In The Matter Of:

Carey vs.

Aspirus Ontonagon Hospital, Inc., et al.

Ira Mehlman, M.D.

June 18, 2015

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF ONTONAGON

BRENDA CAREY,

Plaintiff,

-against-

ASPIRUS ONTONAGON HOSPITAL, INC., DEPLOYABLE EMERGENCY SERVICES, L.L.C., RICHARD CHALTRY, D.O., MAURA MANNING, M.D., BRAD GOLDMAN, M.D., DOUGLAS SEGAN, M.D., and JOHN AUSTIN, M.D.,

Defendants.

Case No.: 13-000079-NH

126 East 56th Street
New York, New York

June 18, 2015
10:15 a.m.

VIDEOCONFERENCE DEPOSITION of IRA MEHLMAN, M.D., taken pursuant to Notice, before ALEXIS PEREZ JENIO, a Professional Shorthand Reporter and Notary Public of the State of New York.

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EXHIBITS

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EXHIBITS (Cont'd)

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

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IRA MEHLMAN, M.D., the witness herein, having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

EXAMINATION

BY MS. MacGREGOR:

Q. Doctor, will you state your name for the record, please?

A. Ira Mehlman. M-E-H-L-M-A-N.

MS. MacGREGOR: I'm getting some feedback.

(Off the record)

Q. You are currently practicing what specialty, Doctor?

A. Well, I'm an emergency medicine physician, and I'm currently not clinically active.

Q. All right.

Are you currently employed by anybody?

A. No.

Q. When did you last practice emergency medicine?

A. July -- in late July 2010 I had an injury lifting a 400-pound patient, and I wound up with a herniated C4-5 disc in my neck, and I

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was on workman's comp -- I was still on the staff, but I was on workman's comp for about 18, 20 months. And then I -- when I came off of it, I was about to go back to work. I had a contract to start working with Urgent Care Emergency Medicine Group in New York City, and just as I was about -- I was on the schedule, I was about to begin working, a taxi ran over my foot, a yellow cab in Manhattan. So that was another 14 months of recovery. I was in one of these cam walker boots for six months, and I was trying to -- I've had a number of surgeries in the past, and I was running out of lives, so I was trying not to have surgery. So that's about 90 percent improved, and I'm about to start working again.

Clinically, I've been in conversation with Cornell New York Hospital about a teaching position, possibly, and I've got some offers. So probably in the next two to three months I'm going to begin one of them.

MR. LaPARL: Doctor, you said, "2010." Did you mean to say --

THE WITNESS: Let me look at my --

MR. LaPARL: -- July of 2011?

THE WITNESS: -- CV. I think my injury

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was actually in July -- I think it was actually July 2010, because then I was about to start working in 2012 again, and I was out for about 20 months with my disc and my neck.

Q. Do you know when it was that the taxi injury occurred?

A. Yeah, that was in 2012, as I recall.

Q. What month?

A. That was in September 2012.

MS. MacGREGOR: Okay. Let's go off the record.

(An off-the-record conversation was held.)

MS. MacGREGOR: While we were off the record, I asked Mr. LaParl whether we needed to proceed, given that the doctor wasn't practicing after July 2010, and he said that we should.

BY MS. MacGREGOR:

Q. So what were you doing professionally, if anything, after -- between July 2010 and, let's say, May 2011?

A. I was doing some teaching at Pace. That's a mid level -- it's actually a nurse

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

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

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

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

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

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

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Q. Okay. In the list of articles, are there any articles that deal with emergency medicine?
A. There's no article that deals with the subject at hand here. There's a -- one or two articles that deal with, very tangentially, emergency medicine, but nothing that's at all involved to the case at hand.
Q. Very good. Thank you.
Then also on your CV for the time frame I'm most interested in, and on the CV it reflects 5 -- May 2009 to the present time, senior consultant emergency medicine for the VA?
A. Yes.
Q. Tell me what that is and what your role is.
A. That's -- I'm not sure how they contacted me, but I've been in -- I was contacted and involved in doing peer review. It had nothing to do with any litigation that might have any monetary concern. It was mainly about peer review. And so it was a peer-review panel that the VA had, and I would be asked -- I haven't been asked in the last -- I haven't heard from them in the last year or so, but for a number of years I would be sent probably an average of a case every month or two, and I'd be probably one of a half a dozen doctors who would look at it. And then we'd have a -- a telephone conference call, where we would discuss the issues.
And it was all related to -- I'd be involved in cases that were related to emergency medicine issues in VA hospitals. And so then we would come to a conclusion about whether standard of care and appropriate care was met. And then the VA would do what -- I'm not sure what they did with it after. I think they probably -- there would be some action that would be in terms of quality improvement, I guess, afterwards.
Q. Okay --
A. But I would be a part of a group of doctors who would just do a peer-review analysis and then have a conference call and discussions. And then they would write up a report and you would see it after, about actions they were going to recommend. If that is clear.
Q. That is. I understand that process entirely.
So was there -- did there come a time

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

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

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weeks --
Q. Okay.
A. -- with radicular -- radicular symptoms from the root, and then that gradually improved over time.
Q. Okay.
A. There was discussions of surgery, but I didn't want to have surgery at that point.
Q. So was there a period of months when you would not have performed any professional activity?
A. No, I was -- probably the first three weeks, certainly no.
Q. Okay. All right.
Were you also doing expert witness work that summer --
A. What I could do --
Q. -- of that year --
A. What I could do, from home generally. I was pretty much home bound for three weeks.
Q. Right. And then between July 2011 and -- I'm sorry, July 2010 and May, June, July 2011, so for that year period, were you doing expert witness work?
A. Yes.

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

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

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

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

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

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Q. Okay. Great, thanks.
A. When I said "not difficult," I mean impossible for me to go to court.
Q. Right. You're not going to go in and try to support care that you don't believe in.
A. Right. Exactly.
Q. Thank you.
In what are you board certified?
A. Well, I'm board certified currently in internal medicine and in endocrinology metabolism. After my neck injury, I let my boards expire at the end of 2011. I am what's called a past diplomat of the American -- College of Emergency -- Emergency Physicians. And I was board certified up until December 31, 2011.
After that, I elected not to sit for those boards, because I wasn't going to work in an inner city or the kind of ED where I need them, and I'm board certified in medicine and endocrinology for life.
I'm still a fellow of the American College of Emergency Physicians and a fellow of the American College of Physicians for the internal medicine group.
Q. Did you do an emergency medicine

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

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

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

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ethical. I don't -- I mean, that's obvious. It's never come into question.

Q. So nobody has ever questioned the merit or the ethical basis for your testimony as an expert witness?

A. No, nobody.

Q. Has there been any challenges to your testimony through the American College of Emergency Physicians --

A. No, no.

Q. -- let me put it that way.

A. No.

Q. And have you ever been stricken as a witness or denied -- your testimony denied as unreliable or inadmissible, that you know of?

A. Well, in 2006 there was a Daubert process in Michigan on TPA, tissue plasminogen activator, and a patient with a stroke and the -- with, I think, an attorney, Sam Mackler (phon), a case that was -- that came -- with a Daubert process, where I appeared and the attorneys appeared and the defense expert appeared, and the case was thrown out because it was felt that the attorney and I didn't bring enough literature to the court to support that TPA was the standard of

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care in that case.

The defense expert had testified that he gave TPA three times, but somehow the judge concluded that TPA wasn't the standard of care. In fact, TPA is nationally and internally the standard of care. The judge made a lame decision. It was held up by appeals, but it was a lame decision. And in the New England Journal of Medicine, in June of 2011, there was an article, basically, that said the -- that TPA was the standard of care, that places that consider it not are doing a disservice to stroke patients, and TPA is used much more with a much bigger window. So that was an issue that was -- the court made -- I mean, our system --

Q. Right.

A. -- is imperfect. That was one of the imperfect decisions. It was found that we didn't bring enough material to the court to make that judge conclude that -- I've appeared and testified since in Michigan, and it's the only time that a case didn't go forward because the literature didn't convince that judge, who new nothing about medicine.

Q. Okay. So that's the only case that you're aware of in which your testimony was called into question and actually found to be inadmissible?

A. Yeah. There was a conversation in a journal that was unethical and inappropriate, and that was, again, about TPA, because there was a big movement for defense attorneys to try to get around TPA use, which is the standard of care worldwide, with a much bigger window. There was another issue about that. But that was nobody that had any ability to call my testimony in -- and it was an unethical thing, and they stopped doing what they were trying to do, which was just to intimidate doctors from standing up for patients that were injured or maimed or not treated correctly.

Q. Right. Have you ever prepped -- prepared a list for the federal court, or otherwise, of the cases on which you've acted as a consultant?

A. I've appeared in federal court, and they ask for that. And I don't keep a record of these things, and so attorneys -- I mean, there's all sorts of websites, or sites that could be gathered. And I know some attorneys, when --

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I've probably been involved in several federal cases over the years, and the attorneys have put that list together. I know -- but I don't have a copy of it, and I've never tried to do that.

Q. Okay. All right.

In the last couple of years, can you give me an idea of the percentage of your income is attributable to expert witness work?

