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IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

THE ESTATE OF ROBERT J. ROBINSON, : CASE NO.: A1005320
Robin Robinson, Executrix, :
: (Judge Ethna Cooper)
Plaintiff, :
:
vs. :
:
MADEIRA HEALTH CARE CENTER, :
et al., :
:
Defendants. :
_______________________________/

DEPOSITION OF KENNETH C. FISCHER, M.D.
Thursday, July 5, 2012
1:12 p.m. - 2:27 p.m.
Kennth C. Fischer, M.D.
1190 NW 95th Street
Suite 402
Miami, FL 33150
Stenographically Reported By:
JANINE P. CARROLL, FPR
Florida Professional Reporter

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1 APPEARANCES:
2 On behalf of the Plaintiff:
ROBERT L. POOLE & ASSOCIATES
3 2656 Crescent Springs Road
Suite 1
4 Crescent Springs, KY 41017
Phone: (859) 261-3400
5 Fax: (859) 261-3928
BY: ROBERT L. POOLE, ESQ.
6
On behalf of the Defendants:
7 RENDIGS, FRY, KIELY & DENNIS, LLP
600 Vine Street
8 Suite 2650
Cincinnati, OH 45202
9 Phone: (513) 381-9200
Fax: (513) 381-9206
10 BY: PAUL W. McCARTNEY, ESQ.
11
12 I N D E X
13 Deposition of KENNETH C. FISCHER, M.D.
14 Direct Examination by Mr. McCartney: Page 3
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16 DEFENDANTS' EXHIBITS
17 1 Curriculum Vitae Page 4
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1 Deposition taken before Janine P. Carroll,
2 Florida Professional Reporter and Notary Public in
3 and for the State of Florida at Large in the above
4 cause.
5 THE COURT REPORTER: Swear or affirm that the
6 testimony you're about to give will be the truth, the
7 whole truth, and nothing but the truth?
8 THE WITNESS: Yes, I do.
9 THEREUPON,
10 KENNETH R. FISCHER, M.D.
11 having been first duly sworn, was examined and testified
12 as follows:
13 DIRECT EXAMINATION
14 BY MR. McCARTNEY:
15 Q. Can you please state your full name?
16 A. Kenneth C. Fischer, M.D.
17 Q. Doctor, my name is Paul McCartney. I represent
18 Madeira Health Care Center in a lawsuit that's been filed
19 on behalf of the Estate of Robert Robinson. I'm going to
20 be taking you deposition today. I know you've given
21 depositions in the past. I just want to remind you, if
22 you don't understand one of my questions, please let me
23 know and I will try to rephrase it so you do understand
24 it. Okay?
25 A. That's fine, sir.

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1 Q. And, you've been kind enough to leave out a copy
2 of your curriculum vitae, that I assume is the most
3 up-to-date version of that?
4 A. It is.
5 MR. McCARTNEY: We'll go ahead and mark that as
6 Exhibit 1.
7 (Document marked Defendants' Exhibit Number 1 for
8 identification.)
9 BY MR. McCARTNEY:
10 Q. I'll hand you what's been marked as Exhibit 1,
11 and have you identify that as your curriculum vitae. Is
12 that correct?
13 A. Yes, sir, it is.
14 Q. Are there any additions or changes that should be
15 made to it since it was last prepared?
16 A. No, sir.
17 Q. When was this CV prepared?
18 A. January of this year.
19 Q. Are there any articles or publications, or
20 presentations you have done that are listed in your
21 curriculum vitae that are relevant to the issues as you
22 see them in this case?
23 A. No, sir.
24 Q. You're a neurologist. Is that correct?
25 A. Yes, sir.

