by  
 8 any reasonably firm mattress that people lie down  
 9 on. Hers is apparently exacerbated in that  
 10 position, which sort of makes you think of  
 11 mechanical things, like any kind of a  
 12 space-occupying lesion, whether it be a  
 13 hematoma -- paraspinal -- or an abscess or a  
 14 neoplasm, benign or malignant.  
 15 So you have to think of -- of -- of  
 16 something space occu -- why does somebody have  
 17 two months of pain on many medications with  
 18 weight loss, which ought to make any  
 19 musculoskeletal pain or pain related to severe  
 20 morbid obesity better -- I mean, people weighing  
 21 500 pounds, as she did initially, getting down to  
 22 300 pounds, that should be dramatically better on  
 23 her back, and nobody, ever, in her history in the  
 24 emergency departments ever elucidated, or  
 25 attempted to, or drilled down on any previous

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1 history that she had of terrible back pain.  
 2 Nobody said that Brenda Carey had severe back  
 3 pain and described it and drilled into it and  
 4 talked about it. In the past -- and nobody ever  
 5 really did it appropriately, including  
 6 Dr. Goldman here, about the nature of it, the  
 7 duration of it, what relieves it. It never was  
 8 explored, really, or any past history. So those  
 9 things are initially, in the historical part of  
 10 Dr. Goldman's evaluation on 7/28, lacking and a  
 11 deviation from the standard of care in this  
 12 patient.  
 13 With respect to the physical, the  
 14 examination is -- is -- I can't say -- I mean,  
 15 the examination of this patient getting  
 16 significant medications, two months of pain,  
 17 including the vital signs, the examination is  
 18 roughly five lines and doesn't drill down into  
 19 anything. It says straight leg raise is  
 20 negative, and it says neurovascular in tact.  
 21 That doesn't cut -- that doesn't anywhere near  
 22 cut it for what the standard of care would  
 23 require when you're loading such a patient with  
 24 Lortab, Percocet, Flexeril, Ambien -- a month of  
 25 Ambien, which is not one of my favorite sleep

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1 medications because of the incidence of some  
 2 people getting --  
 3 Q. Dependency?  
 4 A. Well, dependency and disorientation and  
 5 forgetfulness. I mean, to give somebody a month  
 6 of Lortab, Percocet, Flexeril, and Ambien, that's  
 7 a heck of medication load and would lead anybody  
 8 to start becoming addicted to these things. And  
 9 this is two months into the course.  
 10 So by history and by physical, this  
 11 evaluation on this patient that's been seen by so  
 12 many members and so -- a number of times, too  
 13 many times, to not have explored really in depth  
 14 what was going on and start ordering tests, which  
 15 I think would have made a diagnosis. So it  
 16 doesn't meet the standard of care by history,  
 17 physical, by ancillary tests which should have  
 18 been done by, certainly, long before this.  
 19 And the discharge diagnosis should not  
 20 be pain management, refill on these addictive,  
 21 powerful drugs. It should be either -- it had to  
 22 be getting some imaging. Plain x-rays could be a  
 23 start; best would be a CAT scan, which was  
 24 available in the hospital; and even better would  
 25 be to get an MRI set up, which would be excellent

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1 for these; and consultation with appropriate  
 2 consultants, since nobody on the team felt it  
 3 necessary to conference her -- I mean, here  
 4 you've got a small group of doctors in a small  
 5 hospital with a three- to four-bed ER and nobody  
 6 is conferencing her after two months. This is  
 7 the kind of case you sit down and you order some  
 8 sandwiches for lunch and say, What's going on  
 9 with Brenda Carey? What are we doing here,  
 10 except medicating her and delaying a diagnosis?  
 11 So I think it's -- for each doctor whom  
 12 I'll talk about, and for the system in total,  
 13 this is an egregious deviation from the standard  
 14 of care with a serious diagnosis where it's  
 15 better to make a diagnosis for Non-Hodgkin's  
 16 lymphoma, or, if she had an epidural abscess,  
 17 certainly any of these things before she becomes  
 18 possibly incurable, or, if it were an epidural  
 19 abscess, has endocarditis on top it from  
 20 continuous vegetations of bacteria on a valve,  
 21 because that would be an another thing that  
 22 should be in a differential, and why you would,  
 23 way long ago, have done a sedimentation rate or a  
 24 C-reactive active protein, which almost every  
 25 orthopedist would order because they love that

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1 kind of test for this kind of patient, to  
 2 diagnose occult infections around the spine.  
 3 MR. LaPARL: Can we go off the record  
 4 for just a second?  
 5 THE WITNESS: Yes.  
 6 MS. MacGREGOR: Sure.  
 7 (An off-the-record conversation was  
 8 held.)  
 9 MR. LaPARL: Could we take a 5-minute  
 10 break? I just got a text message from my  
 11 daughter, whose car was not working, and I  
 12 need to get back with her. Is that okay?  
 13 MS. MacGREGOR: Sure, no problem.  
 14 (Recess)  
 15 EXAMINATION CONTINUED  
 16 BY MS. MacGREGOR:  
 17 Q. Let me ask you just a little more about  
 18 your background.  
 19 Have you worked in a clinic setting in,  
 20 let's say, the last 10 years?  
 21 A. In a clinic setting in the last 10  
 22 years... You mean --  
 23 MR. LaPARL: I'm going to object to the  
 24 form of the question.  
 25 Q. Okay. So have you practiced family

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1 medicine?

2 **A. In the last 10 years... Probably not in**

3 **the last 10 years.**

4 Q. All right. And have you acted as a

5 primary care physician in the last 10 years?

6 **A. I've taken care of a number of people.**

7 **I mean, I'm an internist, which is a primary care**

8 **physician. So is emergency medicine, and -- but**

9 **I've taken care of people, friends, and**

10 **prescribed medications and -- but, you know, this**

11 **is like, you know, once every three or four weeks**

12 **somebody says, What should I do? And I prescribe**

13 **medicine, I see them, but not in a formal**

14 **setting.**

15 Q. Okay. All right.

16 The idea of differential diagnosis,

17 you've mentioned that a couple of times, Doctor.

18 Would you agree that at -- well, tell me what you

19 think the differential diagnosis should have

20 been, or what should have been on that list for

21 this encounter of July 28, 2011.

22 **A. Well, I think from the get-go in a**

23 **patient, certainly after -- by the second or**

24 **third visit, when the patient, such as Brenda**

25 **Carey, is being seen and she's not getting**

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1 better, right out of the gate, an appropriate and

2 complete history needs to be obtained, like, Is

3 this like anything she's had? Has she had back

4 pain? And then the exam needs to be focused, and

5 in somebody with severe back pain it needs to

6 include a real neurological exam. I don't think

7 anywhere in any of the emergency medicine people

8 I'd be speaking about did anybody do an

9 appropriate neurologic exam, like would be

10 examined by the standard.

11 But what would the differential

12 include? The differential I sort of touched on

13 of severe back pain can include -- early on it

14 can include anything that's space occupying and

15 compressing important pain-generating parts of

16 the body, which would include nerves and the

17 spinal cord. And that could be significant

18 herniated disc and -- but that would be something

19 that would not be worse lying down, typically.

20 It would be more upright. It would be more

21 radicular.

22 And then, in the differential, the most

23 important things in space-occupying lesions,

24 which you have to consider, is the things that

25 cause space occupying, which could be a hematoma

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1 from bleeding. People can get spontaneous

2 bleeds. But usually, these things are not going

3 to last so long; they're going to get resorbed.

4 And then the two other things that

5 would be on the top of the list would be

6 infection versus neoplasm. Neoplasm being all

7 tumors, some of which could be benign, like

8 meningiomas; others, which are be malignant,

9 which can be the blood malignancies like, in this

10 case, or solid tumors, like cancers from lung,

11 from kidney, from whatever. And it can include

12 those organs that are nearby, like the kidneys,

13 the adrenal glands that sit on top of the

14 kidneys, the retroperitoneal space, like the

15 pancreas.

16 So, again, when you have severe pain

17 like this that's not only related to movement,

18 which is more classical of musculoskeletal, the

19 relatively nonlife threatening, musculoskeletal

20 pains are going to be like tears or injuries or

21 discs. And those are almost always going to be

22 if you don't move, you can often find positions

23 of relief, because they are what they are.

24 Musculoskeletal, they're related to the skeleton,

25 the movement of the skeleton. The non-benign

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1 things, like space-occupying lesions, the worst

2 being infection versus neoplasm, cancers

3 possibly, are going to be painful all the time.

4 They're going to give you pain when you're laying

5 in bed, which should be relieving it, or in --

6 it's going to be hurting all the time and

7 unrelenting, and medications are not going to

8 control it, and it's going to last for months and

9 months until it either kills you or eventually

10 gets diagnosed. And so that would be the

11 differential, the basic differential.

12 Q. Okay. And --

13 A. And the body -- the body -- just to

14 finish, the body is an open book. Any fool

15 practicing medicine can order an MRI. Some of

16 these tests get ordered too much. But this

17 patient needed it real early on, you know, by,

18 certainly, in June should have had imaging done.

19 And CAT scan was available in Aspirus

20 Ontonagon -- Ontonagon, I hope it got it, I think

21 I got it. A CAT scan was available. And the

22 best test would have been an MRI, because that

23 part of the body is very good for MRIs.

24 Q. Do you know how far she would have had

25 to go for the MRI, one that would accommodate her

Page 61

1 size?

2 **A. Well, you raise a good point: Her**

3 **size. It has to be sort of an open MRI. Even**

4 **for a CAT scan it has to be a special open**

5 **scanner.**

6 **If there's a zoo nearby, I mean, they**

7 **have them for elephants. I mean, I've sent**

8 **patients to zoos who are large and need to be**

9 **scanned. I don't know how the closest one -- but**

10 **this one was in Michigan, so it was probably**

11 **within 100 miles.**

12 Q. We don't have any zoos in the UP that

13 would have an MRI for an elephant or hippo or

14 something, and Marquette is two and a half to

15 three hours away.

16 **A. Well, this was May. She could have**

17 **even been flown, but I mean, it would have been**

18 **reasonable to go by ambulance.**

19 Q. Well, I don't know that they even had

20 flight service in 2011 to Marquette. But in any

21 event, okay.

22 All right. Just generally on that

23 differential that you listed, you listed a couple

24 of reasons why perhaps some of the items there

25 might not be on the top of the list; for example,

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1 disc.

2 In your opinion, was it necessary that

3 Dr. Goldman on this day take those steps

4 necessary to rule in or rule out each of those

5 items on the list?

6 **A. Yes.**

7 Q. Okay. So he had to -- so in terms of

8 the disc, the MRI would address that, correct?

9 **A. Yeah. I mean, that wouldn't have been**

10 **the top of my list, just because of the supine --**

11 **when she's in bed it hurts more. And -- and I**

12 **would have been a little -- I would have**

13 **looked -- I didn't see anybody ask or be**

14 **concerned: She had a dramatic weight loss within**

15 **a half a year of bariatric surgery. There's**

16 **something else going -- you have to wonder, you**

17 **know, why. It's not just the surgery, you know.**

18 **I think her weight loss was related to the fact**

19 **that there was something else doing on too that**

20 **caused her to have anorexia and weight loss.**

21 Q. Did you --

22 **A. So her picture, I would worry more**

23 **about abscess and neoplasm, tumors.**

24 Q. Okay. As far as weight loss goes, did

25 you recognize that she lost quite a lot of that

Page 63

1 weight before she had the surgery in January?

2 She maybe lost 35, 40 pounds --

3 **A. Yes.**

4 Q. -- beforehand?

5 **A. Yes.**

6 Q. And she was working hard to do that?

7 **A. Yes.**

8 Q. Would you expect somebody who had a BMI

9 of... let's see -- eighty... I think it was 84.

10 Let me just find it...

11 Yeah, a BMI of 84 in June 20th. So

12 she's 5-foot 2 --

13 **A. Five feet.**

14 Q. -- at one point I saw 5-foot 2, so I

15 gave her that --

16 **A. She was --**

17 Q. -- 5-foot 2, so I --

18 **A. She was 5-2, but she was 5-foot, she**

19 **said, at the time of all this.**

20 Q. Okay. And her weight was 461.5, and it

21 was actually Dr. Griffin in the weight loss

22 clinic who puts her BMI at 84.54 in August

23 of 2010.