A. Probably 20 percent, maybe.

Q. Okay and --

A. 18, 20 percent, possibly. Less lately because I'm doing less, but probably about that.

Q. So the income -- other income you have is what, workers' compensation?

A. Well, my Army retirement, investments --

Q. Oh, okay.

A. -- financial things.

Q. Okay, got it. All right.

So the -- and then, are you paid for the peer-review work?

A. What?

Q. For the VA.

A. For the VA, it's around $600 for the total of it. It's sort of almost pro bono,

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

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

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

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

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also after that procedure, during the summer of 2011, leading up to the paniculectomy, and then maybe even after that.

A. I know I've seen some pieces that were preoperative bariatric service records, namely prior to 1/19/2011. And possibly I may have seen some stuff pre-pannus surgical removal. I don't recall specifically. There may be some in there.

Q. Do you have the records from the pannus removal? That would have been September --

A. September --

Q. -- 2011?

A. -- 2011, yeah... I'm not sure, as I sit here.

(Pause)

That would have been September of 2011, I think, as I recall it. Right?

Q. Correct.

A. Yeah. In brief, looking through those pieces of paper -- oh, here's some others.

I thought I might have seen some, but I'm not quickly finding it.

Q. Okay.

A. But I can keep looking, if you would like, while you ask me questions.

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Q. Oh, that's all right. We're going to get copies of nearly all of that.

Other than the last group of records I mentioned starting with the MGH record of January 19, 2011, all the rest of them are marked as exhibits, so...

Okay. So have you seen any photographs of Mrs. Carey?

A. Not that I recall.

Q. Have you seen any of the actual films?

A. As I sit here, not that I can recall.

Q. Have you seen any medical records from pre 2011?

A. Pre 2011, yes, I have, yeah.

Q. What have you seen from prior to 2011?

A. I know I've seen some things that -- I know I have seen some things that were twenty -- have "2010" on them, I'm pretty sure. I don't recall specifically, and, obviously, I didn't think they were too relevant to what I was asked to do.

Q. All right. Have you seen any records for treatment of back pain that pre-existed 2011?

A. Not as I sit here, nor did I ever see it memorialized in the records from -- that I was -- that I thought was a primary thrust. I didn't see it memorialized in the 2011 records either.

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Q. And you have not seen any affidavits of meritorious defense, that would be affidavits by the experts that we've identified?

A. No, I haven't.

Q. Have you reviewed any summaries or lists or any sort of timelines concerning the case?

A. Not -- no, I haven't.

Q. Okay. Have you discussed the case with anyone other than the plaintiff's counsel?

A. No.

Q. Do you have a document that sets out your fee structure?

A. Do I have a document about that --

Q. Yes.

A. -- no.

Q. No?

A. I don't have a document about that.

But what is, I mean, I can tell you. It's $400 an hour for any review work. And for a deposition, like today, $1,400, minimum, and if it goes beyond three and a half hours, it would be greater than $1,400. And for trial appearance, $3,000 plus appropriate expenses, like travel and food.

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Q. Sure. Thank you.

And as far as billing records, you did not bring those with you here today?

A. I don't keep them. I submit an invoice, and if it's paid, I destroy it and I get a 1099 at the end of the year and pay my taxes, like hopefully most Americans.

Q. All right. So you're saying you don't have any billing records for your work on the case to date?

A. That's correct.

Q. Can you estimate how much time you have spent on the case and/or billed to Mr. LaParl to this point?

A. Well, I billed your firm, I assume, $1,400 for the deposition today, and I billed the McKeen firm $2,000 for the preparation for today. And prior to this, I've probably billed $1,500, roughly. I'm pretty -- that's probably what I billed them.

Q. Okay.

A. Give or, maybe, possibly another few

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hundred dollars, but less than $2,000 up till my commencement for the review for today.
Q. Right, okay. And that time is billed on an hourly basis at $400 an hour?
A. Yes.
Q. And before we went on the record, you told me you don't make any independent notes, although you do make record and you do notate the records that you review, and you also have sticky notes on them, the records that we've marked as exhibits, correct?
A. That's correct.
Q. Have you done any research relative to this case, specific to this case?
A. No.
Q. Have you reviewed anything else as you sit here today that comes to mind beyond what we've talked about specific to this case?
A. No.
Q. And at this point, have you completed your review to the extent that you feel comfortable telling me your opinions as you expect them to be, come time of trial?
A. Yes.
Q. Do you know any of the other -- any of

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the defendants?
A. No.
Q. Do you know -- well, do you know any of the experts that have been named? And you may not even know who they are.
A. I don't know who they are. Whom they are.
Q. Okay.
A. Who.
Q. All right. So I have your Affidavit of Merit here, but I guess -- so that's where I want to go next, just to your criticisms of the defendants. Probably the best way for me to handle that is for you to look -- to go to each encounter and tell me what it is that you think should have been done, or that was done that shouldn't have been, and talk about the standards of care for each encounter with that. Is that an okay to go --
A. Yeah.
Q. -- as far as you're concerned?
A. Yeah, that's fine.
Q. So let me have you identify -- tell us, or tell me, how you define the standard of care.
A. Well, the standard of care is the

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

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

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

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

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

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

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make sure you're not missing something. And if they've been seen three times, you'd better have a reason not to admit them, because you are missing something. So that's an axiom about if somebody is seen in whatever setting three times you better admit them, because you're missing something, if they're coming with serious complaints.

Q. Okay.

A. So Brenda Carey was in this very small hospital and being treated, really, by the same set of physicians in either the family practice or the ER setting, and also by a nurse practitioner, Jennifer Weaver.

And so the first complaint I would have about Dr. Brad Goldman is that when he sees this patient on 7/28/11, she has now had, since May 17th, new severe onset back pain and symptoms for a lot more than three times when she came in to see him in the clinic setting and as an emergency medicine physician practicing in the clinic setting.

And she also, when she presented, was having the complaints of back pain, which go back to May 17th, and had lost a significant amount of

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weight. She had bariatric surgery in January, I think 18th, of 2011, roughly, and she had had somewhere around a 100-pound weight loss. That's -- that's either a heck of a great response to her bariatric surgery, or I think, actually, probably a little more than one would have anticipated her weight loss to be, because I think there was actually -- she had the bariatric surgery, but I think she also had a very significant weight loss. I would have been sort of struck by that, and if she has any other complaints and is not doing well, I would wonder if her weight loss would be a result of the bariatric surgery plus something else going on. And, in fact, it's very common for patients with non-Hodgkin's lymphoma or other serious, malignancies or diseases to lose weight with anorexia and weight loss.

So I don't -- I don't think I can just pat the surgeons who did the bariatric surgery on the back, although they did well. I think the fact that she's got pain is emblematic of the fact that her back pain is related to something absolutely separate from her bariatric surgery, which turned out to be the case. So that would

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be --

Q. So if --

A. That would be Point 1 in her history and findings that this weight loss was not just from bariatric surgery, but also from a serious underlying illness unrelated to that. So.

Q. Okay.

A. And she's been taking -- she's being medicated with significant doses of Lortab and Flexeril, but she's still having pain, and simple musculoskeletal pain is -- thank goodness, most patients who have back pain, it's 90 percent, probably, musculoskeletal. But you know what? They start getting better in 72 hours. Even if it's a partially herniated disc, they start eventually getting better.

So the benign musculoskeletal causes of back pain are almost always getting better within a week or two. This is now many visits to a number of doctors in a number of venues over two months into her back pain, many medications, and she's clearly not getting better and has striking back pain, which is uncontrolled by strong medications.

Also in the history is that she's not

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getting sleep at night because things get worse at night. Typically, simple benign musculoskeletal pain is better in bed unless you happen to have the worst bed in the world. But usually, musculoskeletal pain is worse when you're up and about, standing prolonged, lifting, moving things. But it's generally relieved by any reasonably firm mattress that people lie down on. Hers is apparently exacerbated in that position, which sort of makes you think of mechanical things, like any kind of a space-occupying lesion, whether it be a hematoma -- paraspinal -- or an abscess or a neoplasm, benign or malignant.

So you have to think of -- of -- of something space occu -- why does somebody have two months of pain on many medications with weight loss, which ought to make any musculoskeletal pain or pain related to severe morbid obesity better -- I mean, people weighing 500 pounds, as she did initially, getting down to 300 pounds, that should be dramatically better on her back, and nobody, ever, in her history in the emergency departments ever elucidated, or attempted to, or drilled down on any previous

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history that she had of terrible back pain. Nobody said that Brenda Carey had severe back pain and described it and drilled into it and talked about it. In the past -- and nobody ever really did it appropriately, including Dr. Goldman here, about the nature of it, the duration of it, what relieves it. It never was explored, really, or any past history. So those things are initially, in the historical part of Dr. Goldman's evaluation on 7/28, lacking and a deviation from the standard of care in this patient.

With respect to the physical, the examination is -- is -- I can't say -- I mean, the examination of this patient getting significant medications, two months of pain, including the vital signs, the examination is roughly five lines and doesn't drill down into anything. It says straight leg raise is negative, and it says neurovascular in tact. That doesn't cut -- that doesn't anywhere near cut it for what the standard of care would require when you're loading such a patient with Lortab, Percocet, Flexeril, Ambien -- a month of Ambien, which is not one of my favorite sleep

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medications because of the incidence of some people getting --

Q. Dependency?

A. Well, dependency and disorientation and forgetfulness. I mean, to give somebody a month of Lortab, Percocet, Flexeril, and Ambien, that's a heck of medication load and would lead anybody to start becoming addicted to these things. And this is two months into the course.