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1 Q. Have you had any specialty training in the field
2 of geriatrics?
3 A. No, sir.
4 Q. Ever been trained as a nurse?
5 A. No, sir.
6 Q. And you authored one report in this case, or at
7 least one report in this case, dated March 14th, 2011.
8 Is that correct?
9 A. That is correct.
10 Q. Have you updated, or provided any kind of updated
11 report since that time?
12 A. No, sir.
13 Q. Have you reviewed additional materials since you
14 authored that report on March 14th of 2011?
15 A. Yes.
16 Q. What else have you reviewed?
17 A. The deposition of June F-E-I-R-L, taken
18 5/11/12.
19 Q. Any other depositions?
20 A. No, sir.
21 Q. Are there any materials that you've asked to
22 review that you have not been provided?
23 A. No, sir.
24 Q. Did you have a chance to look at any of the
25 actual films taken at either Jewish Hospital or

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1 University Hospital on July 18th, 19th, or 20th of
2 2009?
3 A. I have nothing, sir.
4 Q. And you have a letter there that's right in front
5 of you.
6 MR. McCARTNEY: All right if I look at it,
7 Mr. Poole?
8 MR. POOLE: That's fine.
9 BY MR. McCARTNEY:
10 Q. And it's a letter dated September 18th, 2011.
11 A. Yes.
12 Q. It indicates that you were also provided the
13 autopsy report on Mr. Robinson as of this date, along
14 with neurological assessment flow sheets, and depositions
15 of Sandra Schumacher and Claudia Thompson.
16 A. Yes. I had forgotten I reviewed that after my
17 letter, so I'll have to amend -- I think you asked me
18 after my letter have you reviewed different materials?
19 Q. Yes.
20 A. That material would be included, plus the
21 deposition of Ms. Feirl.
22 Q. I see that on Ms. Feirl's deposition you have one
23 green post-it note.
24 A. Yes, sir.
25 Q. If I could take a look at that, if you wouldn't

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1 mind, please.
2 A. Sure.
3 Q. I'll look at it that way, and that way we won't
4 have to get the rubber band off.
5 A. Okay.
6 Q. And it's on page 69, looks like for the question
7 beginning at line 3 through the answer that's going
8 through line 10.
9 Is that where that note is?
10 A. Yes, sir.
11 Q. What was the significance of that?
12 A. One issue is how Madeira based their assessment
13 of the patient to allow one or two, or more persons to
14 assist in the transfers. And she was responding to a
15 question from Mr. Goff in terms of that.
16 Q. My understanding is you intend to render opinions
17 critical of the nurses in the care and treatment they
18 provided. Is that correct?
19 A. Yes, sir.
20 Q. What in your background gives you the opinion
21 that you have the basis, or the ability to know what
22 nursing standards of care are?
23 A. I supervise nurses on neurological patients on an
24 everyday basis, and have so for many years, particularly
25 intensively the last four years as Director of the Stroke

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1 Center where I review every stroke patient coming into
2 this facility, which is a substantial number.
3 I look at all participants, the physicians, the
4 neurologists, the ER physicians, the internal medicine,
5 other admitting physicians, and the nursing personnel who
6 care for the patient.
7 In addition, I have served, over the last number
8 of years, I think about six years, as the Director of,
9 and I think it's called Professional Relations, at
10 Catholic Health Services, which owns and operates ten
11 different rehabilitation facilities in South Florida.
12 And I review, on a regular basis, all the
13 incident reports, quality issues, different programs for
14 enhancement of quality. I review that care offered
15 by the physiatrists, the internal medicine physicians,
16 and the nursing care at those facilities.
17 Q. And you said the Catholic Health Services, those
18 are rehabilitation facilities?
19 A. That's correct.
20 Q. What is a rehabilitation facility?
21 A. It's a facility which is not acute. In other
22 words, the patient's in a hospital, has a stroke, or
23 transverse myelitis, or spinal cord problem, or some
24 other issue, they need to have further care to recuperate
25 and return to the community, or some other improved

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1 status, and they go for days, or weeks, to a
2 rehabilitative care facility and get inpatient treatment.
3 Q. Are they hospitals?
4 A. Yes.
5 Q. Now, you understand that Madeira Health Care
6 Center is not a hospital. Is that correct?
7 A. Yes. But they also have, in addition to
8 hospitals, they have skilled nursing facilities, subacute
9 facilities, other facilities like Madeira.
10 Q. Do you review charts from those facilities
11 also?
12 A. Yes, I do.
13 Q. You review the actual charts?
14 A. That's correct.
15 Q. Do you ever talk to the nurses after you review
16 the charts?
17 A. At times, yes, if there's a problem. Or I will
18 delegate to someone in the system to do so.
19 Q. Have you ever done a fall risk assessment
20 yourself for a patient that's in a long term care
21 facility, such as Madeira?
22 A. Say done them, I will review them typically done
23 by nursing personnel or by physical therapists.
24 Q. So you've never done an actual fall risk
25 assessment yourself. Is that correct?