24 Would you expect a person of 47 years

25 old to have musculoskeletal complaints related to

Page 64

1 her weight --

2 **A. Yes.**

3 Q. -- and body evidence?

4 **A. Yes. And certainly her knees.**

5 Q. And --

6 **A. Like she had a lot of knee problems**

7 **too, because she's carrying all that weight. And**

8 **she certainly could have musculoskeletal**

9 **problems; it wouldn't be a surprise.**

10 Q. Okay. And --

11 **THE WITNESS:** Could you just give me

12 one second, please? I just want to get a

13 little water.

14 **MS. MacGREGOR:** Sure.

15 (Off the record)

16 **BY MS. MacGREGOR:**

17 Q. Was it incumbent on Dr. Goldman in

18 June -- July of 2011 to also look into this knee

19 issue as to whether it is related to the back

20 pain that she's having?

21 **A. Oh, I don't think -- that's a -- that's**

22 **a stretch that I can't make. I don't think her**

23 **knee pain -- her knee pain is not a surprise that**

24 **it would be osteoarthritis and degenerative joint**

25 **disease from that weight, but it's not -- not**

1 related to this back pain.  
 2 Q. But on the other hand you're suggesting  
 3 that it would be unreasonable to conclude that  
 4 the pain she's having in her trunk is related to  
 5 osteoarthritis or degenerative changes, correct?  
 6 A. Yes.  
 7 Q. And that's for the reasons that you've  
 8 stated, particularly the other things that were  
 9 going on?  
 10 A. Yes. And I think -- I think you might  
 11 want to -- that you might include that in your  
 12 differential diagnosis. But the role of any  
 13 physician, and certainly an emergency medicine  
 14 physician, is to rule out  
 15 life-and-limb-threatening problems.  
 16 So there's nothing wrong with saying,  
 17 Well, maybe this is musculoskeletal. But when  
 18 it's not better, it's not getting better, it's  
 19 been going on for months, multiple encounters  
 20 with physicians or nurse practitioners, like  
 21 Jennifer Weaver, possibly, when it's continuing  
 22 and patients are breaking through on generous  
 23 medication, you can't -- you know, everybody can  
 24 say musculoskeletal on the first visit of a back  
 25 patient unless they are paralyzed. But if they

1 and meeting the standard of care, this is really  
 2 unacceptable to see a patient like this go this  
 3 long without having had an appropriate ancillary  
 4 test and consultations.  
 5 Q. Also, would you consider it surprising  
 6 that a patient who has lost 100 pounds, somebody  
 7 with this body habitus, that that person would be  
 8 having various aches and pains, or even pain,  
 9 severe pain, related to the change in her body  
 10 mechanics?  
 11 A. On the contrary, I would expect them to  
 12 be improved, because weight loss is better. It  
 13 makes you better.  
 14 Q. And does that take into consideration  
 15 the size of the pannus that she had that was  
 16 removed in September?  
 17 A. Well, she had the six -- she had the  
 18 65-pound pannus that went down to her ankles  
 19 almost, and certainly -- but she always had that.  
 20 And in fact she was heavier, and that would be  
 21 still out in front of her with more weight and  
 22 more stress on her back.  
 23 And, again, just the history -- and  
 24 histories are important -- and her history is  
 25 that she's better standing up and she's worse

1 don't have anything obvious on a good exam, it's  
 2 okay to say musculoskeletal on a first visit,  
 3 because that's reasonably safe, but not on  
 4 multiple visits and over periods of weeks and  
 5 months in this case. No, it's not acceptable.  
 6 You need to look for, and start ruling out,  
 7 potential limb-or-life-threatening processes.  
 8 Q. Are you familiar with any guidelines  
 9 or -- not protocols, um... algorithms, I guess,  
 10 with regard to the assessment of back pain?  
 11 A. I'm not -- I don't use any algorithm; I  
 12 use, you know, what, clinical practice of  
 13 45 years and what I know from my practice and  
 14 from my reading and attending meetings. And  
 15 there's no protocol that would allow -- there's  
 16 no ethical protocol that would allow anything  
 17 other than what I'm suggesting should have been  
 18 done long before July 28th.  
 19 Q. All right. In terms of imaging, are  
 20 you familiar with any sort of protocol or  
 21 algorithms or guidelines relative to when it's  
 22 appropriate to image a patient with back pain?  
 23 A. No, I'm not familiar. And those are --  
 24 publications or papers on this are nice, but I  
 25 think any clinician who's doing the right thing

1 lying down, so how does that equate to somebody  
 2 carrying around a 65-pound anchor in front of  
 3 them? She should be better lying down. And, in  
 4 fact, clearly it's enunciated that she wasn't  
 5 because of this anatomical mass, this tumor that  
 6 was against her spine and wrapping around her  
 7 spine, in fact from around T-2 and T-8, and  
 8 eroding T-5 when x-rays were obtained there.  
 9 So no, I think the pannus -- her weight  
 10 down, she should have been doing better. She  
 11 should have less reason to have that kind of more  
 12 benign musculoskeletal pain. And no is the short  
 13 answer.  
 14 Q. Okay. Thanks.  
 15 Have we covered your criticisms of the  
 16 July 28th visit fairly --  
 17 A. Yes.  
 18 Q. -- so far?  
 19 A. I believe so.  
 20 Q. Okay. Let's go to the next encounter  
 21 with an ER physician.  
 22 A. The next encounter would be --  
 23 Q. Or in the ER, yeah.  
 24 A. In the ER would be probably the 8/9  
 25 admission with Dr. Chaltry, it looks like.

1 Q. All right.  
2 A. **Let me just get to that.**  
3 **(Pause)**  
4 Q. That's the day that she got a Toradol  
5 shot.  
6 A. **Yeah, I'm trying to get to that.**  
7 **He also saw her on 8/10, but that's in**  
8 **the family practice clinic.**  
9 Q. Right. So for the record, I am not  
10 really sure that he saw the patient this day. I  
11 believe he just sent her over there for the shot.  
12 A. **That makes sense, because I know that's**  
13 **an encounter, but I don't -- I'm not seeing**  
14 **something that says "ER" for that.**  
15 **All right, I'll accept that.**  
16 Q. Do you have any issue with just the  
17 idea of sending a patient to the ER for a pain  
18 shot, independent of the indications?  
19 A. **Well, it's -- it's basically it's**  
20 **after -- all of the -- again, it's a failure --**  
21 **all of this boils down to the failure for him,**  
22 **after all the time now that he's following her,**  
23 **since May 17th and is seeing her and is her**  
24 **doctor, it's the fact that despite the**  
25 **medication, despite the pain going for three**

1 Q. All right. And then I think the next  
2 ER visit -- and correct me if you know  
3 differently -- but I think that would be the  
4 visit of the August 21st --  
5 A. **Right.**  
6 Q. -- of 2011?  
7 A. **Yes. Maura Manning, right.**  
8 Q. -- that she was seen -- right.  
9 Tell me what your criticisms of that  
10 one are.  
11 A. **Yeah, and I just found the 8/9 visit**  
12 **for the shot. I just found that.**  
13 **(Pause)**  
14 **I'm looking, since I found the 8/9**  
15 **visit. I mean, her pain was 8/10 at that time,**  
16 **so that's reasonably severe pain, and he's**  
17 **sending her for a shot.**  
18 **Okay. I'm on the 8/21 visit of the**  
19 **Dr. Maura Manning. And...**  
20 Q. The chief complaint was?  
21 A. **Constipation.**  
22 Q. All right.  
23 A. **And I'd say that's probably from all**  
24 **the medications she was getting. I think I read**  
25 **somewhere that the bariatric service -- in all my**

1 months now, despite the failure of anybody to  
2 drill it and take an appropriate history and  
3 appreciate its clinical significance, the failure  
4 of anybody to do a neurologic appropriate exam  
5 and -- including a real appropriate neurologic  
6 exam and appreciate its significance, the failure  
7 of any imaging or ancillary tests, it's  
8 inappropriate just to send this patient for a  
9 shot.  
10 If he's going to send her somewhere, it  
11 should have been to an orthopedist, a  
12 neurologist, a neurosurgeon, at another hospital,  
13 because she was basically an elephant in the room  
14 where a number of providers are feeling one leg,  
15 one tail, one side. Nobody knew it was an  
16 elephant in their hospital. They were moving  
17 this elephant between the ER and the clinic, and  
18 nobody knew it was an elephant. She was like  
19 basically a large lady in a box that they refused  
20 to find the key to of what was going on with her.  
21 So, yeah, I have an issue with him  
22 giving her an IM shot of Toradol because she's in  
23 that much pain. It's a reflection of the fact  
24 that she had severe pain still, after three  
25 months.

1 reading, I think -- I think I saw that the  
2 bariatric service wasn't happy about her getting  
3 all the narcotic-like medications.  
4 But this -- her constipation could well  
5 have been most likely from the narcotic-like and  
6 other medications, plus her obvious increased  
7 immobility from the pains that she was having.  
8 And it's amazing that she survived it, actually,  
9 in my opinion.  
10 But, you know, I think here,  
11 Dr. Manning is in this same, small hospital with  
12 all the records available to her, and she -- the  
13 best she can do with this patient on Percocet,  
14 Ambien, Flexeril, the shot of Toradol, and  
15 everything, the best she could do is to write a  
16 two-page report, not review the old records --  
17 patient had a pulse of 118, which is elevated; a  
18 respiratory rate of 20, which is the upper limit  
19 of normal. Anybody at continually 20 would be  
20 abnormal to breathe. Most of us breathe at 12 to  
21 14 regularly. So she's got abnormal vital signs  
22 to a degree, she's having constipation, and she's  
23 got this history now of over three months of  
24 undiagnosed, really unexplored, unevaluated,  
25 actually, back pain. And the sum of her review

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1 of systems is -- her neurologic exam, her history  
 2 is no headache. I'm not sure why she's asking  
 3 about a headache in this patient who's there, in  
 4 quotation marks, for constipation, close  
 5 quotation marks. I'm not sure why she's not  
 6 asking about a whole bunch of other neurologic  
 7 things. And her neuro exam says no focal neuro  
 8 deficits in this patient with abnormal vital  
 9 signs and three months of pain.  
 10 So I -- ah -- ah -- and if she's really  
 11 impacted or constipated from medication, I would  
 12 have thought that it would have been -- she might  
 13 have been disimpacted digitally with a rectal, a  
 14 rectal glove. Because usually, when patients are  
 15 constipated like that -- I think it was eight  
 16 days or something -- you can feel a mass of stool  
 17 at the anal orifice that you can disimpact.  
 18 So, again, it boils down to a doctor in  
 19 the geographic area of this small hospital who  
 20 doesn't take the time to pull the old records on  
 21 this patient, who is obviously a frequent flier  
 22 to the clinic and the ER, with an unresolved  
 23 severe symptom, none of this related to bariatric  
 24 surgery. It's a failure to do the appropriate  
 25 history and drill into it; a failure to do the

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1 appropriate physical, including a real neuro; and  
 2 a failure to appreciate the clinical significance  
 3 of the fact that this patient is still an  
 4 undiagnosed serious, potentially  
 5 life-and-limb-threatening problem.  
 6 Q. So, Doctor, are you suggesting, or is  
 7 it your opinion that the standard of care under  
 8 these circumstances require Dr. Manning to assess  
 9 the patient more broadly than just for the chief  
 10 complaint that she came in for?  
 11 A. If somebody comes in with constipation  
 12 and they're absolutely fine otherwise, and they  
 13 don't have the history and they're not as complex  
 14 as this patient with her problems and her  
 15 surgery, then you can just give them -- you know,  
 16 you can do a brief, general exam. The  
 17 differential diagnosis doesn't have to be, you  
 18 know, explored in depth. You can ask them if  
 19 they've had constipation in the past, how often  
 20 do they have bowel movements, how many days do  
 21 they go, is this very unusual. None of that do I  
 22 see explored. So she's just giving her some  
 23 laxatives and trying to evacuate her, so it's not  
 24 acceptable.  
 25 I mean, she didn't explore the history,

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1 she -- this woman has a history, and she hasn't  
 2 had a bowel movement for ten days. The history  
 3 is that she's taking a ton of medicines that will  
 4 constipate her. And the history is she's taking  
 5 those medications for back pain. And none of  
 6 this is in the review of systems, is in the  
 7 history of the present illness -- I'm going to  
 8 look at it again. I've got a few marks on it.  
 9 I mean, the idea that she writes, Some  
 10 right flank pain, give me a break. She was just  
 11 in there -- she's been on narcotics, Flexeril,  
 12 and had a shot of Toradol in that same ED a  
 13 couple of weeks ago, and the pain is still there,  
 14 because it was there after and it was there  
 15 before. This is not some flank pain; this is a  
 16 severe pain that's persistent.  
 17 So she -- she did what she did. It  
 18 doesn't meet the standard of care at all in my  
 19 opinion regarding history, the total patient, the  
 20 exam, the neuro exam, which is -- does not meet  
 21 any standard of care with what should have been  
 22 done.  
 23 Q. Do you have -- what is your assumption  
 24 with regard to the availability of past medical  
 25 records?