So by history and by physical, this evaluation on this patient that's been seen by so many members and so -- a number of times, too many times, to not have explored really in depth what was going on and start ordering tests, which I think would have made a diagnosis. So it doesn't meet the standard of care by history, physical, by ancillary tests which should have been done by, certainly, long before this.

And the discharge diagnosis should not be pain management, refill on these addictive, powerful drugs. It should be either -- it had to be getting some imaging. Plain x-rays could be a start; best would be a CAT scan, which was available in the hospital; and even better would be to get an MRI set up, which would be excellent

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for these; and consultation with appropriate consultants, since nobody on the team felt it necessary to conference her -- I mean, here you've got a small group of doctors in a small hospital with a three- to four-bed ER and nobody is conferencing her after two months. This is the kind of case you sit down and you order some sandwiches for lunch and say, What's going on with Brenda Carey? What are we doing here, except medicating her and delaying a diagnosis?

So I think it's -- for each doctor whom I'll talk about, and for the system in total, this is an egregious deviation from the standard of care with a serious diagnosis where it's better to make a diagnosis for Non-Hodgkin's lymphoma, or, if she had an epidural abscess, certainly any of these things before she becomes possibly uncurable, or, if it were an epidural abscess, has endocarditis on top it from continuous vegetations of bacteria on a valve, because that would be an another thing that should be in a differential, and why you would, way long ago, have done a sedimentation rate or a C-reactive active protein, which almost every orthopedist would order because they love that

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kind of test for this kind of patient, to diagnose occult infections around the spine.

MR. LaPARL: Can we go off the record for just a second?

THE WITNESS: Yes.

MS. MacGREGOR: Sure.

(An off-the-record conversation was held.)

MR. LaPARL: Could we take a 5-minute break? I just got a text message from my daughter, whose car was not working, and I need to get back with her. Is that okay?

MS. MacGREGOR: Sure, no problem.

(Recess)

EXAMINATION CONTINUED

BY MS. MacGREGOR:

Q. Let me ask you just a little more about your background.

Have you worked in a clinic setting in, let's say, the last 10 years?

A. In a clinic setting in the last 10 years... You mean --

MR. LaPARL: I'm going to object to the form of the question.

Q. Okay. So have you practiced family

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medicine?
A. In the last 10 years... Probably not in the last 10 years.
Q. All right. And have you acted as a primary care physician in the last 10 years?
A. I've taken care of a number of people. I mean, I'm an internist, which is a primary care physician. So is emergency medicine, and -- but I've taken care of people, friends, and prescribed medications and -- but, you know, this is like, you know, once every three or four weeks somebody says, What should I do? And I prescribe medicine, I see them, but not in a formal setting.
Q. Okay. All right.
The idea of differential diagnosis, you've mentioned that a couple of times, Doctor. Would you agree that at -- well, tell me what you think the differential diagnosis should have been, or what should have been on that list for this encounter of July 28, 2011.
A. Well, I think from the get-go in a patient, certainly after -- by the second or third visit, when the patient, such as Brenda Carey, is being seen and she's not getting

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better, right out of the gate, an appropriate and complete history needs to be obtained, like, Is this like anything she's had? Has she had back pain? And then the exam needs to be focused, and in somebody with severe back pain it needs to include a real neurological exam. I don't think anywhere in any of the emergency medicine people I'd be speaking about did anybody do an appropriate neurologic exam, like would be examined by the standard.
But what would the differential include? The differential I sort of touched on of severe back pain can include -- early on it can include anything that's space occupying and compressing important pain-generating parts of the body, which would include nerves and the spinal cord. And that could be significant herniated disc and -- but that would be something that would not be worse lying down, typically. It would be more upright. It would be more radicular.
And then, in the differential, the most important things in space-occupying lesions, which you have to consider, is the things that cause space occupying, which could be a hematoma

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from bleeding. People can get spontaneous bleeds. But usually, these things are not going to last so long; they're going to get resorbed.
And then the two other things that would be on the top of the list would be infection versus neoplasm. Neoplasm being all tumors, some of which could be benign, like meningiomas; others, which are be malignant, which can be the blood malignancies like, in this case, or solid tumors, like cancers from lung, from kidney, from whatever. And it can include those organs that are nearby, like the kidneys, the adrenal glands that sit on top of the kidneys, the retroperitoneal space, like the pancreas.
So, again, when you have severe pain like this that's not only related to movement, which is more classical of musculoskeletal, the relatively nonlife threatening, musculoskeletal pains are going to be like tears or injuries or discs. And those are almost always going to be if you don't move, you can often find positions of relief, because they are what they are. Musculoskeletal, they're related to the skeleton, the movement of the skeleton. The non-benign

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things, like space-occupying lesions, the worst being infection versus neoplasm, cancers possibly, are going to be painful all the time. They're going to give you pain when you're laying in bed, which should be relieving it, or in -- it's going to be hurting all the time and unrelenting, and medications are not going to control it, and it's going to last for months and months until it either kills you or eventually gets diagnosed. And so that would be the differential, the basic differential.
Q. Okay. And --
A. And the body -- the body -- just to finish, the body is an open book. Any fool practicing medicine can order an MRI. Some of these tests get ordered too much. But this patient needed it real early on, you know, by, certainly, in June should have had imaging done. And CAT scan was available in Aspirus Ontanagon -- Ontanagon, I hope it got it, I think I got it. A CAT scan was available. And the best test would have been an MRI, because that part of the body is very good for MRIs.
Q. Do you know how far she would have had to go for the MRI, one that would accommodate her

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size?
A. Well, you raise a good point: Her size. It has to be sort of an open MRI. Even for a CAT scan it has to be a special open scanner.
If there's a zoo nearby, I mean, they have them for elephants. I mean, I've sent patients to zoos who are large and need to be scanned. I don't know how the closest one -- but this one was in Michigan, so it was probably within 100 miles.
Q. We don't have any zoos in the UP that would have an MRI for an elephant or hippo or something, and Marquette is two and a half to three hours away.
A. Well, this was May. She could have even been flown, but I mean, it would have been reasonable to go by ambulance.
Q. Well, I don't know that they even had flight service in 2011 to Marquette. But in any event, okay.
All right. Just generally on that differential that you listed, you listed a couple of reasons why perhaps some of the items there might not be on the top of the list; for example,

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disc.
In your opinion, was it necessary that Dr. Goldman on this day take those steps necessary to rule in or rule out each of those items on the list?
A. Yes.
Q. Okay. So he had to -- so in terms of the disc, the MRI would address that, correct?
A. Yeah. I mean, that wouldn't have been the top of my list, just because of the supine -- when she's in bed it hurts more. And -- and I would have been a little -- I would have looked -- I didn't see anybody ask or be concerned: She had a dramatic weight loss within a half a year of bariatric surgery. There's something else going -- you have to wonder, you know, why. It's not just the surgery, you know. I think her weight loss was related to the fact that there was something else doing on too that caused her to have anorexia and weight loss.
Q. Did you --
A. So her picture, I would worry more about abscess and neoplasm, tumors.
Q. Okay. As far as weight loss goes, did you recognize that she lost quite a lot of that

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weight before she had the surgery in January?
She maybe lost 35, 40 pounds --
A. Yes.
Q. -- beforehand?
A. Yes.
Q. And she was working hard to do that?
A. Yes.
Q. Would you expect somebody who had a BMI of... let's see -- eighty... I think it was 84.
Let me just find it...
Yeah, a BMI of 84 in June 20th. So she's 5-foot 2 --
A. Five feet.
Q. -- at one point I saw 5-foot 2, so I gave her that --
A. She was --
Q. -- 5-foot 2, so I --
A. She was 5-2, but she was 5-foot, she said, at the time of all this.
Q. Okay. And her weight was 461.5, and it was actually Dr. Griffin in the weight loss clinic who puts her BMI at 84.54 in August of 2010.
Would you expect a person of 47 years old to have musculoskeletal complaints related to

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her weight --
A. Yes.
Q. -- and body evidence?
A. Yes. And certainly her knees.
Q. And --
A. Like she had a lot of knee problems too, because she's carrying all that weight. And she certainly could have musculoskeletal problems; it wouldn't be a surprise.
Q. Okay. And --
THE WITNESS: Could you just give me one second, please? I just want to get a little water.
MS. MacGREGOR: Sure.
(Off the record)
BY MS. MacGREGOR:
Q. Was it incumbent on Dr. Goldman in June -- July of 2011 to also look into this knee issue as to whether it is related to the back pain that she's having?
A. Oh, I don't think -- that's a -- that's a stretch that I can't make. I don't think her knee pain -- her knee pain is not a surprise that it would be osteoarthritis and degenerative joint disease from that weight, but it's not -- not

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

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

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

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

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

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

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

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

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of systems is -- her neurologic exam, her history is no headache. I'm not sure why she's asking about a headache in this patient who's there, in quotation marks, for constipation, close quotation marks. I'm not sure why she's not asking about a whole bunch of other neurologic things. And her neuro exam says no focal neuro deficits in this patient with abnormal vital signs and three months of pain.