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1 A. That's correct.
2 Q. And you're reviewing, I assume, charts and things
3 when there's been some kind of problem and some kind of
4 issue?
5 A. Often that's the case.
6 Q. Are there cases when you're just reviewing the
7 chart just for, sort of a random audit?
8 A. We do that as well.
9 Q. And you review the actual chart yourself in those
10 situations?
11 A. That's correct.
12 Q. And from the skilled nursing portions of the
13 Catholic Health Services?
14 A. That's right.
15 Q. How often do you that, do you review a chart from
16 the skilled nursing units?
17 A. Quarterly.
18 Q. And how many charts do you review?
19 A. It depends what our programs are. We may have a
20 program on psychotropic drugs, we may have a program on
21 falls. Right now actually we have a program on falls, so
22 I've been doing it on ten charts, sometimes more.
23 Q. And you believe just based on having reviewed
24 charts that you're in a position where you know the
25 nursing standards of care?

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1 A. I'm sorry, I didn't catch your question,
2 Mr. McCartney.
3 Q. You believe just based on your having reviewed
4 charts from long term care skilled units that you know
5 what the nursing standards of care is then?
6 A. Not just that. That's one thing I do, but I
7 review the overall care, I look at the problems. We have
8 directives to try to reduce falls, reduce psychotropics,
9 reduce bed sores. And we have programs in vogue to that.
10 I look at the programs, approve them, I watch the
11 results. If we have difficulty in a particular facility
12 we try to analyze why that facility has a higher
13 incidence of problems, either by personnel or by other
14 reasons or causes.
15 Q. And how much time do you spend on a weekly,
16 monthly, quarterly basis doing that?
17 A. It fluctuates. I'd say five to fifteen hours.
18 Q. A week, a month?
19 A. No, that's during a quarter.
20 Q. When was the last time that you were actually in
21 a long term care facility such as Madeira Health Care
22 Center?
23 A. Yesterday.
24 Q. What were you doing there yesterday?
25 A. Seeing a consult.

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1 Q. And before that, when was the last time?
2 A. Sunday.
3 Q. How often do you go into long term care
4 facilities?
5 A. I'd say three or four times a week.
6 Q. What facilities do you go to?
7 A. Primarily, St. Catherine's -- well, St.
8 Catherine's Rehabilitation, and accompanying long term
9 facility is Villa Maria Nursing home.
10 Q. When you were in yesterday were you in St.
11 Catherine's or were you in Villa Maria?
12 A. Both.
13 Q. How many patients did you see in Villa Maria?
14 A. Two.
15 Q. Have you ever been asked to draft any policies or
16 procedures relative to a skilled nursing facility?
17 A. I have reviewed them and approved them. I
18 usually do not draft them. There are usually who do that
19 and go to our committees, and I review them and I approve
20 them or not, and I report to the Archbishop.
21 Q. Have you ever served as the medical director for
22 a long term care facility?
23 A. No. Although I've been on the advisory board of
24 such a facility. In fact, I am on the advisory board of
25 that facility.