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1 A. From what I read in deposition  
 2 testimony, they're available if requested.  
 3 Now, I'm looking -- you know, I mean, I  
 4 know it -- usually in small hospitals you can get  
 5 anything easier than you can in big hospitals.  
 6 Q. When have you last worked at a critical  
 7 access hospital?  
 8 A. A what? A critical access?  
 9 Q. Right, that's fewer than 25 beds.  
 10 A. Hospital, that would be when I was  
 11 director of the emergency department in South  
 12 Amboy, which would have been around the year 2000  
 13 or so, I think, when I was at Memorial Medical  
 14 Center. That was -- let me see where that would  
 15 have been...  
 16 That would have been '98 to '99. It  
 17 was a small hospital in the middle of a bunch of  
 18 big hospitals that ultimately went out of  
 19 business about nine months after I got there.  
 20 But that was a small ER, a small hospital. You  
 21 know, that would be that kind of hospital.  
 22 Q. So in your opinion, under these  
 23 circumstances it was -- the standard of care  
 24 required Dr. Manning to review past medical  
 25 records, correct?

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1 A. Yeah, to take a good history and  
 2 realize that -- that -- an appropriate history,  
 3 and realize this is not just constipation in an  
 4 otherwise absolutely normal person.  
 5 Q. But the question was: It was required  
 6 by standard of care for her to pull the old  
 7 charts?  
 8 A. Well, to take the history, which would  
 9 have then led to the old charts.  
 10 Q. So she -- after having taken a history  
 11 from the patient, she would have been required to  
 12 look at records, past records, correct?  
 13 A. Yeah. I mean, this is not  
 14 somebody that she has been having some right  
 15 flank pain; this is somebody who has been taking  
 16 major medications for three months for this pain,  
 17 was in for a shot of Toradol with 8/10 pain sent  
 18 in by her doctor to the ER. This is not -- this  
 19 is not just benign constipation in a 90-year-old  
 20 lady from the nursing home who's otherwise okay.  
 21 Q. Was it Dr. Manning's role or  
 22 responsibility on that day to explore the  
 23 etiology of the chief complaint, why she was  
 24 having the constipation?  
 25 A. Yeah, sure. I mean, every doctor is

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1 supposed to do what's right, this patient who's  
 2 been having back pain unexplained for three  
 3 months, yes.  
 4 Q. Were there tests that Dr. Manning  
 5 should have done to determine the cause, the  
 6 etiology, of the constipation?  
 7 A. Well, I think if he did the history and  
 8 a complete exam, it would have been reasonable to  
 9 lead her to get some imaging or to admit her or  
 10 set up the following day for her to see if she's  
 11 still having this pain, for her to see an  
 12 orthopedist or a neurosurgeon or a neurologist  
 13 the following day.  
 14 But, yeah, she could have gotten -- it  
 15 would have been not unreasonable for her to admit  
 16 the patient too, if after speaking to  
 17 Dr. Chaltry, saying, Dr. Chaltry, whom she  
 18 obviously had to know, because this is a small  
 19 group of physicians in this sort of close  
 20 practice, she could have called Dr. Chaltry and  
 21 said, I have your patient here and she still has  
 22 back pain after three months; I'm not sure what's  
 23 causing it; have we really worked it up? That  
 24 would have been a reasonable call. And then they  
 25 could have said, Well, let's admit her now, or,

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1 Let's get a CAT scan now, or, Let's have her come  
 2 in tomorrow, let me call radiology and see what  
 3 kind of imaging they recommend; not to just give  
 4 her MiraLAX and assume, you know, it's nothing.  
 5 This is not an otherwise benign, normal patient.  
 6 Q. What do you believe was the most likely  
 7 cause of the constipation?  
 8 A. Probably decreased mobility and the  
 9 medication she was on.  
 10 Q. So are you telling us that  
 11 notwithstanding the fact that the patient  
 12 presented for constipation and left the ER  
 13 better, that it was Dr. Manning's responsibility  
 14 to also get in there and explore and essentially  
 15 manage the back pain issue?  
 16 A. Yeah, it might be a little  
 17 metaphorically like getting a chest x-ray on  
 18 somebody who comes in during the flu season with  
 19 a cough, in the middle of the flu season comes in  
 20 with a cough and has some fever, and so you get a  
 21 chest x-ray, and it doesn't show pneumonia,  
 22 because bronchitis usually just gives you  
 23 increased markings. It doesn't show you  
 24 pneumonia, but there's a 3-centimeter lesion in  
 25 the lung. It's like saying, Well, you don't have

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1 pneumonia, you can go home, and not dealing what  
 2 you're looking for, pneumonia, when you've got a  
 3 lesion.  
 4 You know, this is a lady -- you know, I  
 5 talked a little bit about the axiom of three  
 6 visits; you have to have a reason not to admit  
 7 somebody because you're missing something. This  
 8 lady has been in that system for three months on  
 9 8/21 without an explanation of what's going on  
 10 with her back. I don't think it would have taken  
 11 too many questions to elicit -- I think any  
 12 medical student would have elicited a history  
 13 of -- here, it says, "Constitutionally, patient  
 14 is normal in fairly good health." I mean, what  
 15 kind of a remark is that in this patient? That's  
 16 like a -- you know, that doesn't -- this patient  
 17 has not been constitutionally normal for three  
 18 months. She's had more weight loss than she  
 19 might have been -- that one would expect quickly,  
 20 and she's got severe, continuous back pain.  
 21 She's not --  
 22 Q. Well, how would -- I'm sorry, go ahead.  
 23 A. -- in fairly good health.  
 24 She's on all sorts of narcotics, muscle  
 25 relaxants, sent in for 8/10 pain within two weeks

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1 of this visit, less than two weeks, in that same  
 2 ER, and a neuro exam that doesn't -- a neuro  
 3 exam, no headache, history, that's neither here  
 4 nor there. That's not -- you know, this is not  
 5 the history of what this patient was on that day.  
 6 I mean, she's got down that the patient  
 7 is on Percocet, Ambien, and Flexeril. I mean,  
 8 you know, why is she on those medicines? There's  
 9 no reason in her history of the present illness.  
 10 That's unexplained anywhere, why she -- in this  
 11 history and review of systems there's no  
 12 explanation of why this patient is on Percocet,  
 13 Ambien, and Flexeril.  
 14 Q. So on this day, in your opinion, among  
 15 other things, Dr. Manning should have  
 16 hospitalized the patient?  
 17 A. Dr. Manning wrote two pages that  
 18 signify nothing about what this patient's problem  
 19 was and gave her some Ex-Lax. And she should  
 20 have actually taken a meaningful history and done  
 21 a meaningful exam, and then she would have known  
 22 that this patient is still with symptoms of  
 23 severe back pain, only two weeks earlier sent to  
 24 the ER by her doctor for a shot of 60 milligrams  
 25 of IM Toradol.

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1 If she drilled into that, she would  
 2 know that just because the whole forest wasn't  
 3 burning there was a fire going on here that  
 4 needed to be put out, that she needed to  
 5 attend -- she didn't need to write, you know, two  
 6 pages that signify nothing. She didn't address a  
 7 pulse of 118 that wasn't repeated. That's an  
 8 abnormal pulse. She didn't address an  
 9 respiratory rate of 20, which is the upper limit  
 10 of normal.  
 11 And she -- somebody, somewhere within  
 12 this system needed to finally do what was  
 13 required. None of them did. The whole system  
 14 failed. And each individual doctor taking care  
 15 of her in that ER failed, and this is another one  
 16 of them.  
 17 Q. As far as the neuro exam that was  
 18 required on this day, can you give me -- kind of  
 19 tick off the various tests that should have been  
 20 done?  
 21 A. You know, there's a --  
 22 Q. I mean, are you talking about a  
 23 complete neuro exam or what?  
 24 A. You know, there's a system, and I'm  
 25 sure that you've encountered it, the T-system.

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1 Q. Right.  
 2 A. I haven't looked at it for this case.  
 3 I was part of the beta testing of it when it  
 4 first came out. A couple of smart guys in the  
 5 '80s, one, I think, from Canada and one from the  
 6 Dallas area, and they're very wealthy, because  
 7 it's a good system that was accepted by probably  
 8 a quarter or a third of emergency departments. I  
 9 haven't looked at it in a while, but if you look  
 10 at the back pain the sheet, the T-system sheet,  
 11 I'm willing to -- having not looked at it, I'm  
 12 willing to say there's a reasonable neurologic  
 13 exam for severe back pain.  
 14 Q. Okay.  
 15 A. And it would include a neurologic exam.  
 16 In my opinion, what the exam should be, well, it  
 17 should ask about numbness; tingling; weakness;  
 18 focal weakness, one side or another; upper versus  
 19 lower extremity weakness, which can be important  
 20 in things like myasthenia gravis or other  
 21 syndromes and motor symptoms.  
 22 One up the doctors talked -- I think it  
 23 was Dr. -- well, I forget specifically, was  
 24 talking about vitamin deficiencies. I mean, give  
 25 me a break. I mean, that's like -- you know, he

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1 was doing a metabolic workup. There's no  
 2 metabolic workup for back pain. You know,  
 3 there's a neurologic workup. I mean, I know  
 4 about metabolic diseases as an endocrinologist, I  
 5 think, and I know -- he talks about vitamin  
 6 deficiencies. This is not scurvy; this is not a  
 7 vitamin D deficiency; she doesn't have  
 8 osteoporosis. In fact, she's pretty well, other  
 9 than having had non-Hodgkin's lymphoma.  
 10 But the neurologic is focality, left or  
 11 right side, upper or lower extremities.  
 12 Weakness, what's a weakness? "Weakness" is  
 13 defined -- when you seriously look for weakness,  
 14 5/5 strength is normal; 0/5 is not. When the  
 15 first appropriate strength exam was done, like in  
 16 the end of October by -- I'm not sure -- I  
 17 couldn't tell. It was probably not a physician;  
 18 it was probably some mid-level person doing  
 19 physical, left, right, 5/10, she had three --  
 20 rather 5/5, she had 3/5 strength in her lower  
 21 extremities. Abnormal.  
 22 So that's what a neurologic should  
 23 include, including sensory mode of vibratory  
 24 positional sensations. You stroke -- you take --  
 25 and I'm -- it takes me maybe 5 minutes to talk

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1 about it; it takes me 15 seconds to do it. I  
2 break a tongue blade, I stroke the legs, I see if  
3 it's symmetric, I see if sensation is decreased.  
4 I stroke the cheeks and I see if sensation is  
5 symmetric and decreased. I ask them to look up  
6 and look down, to smile, to look at the nerves,  
7 the cranial nerves. And I check proximal and  
8 distal strengths: extend the fingers and see if  
9 you can contract them; make a wrist, dorsiflect a  
10 wrist; have somebody stand up, see if they can  
11 stand on one leg and the other; have them walk a  
12 straight line on a crack in the hospital floor to  
13 see if they have positional and cerebella brain  
14 stem findings; finger-nose or toe-nose touch to  
15 see strength, and also positional.  
16 These things take -- I just said what  
17 it takes. Reflexes of the ankles and the knees,  
18 knee jerks, which -- spasm, if you take and push  
19 the foot back all the way, dorsiflect it, you can  
20 see clonus in people with spinal injuries. So  
21 how long did I take to say that? Probably a  
22 minute, possibly. Probably less. And it takes  
23 me, if you've an experienced physician who knows  
24 what you're doing, starting from the head, where  
25 I like to start, to the toes, or, as I've watched