So I -- ah -- ah -- and if she's really impacted or constipated from medication, I would have thought that it would have been -- she might have been disimpacted digitally with a rectal, a rectal glove. Because usually, when patients are constipated like that -- I think it was eight days or something -- you can feel a mass of stool at the anal orifice that you can disimpact.

So, again, it boils down to a doctor in the geographic area of this small hospital who doesn't take the time to pull the old records on this patient, who is obviously a frequent flier to the clinic and the ER, with an unresolved severe symptom, none of this related to bariatric surgery. It's a failure to do the appropriate history and drill into it; a failure to do the

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appropriate physical, including a real neuro; and a failure to appreciate the clinical significance of the fact that this patient is still an undiagnosed serious, potentially life-and-limb-threatening problem.

Q. So, Doctor, are you suggesting, or is it your opinion that the standard of care under these circumstances require Dr. Manning to assess the patient more broadly than just for the chief complaint that she came in for?

A. If somebody comes in with constipation and they're absolutely fine otherwise, and they don't have the history and they're not as complex as this patient with her problems and her surgery, then you can just give them -- you know, you can do a brief, general exam. The differential diagnosis doesn't have to be, you know, explored in depth. You can ask them if they've had constipation in the past, how often do they have bowel movements, how many days do they go, is this very unusual. None of that do I see explored. So she's just giving her some laxatives and trying to evacuate her, so it's not acceptable.

I mean, she didn't explore the history,

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she -- this woman has a history, and she hasn't had a bowel movement for ten days. The history is that she's taking a ton of medicines that will constipate her. And the history is she's taking those medications for back pain. And none of this is in the review of systems, is in the history of the present illness -- I'm going to look at it again. I've got a few marks on it.

I mean, the idea that she writes, Some right flank pain, give me a break. She was just in there -- she's been on narcotics, Flexeril, and had a shot of Toradol in that same ED a couple of weeks ago, and the pain is still there, because it was there after and it was there before. This is not some flank pain; this is a severe pain that's persistent.

So she -- she did what she did. It doesn't meet the standard of care at all in my opinion regarding history, the total patient, the exam, the neuro exam, which is -- does not meet any standard of care with what should have been done.

Q. Do you have -- what is your assumption with regard to the availability of past medical records?

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A. From what I read in deposition testimony, they're available if requested.

Now, I'm looking -- you know, I mean, I know it -- usually in small hospitals you can get anything easier than you can in big hospitals.

Q. When have you last worked at a critical access hospital?

A. A what? A critical access?

Q. Right, that's fewer than 25 beds.

A. Hospital, that would be when I was director of the emergency department in South Amboy, which would have been around the year 2000 or so, I think, when I was at Memorial Medical Center. That was -- let me see where that would have been...

That would have been '98 to '99. It was a small hospital in the middle of a bunch of big hospitals that ultimately went out of business about nine months after I got there. But that was a small ER, a small hospital. You know, that would be that kind of hospital.

Q. So in your opinion, under these circumstances it was -- the standard of care required Dr. Manning to review past medical records, correct?

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

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

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

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

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of this visit, less than two weeks, in that same ER, and a neuro exam that doesn't -- a neuro exam, no headache, history, that's neither here nor there. That's not -- you know, this is not the history of what this patient was on that day.

I mean, she's got down that the patient is on Percocet, Ambien, and Flexeril. I mean, you know, why is she on those medicines? There's no reason in her history of the present illness. That's unexplained anywhere, why she -- in this history and review of systems there's no explanation of why this patient is on Percocet, Ambien, and Flexeril.

Q. So on this day, in your opinion, among other things, Dr. Managing should have hospitalized the patient?

A. Dr. Manning wrote two pages that signify nothing about what this patient's problem was and gave her some Ex-Lax. And she should have actually taken a meaningful history and done a meaningful exam, and then she would have known that this patient is still with symptoms of severe back pain, only two weeks earlier sent to the ER by her doctor for a shot of 60 milligrams of IM Toradol.

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If she drilled into that, she would know that just because the whole forest wasn't burning there was a fire going on here that needed to be put out, that she needed to attend -- she didn't need to write, you know, two pages that signify nothing. She didn't address a pulse of 118 that wasn't repeated. That's an abnormal pulse. She didn't address an respiratory rate of 20, which is the upper limit of normal.

And she -- somebody, somewhere within this system needed to finally do what was required. None of them did. The whole system failed. And each individual doctor taking care of her in that ER failed, and this is another one of them.

Q. As far as the neuro exam that was required on this day, can you give me -- kind of tick off the various tests that should have been done?

A. You know, there's a --

Q. I mean, are you talking about a complete neuro exam or what?

A. You know, there's a system, and I'm sure that you've encountered it, the T-system.

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Q. Right.

A. I haven't looked at it for this case. I was part of the beta testing of it when it first came out. A couple of smart guys in the '80s, one, I think, from Canada and one from the Dallas area, and they're very wealthy, because it's a good system that was accepted by probably a quarter or a third of emergency departments. I haven't looked at it in a while, but if you look at the back pain the sheet, the T-system sheet, I'm willing to -- having not looked at it, I'm willing to say there's a reasonable neurologic exam for severe back pain.

Q. Okay.

A. And it would include a neurologic exam. In my opinion, what the exam should be, well, it should ask about numbness; tingling; weakness; focal weakness, one side or another; upper versus lower extremity weakness, which can be important in things like myasthenia gravis or other syndromes and motor symptoms.

One up the doctors talked -- I think it was Dr. -- well, I forget specifically, was talking about vitamin deficiencies. I mean, give me a break. I mean, that's like -- you know, he

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was doing a metabolic workup. There's no metabolic workup for back pain. You know, there's a neurologic workup. I mean, I know about metabolic diseases as an endocrinologist, I think, and I know -- he talks about vitamin deficiencies. This is not scurvy; this is not a vitamin D deficiency; she doesn't have osteoporosis. In fact, she's pretty well, other than having had non-Hodgkin's lymphoma.

But the neurologic is focality, left or right side, upper or lower extremities. Weakness, what's a weakness? "Weakness" is defined -- when you seriously look for weakness, 5/5 strength is normal; 0/5 is not. When the first appropriate strength exam was done, like in the end of October by -- I'm not sure -- I couldn't tell. It was probably not a physician; it was probably some mid-level person doing physical, left, right, 5/10, she had three -- rather 5/5, she had 3/5 strength in her lower extremities. Abnormal.

So that's what a neurologic should include, including sensory mode of vibratory positional sensations. You stroke -- you take -- and I'm -- it takes me maybe 5 minutes to talk

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about it; it takes me 15 seconds to do it. I break a tongue blade, I stroke the legs, I see if it's symmetric, I see if sensation is decreased. I stroke the cheeks and I see if sensation is symmetric and decreased. I ask them to look up and look down, to smile, to look at the nerves, the cranial nerves. And I check proximal and distal strengths: extend the fingers and see if you can contract them; make a wrist, dorsiflect a wrist; have somebody stand up, see if they can stand on one leg and the other; have them walk a straight line on a crack in the hospital floor to see if they have positional and cerebella brain stem findings; finger-nose or toe-nose touch to see strength, and also positional.

These things take -- I just said what it takes. Reflexes of the ankles and the knees, knee jerks, which -- spasm, if you take and push the foot back all the way, dorsiflect it, you can see clonus in people with spinal injuries. So how long did I take to say that? Probably a minute, possibly. Probably less. And it takes me, if you've an experienced physician who knows what you're doing, starting from the head, where I like to start, to the toes, or, as I've watched

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some young doctors when I was precepting them so they could take their boards, sometimes they'd start in one leg and go to one arm and then they would go back to a leg. I look for the organized approach, but it takes literally less than a minute to do it. It wasn't done by any of these emergency medicine providers. Nobody described --

Q. And it --

A. -- it. Nobody, until October 26th, I think, at the end, just before she was sent to Marquette, nobody did a 5/5 strength in somebody who ultimately came in saying her legs were mush. She couldn't stand up. Her husband couldn't get her up off the floor. She came in by ambulance, at which time they still watched her for two days before sending her to Marquette, which is a particularly critical period, which is when the cords is really being compressed, and that's the most critical end period. But all these periods are critical, because the earlier the better, always, in anything we treat.

So that's why this exam, this history, this absence of doing anything that needed to be done by the standard of care, that's why it's all

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a deviation. It doesn't meet the standards. It's not -- it doesn't meet the minimal that should have been done.

Q. If a neuro exam, as you have described it, had been done on August 21st, what do you expect it would have shown?

A. I know what should be done; I don't have a crystal ball to see what would be done. I can't say if it would have been abnormal on August 21st or not, but I do believe that if appropriate imaging, namely a CAT scan, would have been done, it definitely would have been abnormal. And the history would have clearly been abnormal.

What the physical would have been, I can't honestly say, but I know the history would have been abnormal, and it would have -- it would have led to an admission somewhere, if not here, then elsewhere at a higher level of care. And a CAT scan could have been done there, and it would have been abnormal.

Q. Is it your opinion that on this date she did have lymphoma that was causing symptoms?

A. Yes. Yes, very much so. I don't ever say 100 or never, but this is a 99.9 percent

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there would have been masses of lymphadenopathy.