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1 Q. Have you ever served as the attending physician
2 for a person who's in a long term care skilled nursing
3 facility?
4 A. No.
5 Q. So, what other criticisms do you have with the
6 staff and Madeira Health Care Center?
7 A. Okay. I'll try to be duplicative of my report of
8 3/14/11.
9 The gentleman, Mr. Robinson, was a high risk
10 patient, as indicated. In their depositions, the
11 personnel at Madeira indicate they would base their
12 assessments on several factors. Number One, the previous
13 records from the hospital from which the patient came.
14 In this case it would be Christ Hospital.
15 If one reviews the records from Christ Hospital,
16 the patient was certainly severely impaired. He had at
17 least three or four different assessments between June
18 19th, 2009 and July 6th, 2009, by physical therapist
19 Chris Vockell, V-O-C-K-E-L-L, and occupational therapist
20 Jennifer O'Brien, capital O, apostrophe, capital
21 B-R-I-E-N. These indicate the patient had substantial
22 difficulty with gait and transfers. He required two or
23 more persons for such endeavors. He, in this period of
24 time, they indicated had not improved. He still was
25 substantially impaired.

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1 So, based on what the antecedent records were
2 prior to his transfer to Madeira, the patient required at
3 least two, and possibly three persons to effectuate
4 transfers.
5 So, when Ms. F-E-I-R-L indicates they based their
6 plan on the previous records, those records indicate a
7 substantial greater degree of care than was afforded
8 Mr. Robinson during his stay at Madeira.
9 Additionally, they say they go by the assessments
10 in their own facility. Their own facility assessments,
11 which were performed on July 10th, 2009, demonstrated,
12 again, a two or three person necessity for transfers.
13 And he was -- he was assessed as progressing to some
14 degree between that date and his fall.
15 There was no formal assessment indicating any
16 lessening of the need for assistance. Therefore, to have
17 one person only involved in his care, Ms. Thompson, on
18 7/19/09, was below the standard of care.
19 The other thing I'm very concerned about is
20 fabrication of records at this facility. And I say that
21 because on 7/18/09, after the fall, there's a series --
22 two different pages authored by Ms. Schumacher, which are
23 different. In other words, some with different times,
24 some with different numbers. They're not consistent.
25 Additionally, on that same time frame, when Ms.

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1 Schumacher allegedly was seeing the patient every fifteen
2 minutes, the patient, in a deposition authored by Ms.
3 Thompson, she said she didn't see anybody in there. So
4 there's an inconsistency there.
5 Furthermore, there's an inconsistency in the
6 physical therapy note on 7/18/09. Physical therapy
7 sessions typically last an hour. Now, how is it he was
8 being assessed on the floor every fifteen minutes by Ms.
9 Schumacher, but simultaneously was in physical therapy?
10 One or the other is inaccurate and misleading, and
11 fabricated. I don't know which one, but they're mutually
12 inconsistent.
13 Q. Doctor, do you know where the physical therapy
14 department is visa vis Mr. Robinson's room?
15 A. I do not know that, sir.
16 Q. Do you know whether physical therapy was being
17 rendered in the department versus in his room?
18 A. I don't know that.
19 Q. Do you know whether it was possible for Nurse
20 Schumacher to go down to the physical therapy department
21 and assess him every fifteen minutes during that time
22 period or not?
23 A. That is highly unusual.
24 Oh, by the way -- the answer is highly unusual.
25 Also, I want to add a criticism. If indeed he did go to

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1 physical therapy on July 18th, 2009, that's a gross
2 deviation. The man had just fallen under the
3 circumstances I described in my letter and described
4 in the chart, he should not have been -- he should have
5 been observed in a careful manner in his bed, or in a
6 chair. He should not have gone to physical therapy at
7 that juncture. So if he went to physical therapy, that's
8 itself a departure.
9 Q. Well, how do you know if it's highly unusual
10 if you want to assess a patient the nurse wouldn't go
11 to the physical therapy department. Are you there in
12 facilities everyday to know whether or not that's done?
13 A. I'm in the facility three or four times a week,
14 and I know it's not done.
15 Q. Yeah, but how long are you in the facilities when
16 you're there?
17 A. Depends how many patients I have to see. Could
18 be an hour, could be two hours.
19 Q. Well, and you're basing it on one facility that
20 you go to, Villa Maria?
21 A. Yes -- no, St. Catherine's Rehabilitation and
22 Villa Maria, two facilities.
23 Q. Well, St. Catherine's is not a long term care
24 skilled nursing facility. Is it?
25 A. No, it's a rehabilitation facility.