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1 some young doctors when I was precepting them so  
2 they could take their boards, sometimes they'd  
3 start in one leg and go to one arm and then they  
4 would go back to a leg. I look for the organized  
5 approach, but it takes literally less than a  
6 minute to do it. It wasn't done by any of these  
7 emergency medicine providers. Nobody  
8 described --  
9 Q. And it --  
10 A. -- it. Nobody, until October 26th, I  
11 think, at the end, just before she was sent to  
12 Marquette, nobody did a 5/5 strength in somebody  
13 who ultimately came in saying her legs were mush.  
14 She couldn't stand up. Her husband couldn't get  
15 her up off the floor. She came in by ambulance,  
16 at which time they still watched her for two days  
17 before sending her to Marquette, which is a  
18 particularly critical period, which is when the  
19 cords is really being compressed, and that's the  
20 most critical end period. But all these periods  
21 are critical, because the earlier the better,  
22 always, in anything we treat.  
23 So that's why this exam, this history,  
24 this absence of doing anything that needed to be  
25 done by the standard of care, that's why it's all

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1 a deviation. It doesn't meet the standards.  
2 It's not -- it doesn't meet the minimal that  
3 should have been done.  
4 Q. If a neuro exam, as you have described  
5 it, had been done on August 21st, what do you  
6 expect it would have shown?  
7 A. I know what should be done; I don't  
8 have a crystal ball to see what would be done. I  
9 can't say if it would have been abnormal on  
10 August 21st or not, but I do believe that if  
11 appropriate imaging, namely a CAT scan, would  
12 have been done, it definitely would have been  
13 abnormal. And the history would have clearly  
14 been abnormal.  
15 What the physical would have been, I  
16 can't honestly say, but I know the history would  
17 have been abnormal, and it would have -- it would  
18 have led to an admission somewhere, if not here,  
19 then elsewhere at a higher level of care. And a  
20 CAT scan could have been done there, and it would  
21 have been abnormal.  
22 Q. Is it your opinion that on this date  
23 she did have lymphoma that was causing symptoms?  
24 A. Yes. Yes, very much so. I don't ever  
25 say 100 or never, but this is a 99.9 percent

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1 there would have been masses of lymphadenopathy.  
2 You know, at the very late part of her  
3 course, before she got to Marquette, she had  
4 swelling in her feet. I don't see anybody else  
5 who commented in the depositions, or was it  
6 asked, but the reason she had pedal edema towards  
7 the end was because she had a big massive  
8 lymphadenopathy at the end. She had a lot of  
9 swollen lymph glands, and that's a cause of fluid  
10 not getting up from the lower extremities against  
11 gravity because of the compression of significant  
12 adenopathy.  
13 Non-Hodgkin's diffuse B-cell lymphoma  
14 causes big lymph gland enlargement, big nodes,  
15 like I think she -- like she had. And that can  
16 obstruct -- that in the pelvis and in the body  
17 can block the venous return and the lymphatic  
18 return, contributing to pedal edema, which I  
19 don't see anybody having addressed in the review  
20 of this material.  
21 Q. Do you know, Doctor, how non-Hodgkin's  
22 large B-cell diffuse usually presents, what's the  
23 early symptoms of that?  
24 A. Well, it can present with fevers, like  
25 most lymphomas, but not necessary -- and, by the

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1 way, most of the doctors weren't checking the  
2 fevers, really, and when you really want to check  
3 a fever, you need to do a core temperature, like  
4 a rectal temperature, and sometimes they weren't  
5 even done. So you can have fever.  
6 She did present once diaphoretic,  
7 sweaty. I don't know what her real temperature  
8 was, but you can have a fever. You certainly,  
9 with lymphomas, have anorexia and weight loss.  
10 And then a lot of lymph tissue can be -- you can  
11 find it -- it can be anywhere. It can be --  
12 thank goodness in her, as far as I know, she  
13 didn't have it in the brain, in the central  
14 nervous system, because that's a big deal, a  
15 different disease sort of almost.  
16 But you can have a lot of adenopathy in  
17 the inguinal areas. You can have splenomegaly,  
18 which might be difficult to feel in a large  
19 person, to feel the spleen under the left rib  
20 cage. And you can have pains anywhere, depending  
21 on where the big lymph nodes are compressing  
22 tissue, nerves. And in her case, it actually  
23 eroded her vertebral body. The mass of growing  
24 lymph tissue, lymphadenopathy, constant pressure  
25 on any bone will ultimately cause it to erode.

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1 And so she had, by the x-ray, I think  
2 on 10/26, possibly, that Nurse -- PA -- PN, Nurse  
3 Practitioner Weaver, Jennifer Weaver, ordered the  
4 first lab tests, as I recall -- and I'm not  
5 looking at her records, but I don't think I'm  
6 speaking out of turn by saying she ordered that  
7 and she ordered the x-rays which showed the  
8 collapsed vertebrae. Then you don't have an  
9 elephant in the room; you have a heard of  
10 elephants, when you see a collapsed vertebra with  
11 this kind of pain history. You know, why they  
12 were keeping her, unless they wanted to have a  
13 heard of elephants in their hospital for a couple  
14 of days longer, why they kept her, I have no idea  
15 at that point, rather than sending her to  
16 Marquette or some other large medical center.  
17 Marquette, I guess, was the most appropriate,  
18 since she had surgery there.  
19 Q. And --  
20 A. So, you know, nobody --  
21 Q. Go ahead.  
22 A. Yeah, sorry. No, I'm done.  
23 Q. Okay. As an endocrinologist, do you  
24 appreciate that a person who goes through  
25 bariatric surgery does have nutritional -- is at

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1 risk for nutritional deficiencies?  
2 A. Well, I don't think I have to be an  
3 endocrinologist to know you can have nutritional  
4 deficiencies. I think any general practitioner  
5 should know that, that a bypass of the  
6 gastrointestinal tract, you need to worry about  
7 nutritional deficiencies. You don't have to be  
8 an endocrinologist -- I think I know a little bit  
9 more, but I think the standard of care for any  
10 physician would be expected to know that.  
11 Q. Right. Okay.  
12 And that surgery also can dramatically  
13 affect a person's bone, vitamin D, and calcium --  
14 A. Yeah.  
15 Q. -- retention?  
16 A. Yes.  
17 Q. Right. Is it reasonable for a  
18 physician to conclude that the compression  
19 fracture is potentially a result of this  
20 patient's body habitus and the nutritional impact  
21 of her bariatric surgery?  
22 A. No, I don't think --  
23 MR. LaPARL: Asked and answered.  
24 A. I -- again, I don't think -- number 1,  
25 this woman was 47, 48, and she's not a

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1 60-year-old. And the surgery was in January of  
2 this year, so when she's coming back, five,  
3 six months later, I think that's -- this is, as  
4 an endocrinologist and a metabolism physician in  
5 the past, and not forgetting that, that's sort of  
6 early to be developing osteoporosis. You don't  
7 develop osteoporosis that promptly. I mean, you  
8 can develop it with multiple myeloma, which is  
9 another bad blood disorder that kills people --  
10 we've gotten a lot better at treating that now,  
11 but it used to kill people, half the people, in  
12 two years. That can give you collapse of a  
13 vertebra.  
14 But no, vitamin or mineral  
15 deficiencies, I don't think that would be  
16 consistent being five months out, six months out,  
17 seven months out from bariatric surgery in a  
18 47-year-old woman, 48-year-old woman. You've got  
19 to think of bad things, like abscesses and  
20 tumors, including multiple myeloma, or  
21 non-Hodgkin's lymphoma, or some other  
22 space-occupying lesion.  
23 And the fact that her vertebral body  
24 was seen on a plain x-ray, it would have been  
25 much more dramatic on a CAT scan. So the bottom

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1 line is, you can't accept, in somebody with this  
2 course, this history, you can't accept that it's  
3 something benign, and you can't sit back on your  
4 haunches in laziness and intellectual lack of  
5 curiosity, you can't sit back until you've  
6 excluded the life-and-limb-threatening disorders.  
7 Then you can say, Well, whatever wastebasket  
8 thing I want to call it -- just like chronic  
9 fatigue syndromes or posttraumatic stress, you  
10 need to rule out the critical things that could  
11 cause that, and then you say, Well, what do we  
12 call it? Maybe just so me -- maybe somehow  
13 related to her bariatric surgery. Not right out  
14 of the gate. You first need to do the  
15 intellectual work and order the tests or send the  
16 patient to someone or somewhere where they will.  
17 Q. All right. Well, let's now go to the  
18 next encounter in the ER, or by an ER physician,  
19 and I would suggest that's probably September  
20 22nd.  
21 A. Yeah, Dr. Austin.  
22 Q. Okay.  
23 A. Well, here's another one of the  
24 doctors -- well, do you want to ask me a  
25 question, or do you want me just to...

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1 Q. Yes -- well, same question. So tell me  
2 what your criticism is of this encounter.  
3 A. Well, here she comes in, it says  
4 presents -- she's run out of pain medication and  
5 sleeping pills. This is a 48-year-old woman,  
6 47-year-old woman. She's run out of her pills.  
7 Let me get it straight. What is it...  
8 she's born in '63... '73, '83, '93...  
9 Q. She's 48.  
10 A. 48. Just to be precise, she's a  
11 48-year-old woman. She run out of pain medicines  
12 and sleeping pills. She presents for evaluation.  
13 She's seen by home nursing. And then he's  
14 talking about her -- she just recently had her  
15 pannus, 60 pounds of so of pannus, removed of the  
16 skin and remaining fat, and will place her --  
17 she's got some erythema around the margins of the  
18 wound, so what he's doing is he's giving her a  
19 gram of Rocephin a day for five days, and he's  
20 giving her another order of Lortab and Ambien and  
21 follow up with her own doctor.  
22 I don't know what that's about. I  
23 mean, you know, this is no history, no exam; more  
24 Lortab and Ambien, and he's doing some regime of  
25 Rocephin, IV or IM. It doesn't specify right

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1 there. I don't know what kind of medicine that  
2 is. It's like sending the patient for the shot  
3 of Toradol by Dr. Chaltry, sending her with 8/10  
4 pain that's been going on for months. You know,  
5 this is intellectually dishonest, lazy,  
6 illogical, intellectually empty medicine. This  
7 is -- this is like -- I don't know what it's  
8 like, but it doesn't resemble anything that I  
9 would call standard of care. It is sort of  
10 really egregious.  
11 Q. Okay. So --  
12 A. This kind of lack of -- lack of  
13 intellectual curiosity. And, you know, I can't  
14 imagine what was going on in this small ED at  
15 those times that was more important than this  
16 patient.  
17 Q. Do you acknowledge that her chief  
18 complaint was that she was worried about her  
19 surgical site, possibility of infection, on the  
20 nursing note?  
21 (Pause)  
22 That's what she presented for?  
23 A. Yeah.  
24 Q. And based on the record, Dr. Austin did  
25 examined that and did conclude that a course of

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1 Rocephin rather than the Keflex might be  
2 appropriate?  
3 A. Yeah, I think a lot of infectious  
4 disease people would say that doesn't meet the  
5 standard of care, and that's sort of a shotgun  
6 and it's why we have resistance to second- and  
7 third-degree cephalosporins, and it's -- and  
8 Rocephin, if he's really worried about a wound,  
9 you have to wonder about methicillin-resistant  
10 Staphylococcus, which Rocephin wouldn't cover.  
11 You would wonder about giving her maybe instead  
12 of the shots, however he gave them, you would  
13 wonder about giving something like Septra, which  
14 would be good for methicillin-resistant staph.  
15 So it's not really logical, and he  
16 doesn't really describe the wound, other than  
17 some erythema around the margins of the wound.  
18 A lot of wounds can have erythema. Erythema  
19 doesn't equate to an infection that requires  
20 Rocephin. And if you did worry about it, you  
21 would start worrying about methicillin-resistant  
22 staph. And I don't know that he did any culture  
23 of any drainage. He doesn't talk about bad  
24 drainage. He says there's no fever, but I don't  
25 see a temperature anywhere recorded. Do you? I

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1 mean, I haven't seen a temperature, and it says,  
2 "No fever."  
3 Q. The temperature is in the nursing  
4 notes.  
5 A. Yeah.  
6 Q. As is -- the temperatures throughout  
7 the clinic record are recorded on the log at the  
8 beginning of the chart. And she had no fever.  
9 A. Right. Okay.  
10 Q. So what I'm hearing is --  
11 A. Yeah.  
12 Q. Go ahead.  
13 A. So I think, again, this is a patient  
14 who -- this is -- her presentation is the tip of  
15 an iceberg, and it wouldn't require a lot of  
16 question, or looking, to realize where the rest  
17 of her problems were. And so it's an inadequate  
18 history, an inadequate exam, a lack of addressing  
19 the real problem. Refilling a prescription for  
20 meds now, in September, that's now five months  
21 of -- that she's getting these medicines for  
22 problems that have been unexplored still.  
23 Q. So what you're saying, I think, is that  
24 he clearly missed the boat, in your opinion,  
25 relative to meeting standards of care for