You know, at the very late part of her course, before she got to Marquette, she had swelling in her feet. I don't see anybody else who commented in the depositions, or was it asked, but the reason she had pedal edema towards the end was because she had a big massive lymphadenopathy at the end. She had a lot of swollen lymph glands, and that's a cause of fluid not getting up from the lower extremities against gravity because of the compression of significant adenopathy.

Non-Hodgkin's diffuse B-cell lymphoma causes big lymph gland enlargement, big nodes, like I think she -- like she had. And that can obstruct -- that in the pelvis and in the body can block the veinous return and the lymphatic return, contributing to pedal edema, which I don't see anybody having addressed in the review of this material.

Q. Do you know, Doctor, how non-Hodgkin's large B-cell diffuse usually presents, what's the early symptoms of that?

A. Well, it can present with fevers, like most lymphomas, but not necessary -- and, by the

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way, most of the doctors weren't checking the fevers, really, and when you really want to check a fever, you need to do a core temperature, like a rectal temperature, and sometimes they weren't even done. So you can have fever.

She did present once diaphoretic, sweaty. I don't know what her real temperature was, but you can have a fever. You certainly, with lymphomas, have anorexia and weight loss. And then a lot of lymph tissue can be -- you can find it -- it can be anywhere. It can be -- thank goodness in her, as far as I know, she didn't have it in the brain, in the central nervous system, because that's a big deal, a different disease sort of almost.

But you can have a lot of adenopathy in the inguinal areas. You can have splenomegaly, which might be difficult to feel in a large person, to feel the spleen under the left rib cage. And you can have pains anywhere, depending on where the big lymph nodes are compressing tissue, nerves. And in her case, it actually eroded her vertebral body. The mass of growing lymph tissue, lymphadenopathy, constant pressure on any bone will ultimately cause it to erode.

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And so she had, by the x-ray, I think on 10/26, possibly, that Nurse -- PA -- PN, Nurse Practitioner Weaver, Jennifer Weaver, ordered the first lab tests, as I recall -- and I'm not looking at her records, but I don't think I'm speaking out of turn by saying she ordered that and she ordered the x-rays which showed the collapsed vertebrae. Then you don't have an elephant in the room; you have a heard of elephants, when you see a collapsed vertebra with this kind of pain history. You know, why they were keeping her, unless they wanted to have a heard of elephants in their hospital for a couple of days longer, why they kept her, I have no idea at that point, rather than sending her to Marquette or some other large medical center. Marquette, I guess, was the most appropriate, since she had surgery there.

Q. And --

A. So, you know, nobody --

Q. Go ahead.

A. Yeah, sorry. No, I'm done.

Q. Okay. As an endocrinologist, do you appreciate that a person who goes through bariatric surgery does have nutritional -- is at

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risk for nutritional deficiencies?

A. Well, I don't think I have to be an endocrinologist to know you can have nutritional deficiencies. I think any general practitioner should know that, that a bypass of the gastrointestinal tract, you need to worry about nutritional deficiencies. You don't have to be an endocrinologist -- I think I know a little bit more, but I think the standard of care for any physician would be expected to know that.

Q. Right. Okay.

And that surgery also can dramatically affect a person's bone, vitamin D, and calcium --

A. Yeah.

Q. -- retention?

A. Yes.

Q. Right. Is it reasonable for a physician to conclude that the compression fracture is potentially a result of this patient's body habitus and the nutritional impact of her bariatric surgery?

A. No, I don't think --

MR. LaPARL: Asked and answered.

A. I -- again, I don't think -- number 1, this woman was 47, 48, and she's not a

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60-year-old. And the surgery was in January of this year, so when she's coming back, five, six months later, I think that's -- this is, as an endocrinologist and a metabolism physician in the past, and not forgetting that, that's sort of early to be developing osteoporosis. You don't develop osteoporosis that promptly. I mean, you can develop it with multiple myeloma, which is another bad blood disorder that kills people -- we've gotten a lot better at treating that now, but it used to kill people, half the people, in two years. That can give you collapse of a vertebra.

But no, vitamin or mineral deficiencies, I don't think that would be consistent being five months out, six months out, seven months out from bariatric surgery in a 47-year-old woman, 48-year-old woman. You've got to think of bad things, like abscesses and tumors, including multiple myeloma, or non-Hodgkin's lymphoma, or some other space-occupying lesion.

And the fact that her vertebral body was seen on a plain x-ray, it would have been much more dramatic on a CAT scan. So the bottom

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line is, you can't accept, in somebody with this course, this history, you can't accept that it's something benign, and you can't sit back on your haunches in laziness and intellectual lack of curiosity, you can't sit back until you've excluded the life-and-limb-threatening disorders. Then you can say, Well, whatever wastebasket thing I want to call it -- just like chronic fatigue syndromes or posttraumatic stress, you need to rule out the critical things that could cause that, and then you say, Well, what do we call it? Maybe just so me -- maybe somehow related to her bariatric surgery. Not right out of the gate. You first need to do the intellectual work and order the tests or send the patient to someone or somewhere where they will.

Q. All right. Well, let's now go to the next encounter in the ER, or by an ER physician, and I would suggest that's probably September 22nd.

A. Yeah, Dr. Austin.

Q. Okay.

A. Well, here's another one of the doctors -- well, do you want to ask me a question, or do you want me just to...

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Q. Yes -- well, same question. So tell me what your criticism is of this encounter.

A. Well, here she comes in, it says presents -- she's run out of pain medication and sleeping pills. This is a 48-year-old woman, 47-year-old woman. She's run out of her pills.

Let me get it straight. What is it... she's born in '63... '73, '83, '93...

Q. She's 48.

A. 48. Just to be precise, she's a 48-year-old woman. She run out of pain medicines and sleeping pills. She presents for evaluation. She's seen by home nursing. And then he's talking about her -- she just recently had her pannus, 60 pounds of so of pannus, removed of the skin and remaining fat, and will place her -- she's got some erythema around the margins of the wound, so what he's doing is he's giving her a gram of Rocephin a day for five days, and he's giving her another order of Lortab and Ambien and follow up with her own doctor.

I don't know what that's about. I mean, you know, this is no history, no exam; more Lortab and Ambien, and he's doing some regime of Rocephin, IV or IM. It doesn't specify right

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there. I don't know what kind of medicine that is. It's like sending the patient for the shot of Toradol by Dr. Chaltry, sending her with 8/10 pain that's been going on for months. You know, this is intellectually dishonest, lazy, illogical, intellectually empty medicine. This is -- this is like -- I don't know what it's like, but it doesn't resemble anything that I would call standard of care. It is sort of really egregious.

Q. Okay. So --

A. This kind of lack of -- lack of intellectual curiosity. And, you know, I can't imagine what was going on in this small ED at those times that was more important than this patient.

Q. Do you acknowledge that her chief complaint was that she was worried about her surgical site, possibility of infection, on the nursing note?

(Pause)

That's what she presented for?

A. Yeah.

Q. And based on the record, Dr. Austin did examined that and did conclude that a course of

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Rocephin rather than the Keflex might be appropriate?

A. Yeah, I think a lot of infectious disease people would say that doesn't meet the standard of care, and that's sort of a shotgun and it's why we have resistance to second- and third-degree cephalosporins, and it's -- and Rocephin, if he's really worried about a wound, you have to wonder about methicillin-resistant Staphylococcus, which Rocephin wouldn't cover. You would wonder about giving her maybe instead of the shots, however he gave them, you would wonder about giving something like Septra, which would be good for methicillin-resistant staph.

So it's not really logical, and he doesn't really describe the wound, other than some erythremia around the margins of the wound. A lot of wounds can have erythema. Erythema doesn't equate to an infection that requires Rocephin. And if you did worry about it, you would start worrying about methicillin-resistant staph. And I don't know that he did any culture of any drainage. He doesn't talk about bad drainage. He says there's no fever, but I don't see a temperature anywhere recorded. Do you? I

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

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

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

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

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standard of care require Dr. Austin to get a CT or back x-ray?

A. He needed to realize that this patient has been having the same complaints and is being given medications only, instead of an evaluation, and he needed to call Chaltry and see if Chaltry was going to -- if he's her designated doctor, admit her. Or he needs to say, Well, what are we doing, Richard -- what are we doing, Richard Chaltry, with your patient who you're supposedly the primary caregiver of, who has been here X-number of the times and is still on these medications for this unresolved problem?

Everybody -- you know, medicine is often like a relay race, and anybody who's got the baton needs to run with it and makes sure it gets handed off correctly. So each one of these runners here, they lose the relay. They're all dropping the baton. Each one of them is not -- this is a -- you know, medicine is a team practice, for better or worse. That's why records are important; that's why positive findings and negative findings are important, because it's a way we communicate periods in time, because no doctor can be taking care of one

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patient 24 hours a day, 365 days.

So this patient comes -- in this case, in this small hospital, is better than when you're in a city where patients sometime wind up going to four places around the beltway and have a CAT scan at each one. That's bad medicine. That's bad, expensive medicine. That's exposure to radiation rather than communicating.

40 years ago, when faxes didn't exist, we would try to talk about how the EKG looks with somebody in LA from New York. Well, the EKG has a bump here, and the PR is this long, and there's no ST changes. Now, we've got all this technology -- we've got records, we've got computer records, we've got retrieval of records -- so you've got to make the records meaningful. None of this is meaningful. They're giving pills; they're giving shots of Toradol. Nobody is saying, There's an elephant here. This is not just a gray, thick, heavy leg; it's an elephant in our ER, and they're just walking around and showing up.

So, yeah, every one of them is responsible. They're all doctors, or supposedly. They're supposed to have the intellectual

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wherewith all to know what they need to do and the lack of laziness to go ahead and do it.

Q. Okay. So how about we go to the next encounter?

A. The next would be, probably, 10/3, maybe, Douglas Segan?

Q. Yes, that's what I've got.

A. That's what I come up with. And apparently Douglas Segan, I guess, for some brief period of time worked at the naval hospital that I was the director of in Bethesda, after reading his deposition. And I'm sad to say I don't remember Doug, so I guess he wasn't around too long. He was probably a locums, during the startup of the contract. He was probably a fill-in while --

MS. MacGREGOR: L-O-C-U-M.

A. -- he was probably a -- it's amazing; you look like an incredible ventriloquist, because we hear the sound but you're not moving your lips.

But he must have been a locums physician, as he is a lot, apparently, or has been, because he -- I don't remember him, and I -- so it must have been during the start-up of

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the contract at the Bethesda Naval Hospital. But in terms of his visit, let me get to that...

(Pause)

So on 10/3 he notes that her chief complaint is back pain. He's got the history that it's been going on for three to four weeks. It's actually really been three to four months, so there's a little problem with that history. And he notes that she's had the bariatric surgery and the pannus removal.

And he says, down about 15 lines, "The patient states she is here because she just needs enough Lortab to get her through from today until Wednesday." So that means she's having significant pain, breakthrough pain, continuing pain, and she's been using up her medicines. And he notes the pain more at the nighttime, and that she's eating and drinking well, but she does have the weight loss, a little more, as I said, than might be anticipated.

So he takes a little better history than a lot of the previous physicians, and he -- and I'm just going to look at his physical here, because I haven't memorized these...

(Pause)

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And then he does -- he does a better exam than others. But, again, the history and exam are, in my opinion, inadequate. And the most pregnant thing being that -- that this is now in September, and this has been going on now for five months, roughly, five to six months of this unexplained back pain, which is being called herpetic neuralgia, and which nobody has described classic herpetic neuralgia anywhere in this chart at all, and which, when the patient got to Marquet was felt not to probably -- that she probably didn't have herpetic neuralgia.

And herpetic herpes zoster, which also causes chickenpox and then remains in the nuclei of nerves and then comes out and becomes active, and can be uncomfortable and occasionally pretty painful, is classically in older patients, usually 60 or so, but can happen sometimes in younger patients. Is classically -- it is always in the dermatome. In the dermatome. It's in one nerve, classically, and it follows that nerve religiously. It just follows it because the nerves in the body are like electric wiring, and so they're pretty hard wired. So if somebody has shingles, they can get it on the nose and the ear

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and some more unusual places, but the classic picture of herpetic neurologia, zoster, shingles, synonyms, is a line that's pretty clear, maybe an inch or two wide, and it just goes from the back midline, from that side, around to the front midline on the stomach, or the anterior torso, and it follows a nerve dermatome, the level in which a derm goes -- a nerve goes. And it's usually in older patients. And if you really believe that, then there's treatments, like early on, possibly with antiviral agents like acyclovir or Valtrex and others, or sometimes with hot chili pepper creams, like capsaicin.

We don't really know well how to treat it. If it's on the body, we probably wouldn't want to give prednisone, because it might reduce -- in certain patients, it could reduce the host resistance to any virus. And I don't think she ever had classic shingles or herpetic neuralgia, which usually doesn't last for six months, although it could, I guess, but it usually doesn't. And if it did, I would ask a dermatologist to take a look at it and say, Is this really that?

So, I mean, if she had something that

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was like erythema and possibly a rash, I would worry about it being more -- I would wonder about it being more related to her pendulous breasts and obesity and the accumulation of sweat causing that kind of inflammation and irritation from sweat in people with lots of fat folds. I don't think she ever had shingles or herpetic neuralgia. And --

Q. Let me ask you -- go ahead.

A. No, I'll stop there.

Q. Okay. As far as shingles goes, the rash, how long does that typically last?

A. Well, typically it's less than six weeks, probably, but it -- and it usually is a vesicular form. It usually looks like a very small pimple that comes to a head, and it's extremely tender at times in parts of that area.

Q. And is it --

A. But usually --

Q. And it follows the pattern as well?

A. Yes.

Q. Okay.

A. And it can go on for six to eight weeks sometimes, but usually it's resolved. And I think it's particularly unusual to see anybody

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with it for months on end --

Q. Right --

A. -- but it might happen --

Q. And that rash --

A. Yeah, go ahead. I'm sorry.

Q. And the rash can be exquisitely painful, correct?

A. Usually not exquisite, but it can be, occasionally.

Q. And the neuralgia that results, you indicated that it usually follows a dermatomal pattern, and the most common presentation is on the trunk --

A. Yes.

Q. -- correct?

A. Yes.

Q. And the pain --

A. You know -- you know, interestingly, as an aside, when I went to medical school 45 years ago, whenever we saw an elderly patient, like in their 60s to 70s, with zoster, with shingles, we would, in those days, do a malignancy workup, interestingly, because we would -- it used to be felt that the people who got reactivated chicken pox, reactivated herpes zoster with shingles

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manifestation, were people with -- were compromised hosts because of an underlying occult malignancy. It's not -- I don't think it's believed to be that anymore. That was 40, 50 years ago. They would get a mini workup, like a barium enema for an occult colon cancer in those days, and this and that. And I used to do those workups as an intern and a medical student. But we don't do that anymore. I think it happens, but you always have to -- you know, there is the historical precedence that that was the history, and I think, coincidentally, she turned out to have the malignancy. But I'm not saying that it's cart and horse, but it used to be felt to possibly be.

Q. Right. And typically shingles is self-limiting and standard of care does not require treatments, correct?

A. Well, there's some treatment, whether they -- how effective, I don't know. And it's usually self-limiting. It would not possibly be in somebody, say, with HIV or some other severe compromised immune condition, but in an otherwise normal host patient, it's usually a self-limiting, although sometimes painful,

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process.

Q. And the pain that -- the neurological pain that they have, or neurogenic pain that they have, can be severe, can be debilitating, correct?

A. Yeah. Usually not, but the occasional case, yes.

Q. The diagnosis of that condition, is it typically clinical as opposed to based on testing?

A. Yeah, typically it's a clinical picture. I mean, it's pretty unique. It's clear; a dermatome is a dermatome is a dermatome. And the nerve goes, it runs under the ribs, and along with the artery and the vein, and it fits that picture, yes.

Q. Dr. Chaltry did get a titer, a shingles -- or I mean zoster titer, and it was relatively high. Do you --

A. Yes.

Q. What's the significance of a high titer?

A. I'm not a virologist. You know, if somebody is -- titers can -- I mean, clearly, most people who get chickenpox are exposed to it.

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Titers can go up when people are having generalized reactions to -- if you're having a reaction to -- like an allergic reaction, or some sort of reaction, anything that your body has been exposed to can be elevated. They can go up. I'm not sure more than that unless it's something -- I'm not sure what happens to patients with Hodgkin's -- non-Hodgkin's lymphoma B, which are sort of -- which, there's a degree of immunologic phenomena with it. I'm not sure if that can somehow jack up titers.

But -- I don't know -- I don't think she had shingles, and I'm -- and I know shingles is not responsible for the pain she had for six months, for sure. But I can't -- it's interesting, but I can't say anymore. I don't know anymore to speak about why she might have a high titer.

Q. So with regard to Dr. Segan's evaluation of the patient and treatment on October 3, 2011, your primary criticism is that he did not recognize the significance of this ongoing back pain, and that had he done that, he would have taken additional steps --

A. Yes.

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Q. -- is that fair?

A. Yeah. Another missed opportunity --

MR. LaPARL: I'm going to object -- wait, wait, wait. I'm going to object to the form. I think he said a little bit more than that. But go ahead.

MS. MacGREGOR: Well, I said kind of the overriding, or the key criticism. I think I did, anyway.

MR. LaPARL: Okay --

A. I think --

MR. LaPARL: -- fair enough.

A. -- you've got it. Again, basically another missed opportunity to make earlier diagnosis and ensure a better outcome, both with respect to her ultimate paralysis and to the prognosis of her Hodgkin's -- non-Hodgkin's lymphoma.

Q. And then the next encounter in the ED, or by an ED physician, would have been on the 26th of October?

A. 10/26, Dr. Brad Goldman, yes.

Q. So let's get to that one. And we're coming up on your -- I think we're at three hours right now.

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

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

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

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

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her back pain. Now he's giving her a strong, powerful diuretic, Lasix, for her fluid in her leg. Nobody is very curious in this hospital. Nobody is intellectually curious, and everybody is sort of lazy, mentally.