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1 treating this wound issue?  
2 A. Yes.  
3 Q. But it sounds like you're also saying  
4 that he had an obligation to go beyond the chief  
5 complaint and explore her general medical  
6 condition, her back pain?  
7 A. Yeah, I mean, the thing -- why is she  
8 taking so much Lortab and Ambien? Why is she  
9 being seen so much? All of this -- I mean, this  
10 is a small group. I mean, it doesn't seem like  
11 they're speaking to one another or aware of the  
12 fact that a patient continues to come back to  
13 these few, five, six, seven doctors at most, and  
14 none of them are putting 1 and 1 together to  
15 get 2.  
16 Q. Does it make any sense, Doctor, that  
17 having had a panniculectomy nine days earlier,  
18 that she would be on Lortab?  
19 A. Well, she's been on it continuously.  
20 If you look -- you know, he needs -- the history  
21 is, How long have you been on Lortab? And she's  
22 been on Lortab since before any panniculectomy.  
23 And then, Why are you on the Lortab? Is it --  
24 well, I'm having severe back pain, still. Or is  
25 it -- you know, he's not describing any pain

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1 around. He's saying the abdomen is soft. That's  
2 not consistent with having pain requiring the  
3 Lortab. He described a soft abdomen in the  
4 little he's described.  
5 Q. And was Dr. Austin required to do a  
6 neuro exam on this day?  
7 A. Any doctor who's seeing this patient  
8 with this history that's readily available, from  
9 everything I see and know about Brenda Carey is  
10 she was intelligent enough and concerned  
11 enough -- ultimately, she was telling providers  
12 in late October that something is being missed.  
13 You're all missing it; send me somewhere else; do  
14 some tests. That's what she was telling them at  
15 the end. And I think she was sophisticated  
16 enough that if they had asked the right questions  
17 and offered to do the right, appropriate standard  
18 of care tests, she would have been fine and happy  
19 with it. And they -- it was just intellectual  
20 laziness and a failure to meet the standard of  
21 care that all these providers and this system  
22 failed this patient.  
23 Q. So the answer was yes, he was required  
24 by standards of care to do a neuro exam on this  
25 patient presenting for an incisional issue?

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1 A. Yes.  
2 Q. Okay. And was he required by standards  
3 of care to go back and review her past medical  
4 records during this encounter?  
5 A. Yes. I mean --  
6 Q. Okay.  
7 A. -- you always -- it's very easy to see  
8 when people log in to know how many times they've  
9 been seen, when they've been seen. And all this  
10 information is generally available. And the  
11 records were available here. Somebody needed --  
12 of this whole group, one of these, of all these  
13 people, needed to ultimately do something to  
14 protect her and give her the best outcome.  
15 Q. And was it standard of care for him to  
16 admit this patient on this date?  
17 A. It was the standard of care for him to  
18 call Dr. Chaltry, her doctor, and say, When is  
19 somebody going to figure out what's going on with  
20 Brenda Carey? And if you're not going to do it,  
21 where should I transfer and who should I contact?  
22 And so, yes, I mean, what was right in  
23 June and July is still right in September.  
24 Q. All right.  
25 And during this encounter, did the

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1 standard of care require Dr. Austin to get a CT  
 2 or back x-ray?  
 3 **A. He needed to realize that this patient**  
 4 **has been having the same complaints and is being**  
 5 **given medications only, instead of an evaluation,**  
 6 **and he needed to call Chaltry and see if Chaltry**  
 7 **was going to -- if he's her designated doctor,**  
 8 **admit her. Or he needs to say, Well, what are we**  
 9 **doing, Richard -- what are we doing, Richard**  
 10 **Chaltry, with your patient who you're supposedly**  
 11 **the primary caregiver of, who has been here**  
 12 **X-number of the times and is still on these**  
 13 **medications for this unresolved problem?**  
 14 **Everybody -- you know, medicine is**  
 15 **often like a relay race, and anybody who's got**  
 16 **the baton needs to run with it and makes sure it**  
 17 **gets handed off correctly. So each one of these**  
 18 **runners here, they lose the relay. They're all**  
 19 **dropping the baton. Each one of them is not --**  
 20 **this is a -- you know, medicine is a team**  
 21 **practice, for better or worse. That's why**  
 22 **records are important; that's why positive**  
 23 **findings and negative findings are important,**  
 24 **because it's a way we communicate periods in**  
 25 **time, because no doctor can be taking care of one**

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1 **patient 24 hours a day, 365 days.**  
 2 **So this patient comes -- in this case,**  
 3 **in this small hospital, is better than when**  
 4 **you're in a city where patients sometime wind up**  
 5 **going to four places around the beltway and have**  
 6 **a CAT scan at each one. That's bad medicine.**  
 7 **That's bad, expensive medicine. That's exposure**  
 8 **to radiation rather than communicating.**  
 9 **40 years ago, when faxes didn't exist,**  
 10 **we would try to talk about how the EKG looks with**  
 11 **somebody in LA from New York. Well, the EKG has**  
 12 **a bump here, and the PR is this long, and there's**  
 13 **no ST changes. Now, we've got all this**  
 14 **technology -- we've got records, we've got**  
 15 **computer records, we've got retrieval of**  
 16 **records -- so you've got to make the records**  
 17 **meaningful. None of this is meaningful. They're**  
 18 **giving pills; they're giving shots of Toradol.**  
 19 **Nobody is saying, There's an elephant here. This**  
 20 **is not just a gray, thick, heavy leg; it's an**  
 21 **elephant in our ER, and they're just walking**  
 22 **around and showing up.**  
 23 **So, yeah, every one of them is**  
 24 **responsible. They're all doctors, or supposedly.**  
 25 **They're supposed to have the intellectual**

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1 **wherewith all to know what they need to do and**  
 2 **the lack of laziness to go ahead and do it.**  
 3 **Q. Okay. So how about we go to the next**  
 4 **encounter?**  
 5 **A. The next would be, probably, 10/3,**  
 6 **maybe, Douglas Segan?**  
 7 **Q. Yes, that's what I've got.**  
 8 **A. That's what I come up with. And**  
 9 **apparently Douglas Segan, I guess, for some brief**  
 10 **period of time worked at the naval hospital that**  
 11 **I was the director of in Bethesda, after reading**  
 12 **his deposition. And I'm sad to say I don't**  
 13 **remember Doug, so I guess he wasn't around too**  
 14 **long. He was probably a locums, during the**  
 15 **startup of the contract. He was probably a**  
 16 **fill-in while --**  
 17 **MS. MacGREGOR: L-O-C-U-M.**  
 18 **A. -- he was probably a -- it's amazing;**  
 19 **you look like an incredible ventriloquist,**  
 20 **because we hear the sound but you're not moving**  
 21 **your lips.**  
 22 **But he must have been a locums**  
 23 **physician, as he is a lot, apparently, or has**  
 24 **been, because he -- I don't remember him, and**  
 25 **I -- so it must have been during the start-up of**

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1 **the contract at the Bethesda Naval Hospital. But**  
 2 **in terms of his visit, let me get to that...**  
 3 **(Pause)**  
 4 **So on 10/3 he notes that her chief**  
 5 **complaint is back pain. He's got the history**  
 6 **that it's been going on for three to four weeks.**  
 7 **It's actually really been three to four months,**  
 8 **so there's a little problem with that history.**  
 9 **And he notes that she's had the bariatric surgery**  
 10 **and the pannus removal.**  
 11 **And he says, down about 15 lines, "The**  
 12 **patient states she is here because she just needs**  
 13 **enough Lortab to get her through from today until**  
 14 **Wednesday." So that means she's having**  
 15 **significant pain, breakthrough pain, continuing**  
 16 **pain, and she's been using up her medicines. And**  
 17 **he notes the pain more at the nighttime, and that**  
 18 **she's eating and drinking well, but she does have**  
 19 **the weight loss, a little more, as I said, than**  
 20 **might be anticipated.**  
 21 **So he takes a little better history**  
 22 **than a lot of the previous physicians, and he --**  
 23 **and I'm just going to look at his physical here,**  
 24 **because I haven't memorized these...**  
 25 **(Pause)**

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1 And then he does -- he does a better  
2 exam than others. But, again, the history and  
3 exam are, in my opinion, inadequate. And the  
4 most pregnant thing being that -- that this is  
5 now in September, and this has been going on now  
6 for five months, roughly, five to six months of  
7 this unexplained back pain, which is being called  
8 herpetic neuralgia, and which nobody has  
9 described classic herpetic neuralgia anywhere in  
10 this chart at all, and which, when the patient  
11 got to Marquet was felt not to probably -- that  
12 she probably didn't have herpetic neuralgia.  
13 And herpetic herpes zoster, which also  
14 causes chickenpox and then remains in the nuclei  
15 of nerves and then comes out and becomes active,  
16 and can be uncomfortable and occasionally pretty  
17 painful, is classically in older patients,  
18 usually 60 or so, but can happen sometimes in  
19 younger patients. Is classically -- it is always  
20 in the dermatome. In the dermatome. It's in one  
21 nerve, classically, and it follows that nerve  
22 religiously. It just follows it because the  
23 nerves in the body are like electric wiring, and  
24 so they're pretty hard wired. So if somebody has  
25 shingles, they can get it on the nose and the ear

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1 and some more unusual places, but the classic  
2 picture of herpetic neurologia, zoster, shingles,  
3 synonyms, is a line that's pretty clear, maybe an  
4 inch or two wide, and it just goes from the back  
5 midline, from that side, around to the front  
6 midline on the stomach, or the anterior torso,  
7 and it follows a nerve dermatome, the level in  
8 which a derm goes -- a nerve goes. And it's  
9 usually in older patients. And if you really  
10 believe that, then there's treatments, like early  
11 on, possibly with antiviral agents like acyclovir  
12 or Valtrex and others, or sometimes with hot  
13 chili pepper creams, like capsaicin.  
14 We don't really know well how to treat  
15 it. If it's on the body, we probably wouldn't  
16 want to give prednisone, because it might  
17 reduce -- in certain patients, it could reduce  
18 the host resistance to any virus. And I don't  
19 think she ever had classic shingles or herpetic  
20 neuralgia, which usually doesn't last for six  
21 months, although it could, I guess, but it  
22 usually doesn't. And if it did, I would ask a  
23 dermatologist to take a look at it and say, Is  
24 this really that?  
25 So, I mean, if she had something that

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1 was like erythema and possibly a rash, I would  
2 worry about it being more -- I would wonder about  
3 it being more related to her pendulous breasts  
4 and obesity and the accumulation of sweat causing  
5 that kind of inflammation and irritation from  
6 sweat in people with lots of fat folds. I don't  
7 think she ever had shingles or herpetic  
8 neuralgia. And --  
9 Q. Let me ask you -- go ahead.  
10 A. No, I'll stop there.  
11 Q. Okay. As far as shingles goes, the  
12 rash, how long does that typically last?  
13 A. Well, typically it's less than six  
14 weeks, probably, but it -- and it usually is a  
15 vesicular form. It usually looks like a very  
16 small pimple that comes to a head, and it's  
17 extremely tender at times in parts of that area.  
18 Q. And is it --  
19 A. But usually --  
20 Q. And it follows the pattern as well?  
21 A. Yes.  
22 Q. Okay.  
23 A. And it can go on for six to eight weeks  
24 sometimes, but usually it's resolved. And I  
25 think it's particularly unusual to see anybody

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1 with it for months on end --  
2 Q. Right --  
3 A. -- but it might happen --  
4 Q. And that rash --  
5 A. Yeah, go ahead. I'm sorry.  
6 Q. And the rash can be exquisitely  
7 painful, correct?  
8 A. Usually not exquisite, but it can be,  
9 occasionally.  
10 Q. And the neuralgia that results, you  
11 indicated that it usually follows a dermatomal  
12 pattern, and the most common presentation is on  
13 the trunk --  
14 A. Yes.  
15 Q. -- correct?  
16 A. Yes.  
17 Q. And the pain --  
18 A. You know -- you know, interestingly, as  
19 an aside, when I went to medical school 45 years  
20 ago, whenever we saw an elderly patient, like in  
21 their 60s to 70s, with zoster, with shingles, we  
22 would, in those days, do a malignancy workup,  
23 interestingly, because we would -- it used to be  
24 felt that the people who got reactivated chicken  
25 pox, reactivated herpes zoster with shingles