And so he's -- he's basically -- and then he's discussed kiwi fruit and bananas. Okay. There are more pertinent things to discuss, like why she has the back pain and has peripheral edema. And then he's having her follow up with all these unexplored things with Dr. Chaltry and Nurse -- NP Weaver in the next five to seven days. And they're getting ready -- I guess they -- they sort of discharge her, and I guess she comes back after... Did she actually get out of the hospital? I'm trying to figure that out again here.

Q. All right. So this is the afternoon of --

A. Of the 26th.

Q. -- of the 26th, lunchtime-ish.

A. And then she comes back --

Q. She came back the next morning.

A. Yeah, on the 29th.

Q. The next morning.

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A. Yeah, so this is more --

Q. Oh, the 27th.

A. So now she's got a new thing of the edema in her legs. This is not from musculoskeletal disease; this is not from a ligament or a sprain; it's part of something else. And she doesn't have, obviously, heart failure. And she's had, actually, studies before she had her surgery. I mean, she had a good heart, so to speak.

And so this is now peripheral edema. I went into a differential diagnosis of it. Nobody else seems to have there, but they're giving her Lasix to treat the fluid, because Lasix will decrease renal retention of -- kidney retention of free water. But, again, it's an unexplained finding, and so it's, again, a failure to appreciate the history; a failure to -- to -- to appreciate the clinical significance of the physical exam; a failure to create a differential diagnosis of any value in terms of how to deal with her; and discharging her when she's got a new finding now, which is abnormal, instead of, again, everybody either putting their heads together, getting some more lab, doing some imaging, or calling another doctor to help them, or transferring her to another center with a higher level of physicians who are willing and able to put all this together.

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Q. Does peripheral edema cause numbness, tingling, you know, neurological symptoms in the dependent areas?

A. Very much unlikely. That could be more of some of the irritation of nerve -- or tumor or Hodgkin's -- non-Hodgkin's lymphoma around her spinal cord would be more likely to cause the tinging.

Q. All right.

A. And also, I left out that now there's like a major new discovery of a vertebral compression fracture at T-5. So this is like a heard of rhinoceros now in the room, too. That should be -- this is something -- how could they not go into further imaging with a CAT scan of her spinal area, her thoracic spine? I can't imagine how they would not use their CAT scan, which normally gets overused and misused a lot of the times, why they would not have gotten a CAT scan which was available. Now, maybe their CAT scan wouldn't accommodate her size. That I don't know. But there's always around -- somewhere they needed to image her at this point to see what's going on with her thoracic spine and why she's got a vertebral collapse.

And so she should have been admitted here, or somewhere else. She should have had consultations -- if they still couldn't get it, to get somebody else with a better computer in their head and more curiosity and somebody who was going to get to the bottom of this, finally, after six months.

So they send her home, which was a deviation from standard of care, on Lasix, I think was -- just like all the pain medicine they were giving, they're treating fluid but not diagnosing why she's got fluid-dependent edema.

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Q. What do you make of the normal sed rate that --

A. Well, it would -- sorry. Sorry.

Q. What do you make of the normal sed rate?

A. I'd say that it's -- it's -- it's -- it points to -- it points away from an infectious cause of -- of -- of what might be causing a mass effect in her paraspinal area. Because usually

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if you have epidural or some sort of occult abscess, one of the things we like to get is a C-reactive protein, which measures the same thing as the sedimentation rate, basically. And if they're normal, it sort of points away from an infectious process.

Q. How about inflammatory process?

A. And probable inflammatory process, too, like lupus or severe rheumatoid arthritis, or any of those autoimmune phenomena. A normal sed rate and C-reactive protein would be less consistent with those.

Q. Would that not usually be elevated in the --

A. Non-Hodgkin's lymphoma?

Q. -- where there's Hodgkin -- non-Hodgkin's -- yeah, in presence of non-Hodgkin's disease?

A. It could be, but I'm not sure about that. But I would think it possibly could be, but not like an infectious or inflammatory process, auto immune process causing this picture.

Q. All right. Let's go, then, to her return to the ER on the --

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A. 10/27.

MR. LaPARL: I was just going to ask to take a quick break for me to use the restroom. Would this be a good time?

MS. MacGREGOR: Yeah. I think I'm about done.

MR. LaPARL: Okay.

MS. MacGREGOR: I don't know how long we'll talk about this particular admission, but I think I'm about done. Go ahead and take a break.

(Recess)

EXAMINATION CONTINUED

BY MS. MacGREGOR:

Q. Doctor, before I forget, how many cases do you have pending, if you can estimate for me, with the McKeen firm, currently?

A. I'm just chewing, finishing my last cracker here. But, um...

I don't really know, but maybe, at most, maybe one or two. Maybe.

Q. All right. Okay.

Let's go to October 27, 2011, then. And, again, I'll just let you tell me what you see there that represents standard of care

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violations?

A. Well, when you read the history, she fell at home, was unable to get up; husband called 9-11, EMS; legs weak for two days; compression fracture of T-5.

That and -- and that would be -- that would make one have -- I mean, now she's -- she fell. Her legs are weak. They felt mushy. With the previous notes, the same doctor who saw her, Dr. Goldman, who saw her the day before, is seeing her again. She's come back. She's got this six-month history. He could have -- he could have been getting a CAT scan of her back and doing a bunch of lab, general lab. And he needed to be on the phone pretty much immediately after getting that brief amount of material that I said, with her history. He should have maybe been getting a CAT scan, getting some basic lab, and been on the phone to figure out to what major medical center with a neurosurgeon and every imaging needed, she needed to be sent to.

And for whatever reason -- and, again, just to continue, he's saying her strength is 4/5, where he talks about strength, that -- so that -- I'm looking at the occupational therapy

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note there. But he's saying some decreased strength in upper extremities, which I -- which it looks like -- I'm sure it was lower extremities more, as was measured, I think, here by the person who may have seen her.

So, I mean, what this is is a patient who maybe they could spend the time until she was being transferred to the appropriate place getting a CAT scan and some basic lab, but it's a patient who needs to get out of this hospital to a major hospital. She's got weakness; she's falling; she's got legs that are not right; nobody has done an appropriate exam, because she clearly was going to have weakness and neurologic deficits and is not -- he -- he writes, "Neurologic: awake, alert and appropriate." That's his physical exam.

And then he watches her -- and it also is noted that she's generally weak, she had an inability to transfer, even for her therapy, because he's ordered some type of physical therapy. It's remarkable and extraordinary that he's got this patient with these findings and he's watching her until the next day. And then she's saying that I think something -- I need to

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get out of here and get to a real place where I could get a real evaluation. And that happens only -- she's admitted to Marquette, I guess, on -- I think on the 29th. And then studies show that she's got a diffuse heavy load of lymphadenopathy, and with biopsies is determined to be B-cell -- non-Hodgkin's B diffuse lymphoma -- B-cell lymphoma, with cord -- paraspinal involvement, cord involvement, from like T-2 to T-8, I think, and obviously with erosion of the T-5 vertebra pressure on the cord and erosion of bone.

So it's all the failures that I enumerated on Dr. Goldman on the 26th. Plus, now, when she appears with critical findings, like cord compression, which, if you don't treat early, leaves you with permanent loss of nerve, spine and nerve and muscle weakness and spasm, he watches her for another day or so, and in his deposition said something to the effect of, well, he wanted it -- he was watching to see if it would declare itself. And if she doesn't get -- if she doesn't get better or gets worse, that he would transfer her.

Well, this is like an unethical study

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of the natural history of disease. He needed to transfer her as soon as he saw her back. I mean, she shouldn't have been discharged on the 26th, but when she comes back and now has clearly got weakness in her legs and is unable to get up or walk anymore, this is a patient who needs to go to the major appropriate tertiary care centers with neurosurgeons spoken to and where she can be imaged, where they have a scanner that will accommodate her, or a method of looking at her. So that's another critical 24 hours or so that's lost, which translates into lost ability to have the best outcome, namely, with the residual paralysis that she's gotten and spasticity.

So it's, again, the history, physical, and, in this case, the physical findings of weakness in the lower extremities and the failure -- he said in his deposition on a couple of occasions, as I recall, that he didn't -- he just didn't include it in his differential diagnosis. He basically didn't think of it. Well, that's basically the story of this lady in this hospital in this emergency department in this family practice environment with all of these doctors; nobody -- intellectual lack of

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curiosity, intellectual incapacity to put 1 and 1 together in this picture, and then translates, ultimately, into reduced, not the best possible outcome for either her neurologic condition and also her non-Hodgkin's lymphoma, because she's got a much more significant tumor load, obviously six months later.

Q. Given what we do see in the MRI that was done on the 30th of October, do you have an opinion as to what a neurologic exam would have demonstrated on the 27th or 28th?

A. Let me get to those records, to that MRI...

(Pause)

Q. Maybe the way to ask that --

A. So...

Q. Maybe the way to ask that is, would you expect the neurologic exam performed by Dr. Goldman to -- on the 27th -- or -- a neurologic exam performed on the 27th or 28th to have been significantly different from that which was performed on admission at Marquette General?

Those are two different questions, I recognize --

A. Yeah, yeah.

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Q. -- and you can --

A. Yeah, I understand.

Q. You can answer whichever one you want.

A. Yup.

(Pause)

Well, if -- I suspect if a neurologic was done -- I mean, what's described by -- this is the admission -- by the admitting H&P. I'm not sure why -- I don't know if that's performed by a -- by a resident or -- I'm not sure who actually did the H&P, as I sit here. But regardless, it shows she doesn't have any dorsiflexion of the ankles against minimal resistance. She's got -- reflexes appear to be slightly decreased in the lower extremities. There's significant weakness bilaterally in the flexors of the hips, ankles, and knees, and is not able to raise her legs off the bed, which is -- you know, usually when we measure this, it's the 5 system, 1 to 5, 5 being you can't resist -- you can't move them at all. You know, typically 2 being you can't -- you can raise them off the bed but you can't resist gravity much; 5 being in tact.

So she's got a lot of findings that

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show lower extremity weakness and some decreased reflexes, and my opinion would be that they were present, if looked for appropriately, when Dr. Goldman admitted her on the second admission.

Q. Okay.

A. And, you know, that's why she fell. That's why she couldn't lift herself up. That's why her husband called the EMS, because he couldn't get her off the floor. And Dr. Goldman says she can't even transfer from bed to go get exercise, which is a preposterous idea, that he's trying to exercise her. He thinks she needs training or conditioning. Sort of, like, incredulous.

So I think all of that is consistent with the fact that she's got a paraspinal compression from lymph ad -- lymph tissue of her significant lymphadenopathy from her non-Hodgkin's lymphoma. So --

Q. And it's your opinion that it was an emergent situation from the point when she presented on the 27th?

A. Yeah. And I think it was probably present, if he looked -- if anybody did an appropriate physical exam on the 26th, I think it

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would have been present. And in terms of causation, I mean, it would have been possibly dramatically positively able to avoid her having permanent damage if she had been admitted on the 26th, because I believe she -- clearly, if she had a good neurologic exam, would have had evidence of diminished strength in her lower extremities.

And when she's come in on the 27th because she's fallen on the floor and can't get up, can't even, in the hospital, transfer from the bed to exercise, which he apparently ordered for her, you know, then it's worse, but clearly there. And so now this translates into every minute, every hour, you know, diminished outcome.

Q. So, just so I'm clear, in your opinion, in fact it was an emergent situation. But are you also say that he, Dr. Goldman, should have recognized it as an emergent situation on the 26th and then also on the 27th?

A. Yes, both.

Q. Okay. And his recognition of that, was that necessarily dependent on getting a CAT scan or the neurologic exam? Or what would be the basis on the conclusion that it was emergent?

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What would lead a reasonably competent doctor to conclude on most days that it was an emergent situation?

A. Well, she's back and she's complaining -- let me just go back to the note of the 26th again. Sorry. I think that's when she complained that her legs were mush, on the 26th.

On the 26th she had a fall and unable to get up, weakness in her legs.

Q. So the history?

A. She felt her legs were very weak and rubbery and wobbly. So, I mean, the history is there. With this lady with a compression fracture of T-5, the history is there. She needed to be getting -- you know, get a CAT scan while you're getting ready to transfer her to whatever tertiary center which has got a neurosurgeon that's going to be able to aggressively, quickly, timely treat her.

So on the 26th he had no right to let her go out at all.

Q. All right. Do you have any criticisms of anyone else, any of the other defendants -- well, I don't think you'd be qualified to speak to the family practice people, but how about of

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the hospital? Are you intending to testify that hospital itself was negligent somehow?

A. Well, the hospital, this is -- these doctors are working both in the ED and in family practice. And I think the hospital -- the system -- the hospital is the system all of these people are working for, and so I think the hospital is responsible, too, in this case, because it's not just one doctor. It's their whole -- the substance, basically, of staffing, it seems like, in their emergency department, and in their family practice clinic.

I don't know how -- it's hard for me to imagine how this could happen, how this could happen over so long a period, how there's no -- nobody in place to say, What's happening with this Brenda Carey who keeps coming back? Because hospitals -- you know, the country, even in 2011, was sort of pushing towards excellence and outcomes, and this is a patient who keeps coming back, who has to be some sort of a burden, because third parties who try to -- who insure this, they don't like to see patients who keep getting readmitted for the same problem and keep coming back.

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There's usually -- usually the hospital's continuous quality improvement, and other departments, should be monitoring returns. You know, people who are seen twice in two days or bouncing back, those are -- there are -- hospitals and the Joint -- I don't know if this hospital participates in the JCAHO visits, the Joint Commission of Accreditation of Hospitals, but hospitals are supposed to benchmark outcomes, like returns in 24 hours, returns in 48 hours, 72 hours, deaths in an emergency department.

Hospitals are supposed to do CQI, continuous quality improvement. And hospitals are supposed to do these diagrams, these fish diagrams and things, where you try to not point fingers at individuals but look for system breakdowns. This is -- besides each individual doctor, which I enumerated, and the major things like history, physical, and their clinical relevance and tests, here's a system of doctors in a small ED. They must interface -- it's not like some of these industrial medical centers like we have in big cities, like in New York City, where they have these giant centers that cause traffic jams in Manhattan, these are --

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it's a small hospital. These people must bump into each other in the doctors' lounge at the coffee pot, or somewhere. I don't know how -- I don't know how they wouldn't say, Hey, what's happening with that Brenda Carey? She keeps coming back. I don't know how the hospital doesn't have a system, and how the doctors themselves didn't have the curiosity to -- to take six months until she was irreversibly impacted with respect to her neurologic condition and probably also, to a degree, with the likelihood of the best outcome oncologically with her lymphoma. I don't -- it's hard to imagine how this could happen.

Q. Besides the standards of the Joint Commission, are you familiar with any protocols or standards that require a hospital to coordinate care among the various providers that see the patient?

A. No. Joint Commission has -- what it tells hospitals is, make scope of practice -- develop a scope of practice, define what should and shouldn't happen, look at benchmark, the kinds of things like returns, unsuccessful intubations, and they define -- then they say,

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You make the policies. And then you have to live up to your policies, because not every center -- not every hospital is going to be the mega center, tertiary care.

But what the Joint Commission tells hospitals is to define how you're going to practice; define the scope of your practice; define what should and shouldn't be admitted in your hospital; define, you know, what you're benchmarking, and tell me how you're -- what you do for CQI, continuous quality improvement; and then, when the Joint Commission comes, show me how you've done what you said you should do.

And, you know, how this happens -- well, each provider is, as I said, lacked intellectual curiosity, lacked intellectual capacity, possibly, to be dealing with what they were dealing. They didn't meet standards of care, either by failure of interest of doing or failure of intellectual capacity of doing what their scope of practice allowed them to do. And then the system fails, because somehow there is an elephant, and nobody new it was an elephant, despite I don't know how many visits, but many visits and many interactions with the system and

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those doctors.

Q. Doctor, have we covered the key points of the opinion testimony, that the criticisms that you anticipate being asked about at the time of this trial?

A. Yes.

MR. LaPARL: I'm just going to object to form.

Q. Anything else that you think, in fair discovery, you think I should know about in terms of what you anticipate testifying about at the time of trial?

A. No.

MR. LaPARL: Again, object to form.

Q. All right --

A. As I sit here, no.

MS. MacGREGOR: Okay. Thank you. Nothing else.

THE WITNESS: Thank you.

EXAMINATION

BY MR. LaPARL:

Q. Just a few follow-up questions for you, Dr. Mehlman.

I want you to assume the "standard of care" is defined as what a physician of ordinary

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learning, skill, and judgment would do under the same or similar circumstances. Are you with me?
A. Yes.
Q. Using that definition, is it your opinion that the physicians that provided care and treatment to Ms. Carey in the emergency department setting violated the standard of care?
A. Yes.
Q. And for the reasons that you've enumerated earlier today?
A. Yes.
Q. Are you opinions based on a reasonable degree of medical certainty?
A. Yes.
Q. And you are a licensed physician, correct?
A. Yes.
Q. In 2010, you were devoting a substantial portion, or the majority of your professional time, to both the clinical practice of emergency medicine and the instruction of emergency medicine?
A. Yes.
MS. MacGREGOR: Objection to form.
Q. And in 2011, you were devoting the

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

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your professional --
MS. MacGREGOR: Objection; form.
Q. What were you devoting the majority of your professional time to during that period?
A. Teaching.
Q. Emergency medicine?
A. Yes.
Q. And you were board certified in emergency medicine in 2011, correct?
A. Until Jan -- till December 31st, yes.
MR. LaPARL: That's all I have. Thanks very much.
(Off the record)
MS. MacGREGOR: I need the original sent to me, and then I would like just electronic E-tran. So E-tran, or whatever your program is, and PDF the exhibits, please.
MR. LaPARL: And I'll take an E-tran mini, please. PDF exhibits is fine.
MS. MacGREGOR: We don't the require the witness to sign.
MR. LaPARL: It's not required in Michigan.
MS. MacGREGOR: And the doctor would

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

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ACKNOWLEDGMENT

STATE OF)
) ss.:
COUNTY OF)

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

_____
IRA MEHLMAN, M.D.

Signed and subscribed to before me, this _____ day of _____, 20__.

_____
Notary Public, State of _____

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CERTIFICATE

STATE OF NEW YORK)
) ss:
COUNTY OF NEW YORK)

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

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

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

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

ALEXIS PEREZ JENIO, CLR

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