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1 manifestation, were people with -- were  
2 compromised hosts because of an underlying occult  
3 malignancy. It's not -- I don't think it's  
4 believed to be that anymore. That was 40,  
5 50 years ago. They would get a mini workup, like  
6 a barium enema for an occult colon cancer in  
7 those days, and this and that. And I used to do  
8 those workups as an intern and a medical student.  
9 But we don't do that anymore. I think it  
10 happens, but you always have to -- you know,  
11 there is the historical precedence that that was  
12 the history, and I think, coincidentally, she  
13 turned out to have the malignancy. But I'm not  
14 saying that it's cart and horse, but it used to  
15 be felt to possibly be.  
16 Q. Right. And typically shingles is  
17 self-limiting and standard of care does not  
18 require treatments, correct?  
19 A. Well, there's some treatment, whether  
20 they -- how effective, I don't know. And it's  
21 usually self-limiting. It would not possibly be  
22 in somebody, say, with HIV or some other severe  
23 compromised immune condition, but in an otherwise  
24 normal host patient, it's usually a  
25 self-limiting, although sometimes painful,

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1 process.  
2 Q. And the pain that -- the neurological  
3 pain that they have, or neurogenic pain that they  
4 have, can be severe, can be debilitating,  
5 correct?  
6 A. Yeah. Usually not, but the occasional  
7 case, yes.  
8 Q. The diagnosis of that condition, is it  
9 typically clinical as opposed to based on  
10 testing?  
11 A. Yeah, typically it's a clinical  
12 picture. I mean, it's pretty unique. It's  
13 clear; a dermatome is a dermatome is a dermatome.  
14 And the nerve goes, it runs under the ribs, and  
15 along with the artery and the vein, and it fits  
16 that picture, yes.  
17 Q. Dr. Chaltry did get a titer, a  
18 shingles -- or I mean zoster titer, and it was  
19 relatively high. Do you --  
20 A. Yes.  
21 Q. What's the significance of a high  
22 titer?  
23 A. I'm not a virologist. You know, if  
24 somebody is -- titers can -- I mean, clearly,  
25 most people who get chickenpox are exposed to it.

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1 Titers can go up when people are having  
2 generalized reactions to -- if you're having a  
3 reaction to -- like an allergic reaction, or some  
4 sort of reaction, anything that your body has  
5 been exposed to can be elevated. They can go up.  
6 I'm not sure more than that unless it's  
7 something -- I'm not sure what happens to  
8 patients with Hodgkin's -- non-Hodgkin's  
9 lymphoma B, which are sort of -- which, there's a  
10 degree of immunologic phenomena with it. I'm not  
11 sure if that can somehow jack up titers.  
12 But -- I don't know -- I don't think  
13 she had shingles, and I'm -- and I know shingles  
14 is not responsible for the pain she had for six  
15 months, for sure. But I can't -- it's  
16 interesting, but I can't say anymore. I don't  
17 know anymore to speak about why she might have a  
18 high titer.  
19 Q. So with regard to Dr. Segan's  
20 evaluation of the patient and treatment on  
21 October 3, 2011, your primary criticism is that  
22 he did not recognize the significance of this  
23 ongoing back pain, and that had he done that, he  
24 would have taken additional steps --  
25 A. Yes.

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1 Q. -- is that fair?  
2 A. Yeah. Another missed opportunity --  
3 MR. LaPARL: I'm going to object --  
4 wait, wait, wait. I'm going to object to  
5 the form. I think he said a little bit more  
6 than that. But go ahead.  
7 MS. MacGREGOR: Well, I said kind of  
8 the overriding, or the key criticism. I  
9 think I did, anyway.  
10 MR. LaPARL: Okay --  
11 A. I think --  
12 MR. LaPARL: -- fair enough.  
13 A. -- you've got it. Again, basically  
14 another missed opportunity to make earlier  
15 diagnosis and ensure a better outcome, both with  
16 respect to her ultimate paralysis and to the  
17 prognosis of her Hodgkin's -- non-Hodgkin's  
18 lymphoma.  
19 Q. And then the next encounter in the ED,  
20 or by an ED physician, would have been on the  
21 26th of October?  
22 A. 10/26, Dr. Brad Goldman, yes.  
23 Q. So let's get to that one. And we're  
24 coming up on your -- I think we're at three hours  
25 right now.

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1 A. Okie doke.  
2 So here, the patient returns once again  
3 to the same emergency department. At this time,  
4 she had been seen by the nurse practitioner,  
5 Jennifer Weaver, on the 24th, who ordered some  
6 tests including imaging x-rays that revealed a  
7 compression fracture of the 5th thoracic  
8 vertebra, a T-5 compression fracture. And at  
9 this point, he also gets the history that she's  
10 been having increased peripheral edema in her  
11 legs, swelling in her legs, which I talked about,  
12 which I think I proposed an intellectually, I  
13 think, reasonable reason why she might have that  
14 at this point, because she's got massive  
15 lymphadenopathy.  
16 Q. Are there other explanations? If you  
17 take out of the lymphoma diagnosis, what are the  
18 other explanations for her edema?  
19 A. Well, then you could worry about a  
20 number of things. You could worry about a degree  
21 of heart failure, a degree of immobility, because  
22 if you're sitting in a chair, for example, all  
23 day because of back pain, knee pain, whatever, if  
24 you're more immobile, gravity causes fluid to  
25 extravasate. It depends, also, on her albumin --

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1 I would want to know what her albumin level is,  
2 because albumin is a protein made by the liver,  
3 and it helps maintain fluid inside the veins. If  
4 you have a very low albumin, then you could  
5 extravasate fluid into the extremities, into the  
6 interstitial tissue outside the venous-aerial  
7 system.  
8 So, you know, edema, you think of heart  
9 failure, you think of constriction around the  
10 right side of the heart, where blood comes back  
11 through the vena cava. You'd think about what  
12 her protein level is, her albumin, the main  
13 protein in the blood made by the liver. You  
14 would want to know about her renal kidney  
15 function, because that's how fluid gets excreted.  
16 And if somebody is accumulating fluid in their --  
17 I mean, most fluids are going to accumulate in  
18 the legs because we walk on our legs and gravity  
19 pulls it down there. At night, it comes back  
20 into the circulation, because if somebody is in  
21 bed, it can get back in. But when you're  
22 standing up, a long as you're standing on your  
23 feet -- if you're standing on your hands, you'd  
24 probably get it in your hands, but since most of  
25 us walk on our feet, that's where you get

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1 swelling.  
2 So the things you look for when you  
3 have fluid, you look at the protein level, you  
4 look at the kidney function, liver function. You  
5 think about, is there an obstruction, like  
6 lymphadenopathy in the pelvis that would cause  
7 fluid to have trouble getting back up readily.  
8 So there's a differential diagnosis for edema.  
9 And that's sort of a start of it. I mean, even  
10 pericardial tamponade, where you have the sac  
11 that sits around the heart, the pericardial sac,  
12 if that's tight from pericarditis, or from  
13 whatever cause, a number of causes of  
14 pericarditis, then you can get fluid accumulating  
15 in the legs, too, and in the liver also in that  
16 case.  
17 So he sees her with a compression -- he  
18 sees her with a compression fracture, with edema,  
19 and that she's got this thing about her legs  
20 feeling like mush, and that they're a little  
21 tingly and swollen, but there's no weakness, no  
22 paresis -- he says -- and no dietary change. He  
23 accepts the -- and he accepts a diagnosis of  
24 shingles, but he also notes that she's still  
25 having pain in her back. So -- and so in that,

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1 in the context too, of the physical, which talks  
2 about no regional lymphadenopathy -- he's not  
3 feeling lymph nodes in the axilla, in the armpits  
4 or in the groin -- there's a striking, in the  
5 dictation on the second page of his note, it says  
6 BUN of 93, which is impossible, or else she'd  
7 have to be on dialysis. But it's not possible  
8 anyway, because that creatinine is .6, so that's  
9 something, I guess, a typo in that. But that's  
10 intellectually not correct, nor possible.  
11 So he's describing bilateral dependent  
12 peripheral edema, which is a new deal, still with  
13 back pain. He's putting her on Lasix, which is  
14 sort of like a dramatic thing. He -- he --  
15 nobody knows for six months why she's got back  
16 pain; he doesn't know why she's got leg edema,  
17 but he's starting her on a diuretic, which is  
18 like a -- for the next seven days, which is a  
19 little -- I mean, she's not having heart failure.  
20 Why is he starting her on a diuretic? This is  
21 just like -- Lasix. This is just like her --  
22 really, it's really consistent with her first six  
23 months of care: People don't know what she's  
24 got, they're not trying to figure out what she's  
25 got, but they're giving her pain medicines for

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1 her back pain. Now he's giving her a strong,  
2 powerful diuretic, Lasix, for her fluid in her  
3 leg. Nobody is very curious in this hospital.  
4 Nobody is intellectually curious, and everybody  
5 is sort of lazy, mentally.  
6 And so he's -- he's basically -- and  
7 then he's discussed kiwi fruit and bananas.  
8 Okay. There are more pertinent things to  
9 discuss, like why she has the back pain and has  
10 peripheral edema. And then he's having her  
11 follow up with all these unexplored things with  
12 Dr. Chaltry and Nurse -- NP Weaver in the next  
13 five to seven days. And they're getting ready --  
14 I guess they -- they sort of discharge her, and I  
15 guess she comes back after... Did she actually  
16 get out of the hospital? I'm trying to figure  
17 that out again here.  
18 Q. All right. So this is the afternoon  
19 of --  
20 A. Of the 26th.  
21 Q. -- of the 26th, lunchtime-ish.  
22 A. And then she comes back --  
23 Q. She came back the next morning.  
24 A. Yeah, on the 29th.  
25 Q. The next morning.

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1 A. Yeah, so this is more --  
2 Q. Oh, the 27th.  
3 A. So now she's got a new thing of the  
4 edema in her legs. This is not from  
5 musculoskeletal disease; this is not from a  
6 ligament or a sprain; it's part of something  
7 else. And she doesn't have, obviously, heart  
8 failure. And she's had, actually, studies before  
9 she had her surgery. I mean, she had a good  
10 heart, so to speak.  
11 And so this is now peripheral edema. I  
12 went into a differential diagnosis of it. Nobody  
13 else seems to have there, but they're giving her  
14 Lasix to treat the fluid, because Lasix will  
15 decrease renal retention of -- kidney retention  
16 of free water. But, again, it's an unexplained  
17 finding, and so it's, again, a failure to  
18 appreciate the history; a failure to -- to -- to  
19 appreciate the clinical significance of the  
20 physical exam; a failure to create a differential  
21 diagnosis of any value in terms of how to deal  
22 with her; and discharging her when she's got a  
23 new finding now, which is abnormal, instead of,  
24 again, everybody either putting their heads  
25 together, getting some more lab, doing some

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1 imaging, or calling another doctor to help them,  
2 or transferring her to another center with a  
3 higher level of physicians who are willing and  
4 able to put all this together.  
5 Q. Does peripheral edema cause numbness,  
6 tingling, you know, neurological symptoms in the  
7 dependent areas?  
8 A. Very much unlikely. That could be more  
9 of some of the irritation of nerve -- or tumor or  
10 Hodgkin's -- non-Hodgkin's lymphoma around her  
11 spinal cord would be more likely to cause the  
12 tingling.  
13 Q. All right.  
14 A. And also, I left out that now there's  
15 like a major new discovery of a vertebral  
16 compression fracture at T-5. So this is like a  
17 heard of rhinoceros now in the room, too. That  
18 should be -- this is something -- how could they  
19 not go into further imaging with a CAT scan of  
20 her spinal area, her thoracic spine? I can't  
21 imagine how they would not use their CAT scan,  
22 which normally gets overused and misused a lot of  
23 the times, why they would not have gotten a CAT  
24 scan which was available. Now, maybe their CAT  
25 scan wouldn't accommodate her size. That I don't

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1 know. But there's always around -- somewhere  
2 they needed to image her at this point to see  
3 what's going on with her thoracic spine and why  
4 she's got a vertebral collapse.  
5 And so she should have been admitted  
6 here, or somewhere else. She should have had  
7 consultations -- if they still couldn't get it,  
8 to get somebody else with a better computer in  
9 their head and more curiosity and somebody who  
10 was going to get to the bottom of this, finally,  
11 after six months.  
12 So they send her home, which was a  
13 deviation from standard of care, on Lasix, I  
14 think was -- just like all the pain medicine they  
15 were giving, they're treating fluid but not  
16 diagnosing why she's got fluid-dependent edema.  
17 Q. What do you make of the normal sed  
18 rate that --  
19 A. Well, it would -- sorry. Sorry.  
20 Q. What do you make of the normal sed  
21 rate?  
22 A. I'd say that it's -- it's -- it's -- it  
23 points to -- it points away from an infectious  
24 cause of -- of -- of what might be causing a mass  
25 effect in her paraspinal area. Because usually

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1 if you have epidural or some sort of occult  
2 abscess, one of the things we like to get is a  
3 C-reactive protein, which measures the same thing  
4 as the sedimentation rate, basically. And if  
5 they're normal, it sort of points away from an  
6 infectious process.  
7 Q. How about inflammatory process?  
8 A. And probable inflammatory process, too,  
9 like lupus or severe rheumatoid arthritis, or any  
10 of those autoimmune phenomena. A normal sed rate  
11 and C-reactive protein would be less consistent  
12 with those.  
13 Q. Would that not usually be elevated in  
14 the --  
15 A. Non-Hodgkin's lymphoma?  
16 Q. -- where there's Hodgkin --  
17 non-Hodgkin's -- yeah, in presence of  
18 non-Hodgkin's disease?  
19 A. It could be, but I'm not sure about  
20 that. But I would think it possibly could be,  
21 but not like an infectious or inflammatory  
22 process, auto immune process causing this  
23 picture.  
24 Q. All right. Let's go, then, to her  
25 return to the ER on the --

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1 A. 10/27.  
2 MR. LaPARL: I was just going to ask to  
3 take a quick break for me to use the  
4 restroom. Would this be a good time?  
5 MS. MacGREGOR: Yeah. I think I'm  
6 about done.  
7 MR. LaPARL: Okay.  
8 MS. MacGREGOR: I don't know how long  
9 we'll talk about this particular admission,  
10 but I think I'm about done. Go ahead and  
11 take a break.  
12 (Recess)  
13 EXAMINATION CONTINUED  
14 BY MS. MacGREGOR:  
15 Q. Doctor, before I forget, how many cases  
16 do you have pending, if you can estimate for me,  
17 with the McKeen firm, currently?  
18 A. I'm just chewing, finishing my last  
19 cracker here. But, um...  
20 I don't really know, but maybe, at  
21 most, maybe one or two. Maybe.  
22 Q. All right. Okay.  
23 Let's go to October 27, 2011, then.  
24 And, again, I'll just let you tell me what you  
25 see there that represents standard of care

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1 violations?  
2 A. Well, when you read the history, she  
3 fell at home, was unable to get up; husband  
4 called 9-11, EMS; legs weak for two days;  
5 compression fracture of T-5.  
6 That and -- and that would be -- that  
7 would make one have -- I mean, now she's -- she  
8 fell. Her legs are weak. They felt mushy. With  
9 the previous notes, the same doctor who saw her,  
10 Dr. Goldman, who saw her the day before, is  
11 seeing her again. She's come back. She's got  
12 this six-month history. He could have -- he  
13 could have been getting a CAT scan of her back  
14 and doing a bunch of lab, general lab. And he  
15 needed to be on the phone pretty much immediately  
16 after getting that brief amount of material that  
17 I said, with her history. He should have maybe  
18 been getting a CAT scan, getting some basic lab,  
19 and been on the phone to figure out to what major  
20 medical center with a neurosurgeon and every  
21 imaging needed, she needed to be sent to.  
22 And for whatever reason -- and, again,  
23 just to continue, he's saying her strength is  
24 4/5, where he talks about strength, that -- so  
25 that -- I'm looking at the occupational therapy

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1 note there. But he's saying some decreased  
2 strength in upper extremities, which I -- which  
3 it looks like -- I'm sure it was lower  
4 extremities more, as was measured, I think, here  
5 by the person who may have seen her.  
6 So, I mean, what this is is a patient  
7 who maybe they could spend the time until she was  
8 being transferred to the appropriate place  
9 getting a CAT scan and some basic lab, but it's a  
10 patient who needs to get out of this hospital to  
11 a major hospital. She's got weakness; she's  
12 falling; she's got legs that are not right;  
13 nobody has done an appropriate exam, because she  
14 clearly was going to have weakness and neurologic  
15 deficits and is not -- he -- he writes,  
16 "Neurologic: awake, alert and appropriate."  
17 That's his physical exam.  
18 And then he watches her -- and it also  
19 is noted that she's generally weak, she had an  
20 inability to transfer, even for her therapy,  
21 because he's ordered some type of physical  
22 therapy. It's remarkable and extraordinary that  
23 he's got this patient with these findings and  
24 he's watching her until the next day. And then  
25 she's saying that I think something -- I need to

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1 get out of here and get to a real place where I  
2 could get a real evaluation. And that happens  
3 only -- she's admitted to Marquette, I guess,  
4 on -- I think on the 29th. And then studies show  
5 that she's got a diffuse heavy load of  
6 lymphadenopathy, and with biopsies is determined  
7 to be B-cell -- non-Hodgkin's B  
8 diffuse lymphoma -- B-cell lymphoma, with cord --  
9 paraspinal involvement, cord involvement, from  
10 like T-2 to T-8, I think, and obviously with  
11 erosion of the T-5 vertebra pressure on the cord  
12 and erosion of bone.  
13 So it's all the failures that I  
14 enumerated on Dr. Goldman on the 26th. Plus,  
15 now, when she appears with critical findings,  
16 like cord compression, which, if you don't treat  
17 early, leaves you with permanent loss of nerve,  
18 spine and nerve and muscle weakness and spasm, he  
19 watches her for another day or so, and in his  
20 deposition said something to the effect of, well,  
21 he wanted it -- he was watching to see if it  
22 would declare itself. And if she doesn't get --  
23 if she doesn't get better or gets worse, that he  
24 would transfer her.  
25 Well, this is like an unethical study

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1 of the natural history of disease. He needed to  
2 transfer her as soon as he saw her back. I mean,  
3 she shouldn't have been discharged on the 26th,  
4 but when she comes back and now has clearly got  
5 weakness in her legs and is unable to get up or  
6 walk anymore, this is a patient who needs to go  
7 to the major appropriate tertiary care centers  
8 with neurosurgeons spoken to and where she can be  
9 imaged, where they have a scanner that will  
10 accommodate her, or a method of looking at her.  
11 So that's another critical 24 hours or so that's  
12 lost, which translates into lost ability to have  
13 the best outcome, namely, with the residual  
14 paralysis that she's gotten and spasticity.  
15 So it's, again, the history, physical,  
16 and, in this case, the physical findings of  
17 weakness in the lower extremities and the  
18 failure -- he said in his deposition on a couple  
19 of occasions, as I recall, that he didn't -- he  
20 just didn't include it in his differential  
21 diagnosis. He basically didn't think of it.  
22 Well, that's basically the story of this lady in  
23 this hospital in this emergency department in  
24 this family practice environment with all of  
25 these doctors; nobody -- intellectual lack of

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1 curiosity, intellectual incapacity to put 1 and 1  
2 together in this picture, and then translates,  
3 ultimately, into reduced, not the best possible  
4 outcome for either her neurologic condition and  
5 also her non-Hodgkin's lymphoma, because she's  
6 got a much more significant tumor load, obviously  
7 six months later.  
8 Q. Given what we do see in the MRI that  
9 was done on the 30th of October, do you have an  
10 opinion as to what a neurologic exam would have  
11 demonstrated on the 27th or 28th?  
12 A. Let me get to those records, to that  
13 MRI...  
14 (Pause)  
15 Q. Maybe the way to ask that --  
16 A. So...  
17 Q. Maybe the way to ask that is, would you  
18 expect the neurologic exam performed by  
19 Dr. Goldman to -- on the 27th -- or -- a  
20 neurologic exam performed on the 27th or 28th to  
21 have been significantly different from that which  
22 was performed on admission at Marquette General?  
23 Those are two different questions, I  
24 recognize --  
25 A. Yeah, yeah.

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1 Q. -- and you can --  
2 A. Yeah, I understand.  
3 Q. You can answer whichever one you want.  
4 A. Yup.  
5 (Pause)  
6 Well, if -- I suspect if a neurologic  
7 was done -- I mean, what's described by -- this  
8 is the admission -- by the admitting H&P. I'm  
9 not sure why -- I don't know if that's performed  
10 by a -- by a resident or -- I'm not sure who  
11 actually did the H&P, as I sit here. But  
12 regardless, it shows she doesn't have any  
13 dorsiflexion of the ankles against minimal  
14 resistance. She's got -- reflexes appear to be  
15 slightly decreased in the lower extremities.  
16 There's significant weakness bilaterally in the  
17 flexors of the hips, ankles, and knees, and is  
18 not able to raise her legs off the bed, which is  
19 -- you know, usually when we measure this, it's  
20 the 5 system, 1 to 5, 5 being you can't resist --  
21 you can't move them at all. You know, typically  
22 2 being you can't -- you can raise them off the  
23 bed but you can't resist gravity much; 5 being in  
24 tact.  
25 So she's got a lot of findings that

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1 show lower extremity weakness and some decreased  
2 reflexes, and my opinion would be that they were  
3 present, if looked for appropriately, when  
4 Dr. Goldman admitted her on the second admission.  
5 Q. Okay.  
6 A. And, you know, that's why she fell.  
7 That's why she couldn't lift herself up. That's  
8 why her husband called the EMS, because he  
9 couldn't get her off the floor. And Dr. Goldman  
10 says she can't even transfer from bed to go get  
11 exercise, which is a preposterous idea, that he's  
12 trying to exercise her. He thinks she needs  
13 training or conditioning. Sort of, like,  
14 incredulous.  
15 So I think all of that is consistent  
16 with the fact that she's got a paraspinal  
17 compression from lymph ad -- lymph tissue of her  
18 significant lymphadenopathy from her  
19 non-Hodgkin's lymphoma. So --  
20 Q. And it's your opinion that it was an  
21 emergent situation from the point when she  
22 presented on the 27th?  
23 A. Yeah. And I think it was probably  
24 present, if he looked -- if anybody did an  
25 appropriate physical exam on the 26th, I think it

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1 would have been present. And in terms of  
2 causation, I mean, it would have been possibly  
3 dramatically positively able to avoid her having  
4 permanent damage if she had been admitted on the  
5 26th, because I believe she -- clearly, if she  
6 had a good neurologic exam, would have had  
7 evidence of diminished strength in her lower  
8 extremities.  
9 And when she's come in on the 27th  
10 because she's fallen on the floor and can't get  
11 up, can't even, in the hospital, transfer from  
12 the bed to exercise, which he apparently ordered  
13 for her, you know, then it's worse, but clearly  
14 there. And so now this translates into every  
15 minute, every hour, you know, diminished outcome.  
16 Q. So, just so I'm clear, in your opinion,  
17 in fact it was an emergent situation. But are  
18 you also say that he, Dr. Goldman, should have  
19 recognized it as an emergent situation on the  
20 26th and then also on the 27th?  
21 A. Yes, both.  
22 Q. Okay. And his recognition of that, was  
23 that necessarily dependent on getting a CAT scan  
24 or the neurologic exam? Or what would be the  
25 basis on the conclusion that it was emergent?

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1 What would lead a reasonably competent doctor to  
2 conclude on most days that it was an emergent  
3 situation?  
4 A. Well, she's back and she's  
5 complaining -- let me just go back to the note of  
6 the 26th again. Sorry. I think that's when she  
7 complained that her legs were mush, on the 26th.  
8 On the 26th she had a fall and unable  
9 to get up, weakness in her legs.  
10 Q. So the history?  
11 A. She felt her legs were very weak and  
12 rubbery and wobbly. So, I mean, the history is  
13 there. With this lady with a compression  
14 fracture of T-5, the history is there. She  
15 needed to be getting -- you know, get a CAT scan  
16 while you're getting ready to transfer her to  
17 whatever tertiary center which has got a  
18 neurosurgeon that's going to be able to  
19 aggressively, quickly, timely treat her.  
20 So on the 26th he had no right to let  
21 her go out at all.  
22 Q. All right. Do you have any criticisms  
23 of anyone else, any of the other defendants --  
24 well, I don't think you'd be qualified to speak  
25 to the family practice people, but how about of

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1 the hospital? Are you intending to testify that  
2 hospital itself was negligent somehow?  
3 A. Well, the hospital, this is -- these  
4 doctors are working both in the ED and in family  
5 practice. And I think the hospital -- the  
6 system -- the hospital is the system all of these  
7 people are working for, and so I think the  
8 hospital is responsible, too, in this case,  
9 because it's not just one doctor. It's their  
10 whole -- the substance, basically, of staffing,  
11 it seems like, in their emergency department, and  
12 in their family practice clinic.  
13 I don't know how -- it's hard for me to  
14 imagine how this could happen, how this could  
15 happen over so long a period, how there's no --  
16 nobody in place to say, What's happening with  
17 this Brenda Carey who keeps coming back? Because  
18 hospitals -- you know, the country, even in 2011,  
19 was sort of pushing towards excellence and  
20 outcomes, and this is a patient who keeps coming  
21 back, who has to be some sort of a burden,  
22 because third parties who try to -- who insure  
23 this, they don't like to see patients who keep  
24 getting readmitted for the same problem and keep  
25 coming back.

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1 There's usually -- usually the  
2 hospital's continuous quality improvement, and  
3 other departments, should be monitoring returns.  
4 You know, people who are seen twice in two days  
5 or bouncing back, those are -- there are --  
6 hospitals and the Joint -- I don't know if this  
7 hospital participates in the JCAHO visits, the  
8 Joint Commission of Accreditation of Hospitals,  
9 but hospitals are supposed to benchmark outcomes,  
10 like returns in 24 hours, returns in 48 hours, 72  
11 hours, deaths in an emergency department.  
12 Hospitals are supposed to do CQI,  
13 continuous quality improvement. And hospitals  
14 are supposed to do these diagrams, these fish  
15 diagrams and things, where you try to not point  
16 fingers at individuals but look for system  
17 breakdowns. This is -- besides each individual  
18 doctor, which I enumerated, and the major things  
19 like history, physical, and their clinical  
20 relevance and tests, here's a system of doctors  
21 in a small ED. They must interface -- it's not  
22 like some of these industrial medical centers  
23 like we have in big cities, like in New York  
24 City, where they have these giant centers that  
25 cause traffic jams in Manhattan, these are --

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1 it's a small hospital. These people must bump  
2 into each other in the doctors' lounge at the  
3 coffee pot, or somewhere. I don't know how -- I  
4 don't know how they wouldn't say, Hey, what's  
5 happening with that Brenda Carey? She keeps  
6 coming back. I don't know how the hospital  
7 doesn't have a system, and how the doctors  
8 themselves didn't have the curiosity to -- to  
9 take six months until she was irreversibly  
10 impacted with respect to her neurologic condition  
11 and probably also, to a degree, with the  
12 likelihood of the best outcome oncologically with  
13 her lymphoma. I don't -- it's hard to imagine  
14 how this could happen.  
15 Q. Besides the standards of the Joint  
16 Commission, are you familiar with any protocols  
17 or standards that require a hospital to  
18 coordinate care among the various providers that  
19 see the patient?  
20 A. No. Joint Commission has -- what it  
21 tells hospitals is, make scope of practice --  
22 develop a scope of practice, define what should  
23 and shouldn't happen, look at benchmark, the  
24 kinds of things like returns, unsuccessful  
25 intubations, and they define -- then they say,

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1 You make the policies. And then you have to live  
2 up to your policies, because not every center --  
3 not every hospital is going to be the mega  
4 center, tertiary care.  
5 But what the Joint Commission tells  
6 hospitals is to define how you're going to  
7 practice; define the scope of your practice;  
8 define what should and shouldn't be admitted in  
9 your hospital; define, you know, what you're  
10 benchmarking, and tell me how you're -- what you  
11 do for CQI, continuous quality improvement; and  
12 then, when the Joint Commission comes, show me  
13 how you've done what you said you should do.  
14 And, you know, how this happens --  
15 well, each provider is, as I said, lacked  
16 intellectual curiosity, lacked intellectual  
17 capacity, possibly, to be dealing with what they  
18 were dealing. They didn't meet standards of  
19 care, either by failure of interest of doing or  
20 failure of intellectual capacity of doing what  
21 their scope of practice allowed them to do. And  
22 then the system fails, because somehow there is  
23 an elephant, and nobody new it was an elephant,  
24 despite I don't know how many visits, but many  
25 visits and many interactions with the system and

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1 those doctors.  
2 Q. Doctor, have we covered the key points  
3 of the opinion testimony, that the criticisms  
4 that you anticipate being asked about at the time  
5 of this trial?  
6 A. Yes.  
7 MR. LaPARL: I'm just going to object  
8 to form.  
9 Q. Anything else that you think, in fair  
10 discovery, you think I should know about in terms  
11 of what you anticipate testifying about at the  
12 time of trial?  
13 A. No.  
14 MR. LaPARL: Again, object to form.  
15 Q. All right --  
16 A. As I sit here, no.  
17 MS. MacGREGOR: Okay. Thank you.  
18 Nothing else.  
19 THE WITNESS: Thank you.  
20 EXAMINATION  
21 BY MR. LaPARL:  
22 Q. Just a few follow-up questions for you,  
23 Dr. Mehlman.  
24 I want you to assume the "standard of  
25 care" is defined as what a physician of ordinary

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1 learning, skill, and judgment would do under the  
 2 same or similar circumstances. Are you with me?  
 3 **A. Yes.**  
 4 Q. Using that definition, is it your  
 5 opinion that the physicians that provided care  
 6 and treatment to Ms. Carey in the emergency  
 7 department setting violated the standard of care?  
 8 **A. Yes.**  
 9 Q. And for the reasons that you've  
 10 enumerated earlier today?  
 11 **A. Yes.**  
 12 Q. Are you opinions based on a reasonable  
 13 degree of medical certainty?  
 14 **A. Yes.**  
 15 Q. And you are a licensed physician,  
 16 correct?  
 17 **A. Yes.**  
 18 Q. In 2010, you were devoting a  
 19 substantial portion, or the majority of your  
 20 professional time, to both the clinical practice  
 21 of emergency medicine and the instruction of  
 22 emergency medicine?  
 23 **A. Yes.**  
 24 **MS. MacGREGOR:** Objection to form.  
 25 Q. And in 2011, you were devoting the

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1 majority of your professional time, active time,  
 2 to the instruction of emergency medicine?  
 3 **A. Yes.**  
 4 **MS. MacGREGOR:** Objection; form. You  
 5 can't lead him.  
 6 **MR. LaPARL:** Okay.  
 7 Q. Well, to clear it up, in 2010, tell us  
 8 what you were doing relative to the majority of  
 9 your professional time.  
 10 **MS. MacGREGOR:** Asked and answered.  
 11 **A. Shall I -- can I answer?**  
 12 Q. Yeah, you can answer it again. I'm  
 13 just trying to clear it up.  
 14 **A. Through July of 2010, I -- when I got**  
 15 **an acute herniation of C4-5 in my neck and was on**  
 16 **workman's comp and incapacitated, up through July**  
 17 **I was working roughly 32 to 36 hours a week**  
 18 **practicing as a senior attending and -- and**  
 19 **teaching emergency medicine 90 -- probably**  
 20 **85 percent practicing and 10 to 15 percent**  
 21 **instructing at the bedside, house staff, working**  
 22 **in the emergency department, or coming to the**  
 23 **emergency department to see patients.**  
 24 Q. And then from July of 2010 through the  
 25 end of 2011 you were devoting the majority of

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1 your professional --  
 2 **MS. MacGREGOR:** Objection; form.  
 3 Q. What were you devoting the majority of  
 4 your professional time to during that period?  
 5 **A. Teaching.**  
 6 Q. Emergency medicine?  
 7 **A. Yes.**  
 8 Q. And you were board certified in  
 9 emergency medicine in 2011, correct?  
 10 **A. Until Jan -- till December 31st, yes.**  
 11 **MR. LaPARL:** That's all I have. Thanks  
 12 very much.  
 13 (Off the record)  
 14 **MS. MacGREGOR:** I need the original  
 15 sent to me, and then I would like just  
 16 electronic E-tran. So E-tran, or whatever  
 17 your program is, and PDF the exhibits,  
 18 please.  
 19 **MR. LaPARL:** And I'll take an E-tran  
 20 mini, please. PDF exhibits is fine.  
 21 **MS. MacGREGOR:** We don't the require  
 22 the witness to sign.  
 23 **MR. LaPARL:** It's not required in  
 24 Michigan.  
 25 **MS. MacGREGOR:** And the doctor would

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1 appreciate, probably, getting the originals  
 2 back. I don't have any issue with just  
 3 keeping a copy.  
 4 **THE COURT REPORTER:** Okay, then I'll  
 5 ask the production department to PDF them  
 6 and return the originals to the doctor.  
 7 **MR. LaPARL:** Yes, the doctor will need  
 8 the original exhibits back, so send them  
 9 back.  
 10 **MS. MacGREGOR:** Okay, thank you.  
 11 (Time noted: 1:50 p.m.)  
 12  
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 25

1       A C K N O W L E D G M E N T

2

3       STATE OF            )

4       ) ss.:

5       COUNTY OF         )

6

7       I, IRA MEHLMAN, M.D., hereby certify  
8       that I have read the transcript of my testimony  
9       taken under oath in my deposition; that the  
10       transcript is a true, complete and correct  
11       record of my testimony, and that the answers on  
12       the record as given by me are true and correct.

13

14

15

16       \_\_\_\_\_  
17       IRA MEHLMAN, M.D.

17

18       Signed and subscribed to before  
19       me, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

20

21

22       \_\_\_\_\_  
23       Notary Public, State of \_\_\_\_\_

23

24

25

1                   C E R T I F I C A T E

2

3       STATE OF NEW YORK     )

4                                 ) ss:

5       COUNTY OF NEW YORK   )

6

7               I, ALEXIS PEREZ JENIO, a Notary Public,  
8       do hereby certify:

9               That IRA MEHLMAN, M.D., the witness  
10       whose deposition is hereinbefore set forth, was  
11       duly sworn by me and that such deposition is a  
12       true record of the testimony given by such  
13       witness.

14              I further certify that I am not related  
15       to any of the parties to this action by blood or  
16       marriage; and that I am in no way interested in  
17       the outcome of this matter.

18              IN WITNESS WHEREOF, I have hereunto set  
19       my hand this 1st day of July, 2015.

20

21

22

23

24

25       -----  
25       ALEXIS PEREZ JENIO, CLR

	95:17	91:13	51:18;55:24;59:21; 67:19;89:15	34:7
<b>\$</b>	<b>acted (2)</b> 31:19;57:4	<b>affidavit (3)</b> 28:22;34:20;42:10	<b>along (1)</b> 110:15	<b>apparently (6)</b> 44:16;47:14;52:9; 103:9,23;130:12
<b>\$1,400 (3)</b> 39:24;40:1,19	<b>acting (1)</b> 48:14	<b>affidavits (2)</b> 39:4,5	<b>although (5)</b> 26:17;41:8;50:21; 106:21;109:25	<b>appeals (1)</b> 30:7
<b>\$1,500 (1)</b> 40:21	<b>action (1)</b> 16:14	<b>affirmation (1)</b> 28:6	<b>always (9)</b> 11:22;51:18;59:21; 67:19;86:22;100:7; 105:19;109:10;120:1	<b>appear (1)</b> 128:14
<b>\$2,000 (2)</b> 40:20;41:1	<b>actions (2)</b> 16:21;18:8	<b>afternoon (1)</b> 117:18	<b>Amby (1)</b> 76:12	<b>appearance (1)</b> 40:2
<b>\$3,000 (1)</b> 40:2	<b>activator (1)</b> 29:18	<b>afterwards (1)</b> 16:15	<b>ambulance (2)</b> 61:18;86:15	<b>appeared (5)</b> 29:21,22,22;30:20; 31:21
<b>\$400 (2)</b> 39:22;41:4	<b>active (9)</b> 6:17;21:6,15,17; 22:1;23:9;55:24; 105:15;138:1	<b>again (26)</b> 7:15;8:3;11:9;23:6; 31:6;59:16;67:23; 69:20;73:18;75:8; 91:24;97:13;105:2; 112:13;113:2;117:17; 118:16,17,24;122:24; 123:11,22;126:15; 131:6;136:14;138:12	<b>amazing (2)</b> 72:8;103:18	<b>appears (2)</b> 48:1;125:15
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