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1 Q. It's a different animal?
2 A. Yes, it is.
3 Q. Okay. And so, you know, based on your experience
4 at Villa Maria, the practice is not to go not to go every
5 -- the nurse might not do that, but you don't know what
6 the practice is at Madeira Health Care Center. Do you?
7 A. No, but it would be highly unusual, based on my
8 experience doing this kind of work for many years, to see
9 nurses go there every fifteen minutes.
10 Q. You ever been to Madeira Health Care Center?
11 A. No, sir.
12 Q. Now, do you know whether actually there was any
13 physical therapy that was done that day, or whether
14 Mr. Robinson was just assessed by the physical therapist
15 that day?
16 A. No. He used a rolling walker for 75 feet. They
17 assessed his transfer, they assessed his mobility. No,
18 he had a documented, at least allegedly, a documented
19 assessment.
20 Q. Do you know whether or not the note on 7/18 was
21 to reflect, what the physical therapist wrote was to
22 reflect what his discharge status was, rather than actual
23 rendering therapy that day?
24 A. Doesn't seem that way to me, no.
25 Q. If the physical therapist was to testify that she

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1 did not actually give any therapy that day, you would
2 have no reason to dispute that. Would you?
3 A. Well, that's counter documentation, so it's a
4 fraudulent documentation then.
5 Q. Well, it's not fraudulent. I mean, Doctor --
6 A. You say a patient walked for 75 feet, that's just
7 hypothetical, that's a little strange, sir. I'm sorry.
8 Q. Well, Doctor, the reality is that the note
9 actually reflects on 7/18, that's the discharge note as
10 to what his abilities were at the time of discharge.
11 Isn't that right?
12 MR. POOLE: Objection.
13 THE WITNESS: No.
14 BY MR. McCARTNEY:
15 Q. Well, you've chosen to interpret this to be
16 fraudulent documentation if she didn't actually provide
17 the therapy that day, rather than some other explanation
18 that was simply noting what Mr. Robinson's abilities were
19 at time of discharge?
20 A. How would she know unless she did it?
21 Q. Well, they would have been seeing him days before
22 that; wouldn't they?
23 A. They had one on the 15th. It was different than
24 the one on the 15th.
25 Q. Do you have some special training in knowing

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1 whether people are telling the truth or not?
2 A. No, sir, I do not.
3 MR. POOLE: Objection.
4 THE WITNESS: I've just reviewed records for the
5 last 35 years, and this seems extremely unusual and
6 suggests illegitimacy.
7 BY MR. McCARTNEY:
8 Q. Do you know anything about the physical
9 therapist? Can you tell me what her name is?
10 A. I can't read her name on the report.
11 Q. Can you tell me what her level of experience
12 is?
13 A. I do not know that, sir.
14 Q. Can you tell me what her reputation is for
15 truthfulness or untruthfulness?
16 A. I do not know that, sir.
17 Q. And you think it's fair from a thousand miles
18 away to levy a charge against someone that they
19 fraudulently made the record without knowing anything
20 about the person?
21 MR. POOLE: Objection.
22 THE WITNESS: That may have been real. It may
23 have been real and the nurse's notes have been
24 fabricated. I know one or the other is wrong.
25 That's all I can say.

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1 BY MR. McCARTNEY:
2 Q. Well, can you think of any way to reconcile that
3 there wasn't any fabrication?
4 A. I'd like to see the deposition of the physical
5 therapist, if that existed.
6 Q. Well, Doctor, are you familiar with the practice
7 that nurses have of rather than writing things directly
8 in the chart, they write on a piece of paper and then
9 when they have time they go back and do their charting?
10 A. Sure. That happens sometimes.
11 Q. Now, when you looked at the neurologic, the two
12 neurologic flow assessments, on 7/18, would you agree
13 with me that prior to 10:30 there were no neurologic
14 deficits noted in either of those. Is that correct?
15 A. No focal deficits delineated. I agree with
16 that.
17 Q. And do you know whether the nurse aide, Claudia
18 Thompson, was in the room constantly from 7:45 to
19 10:30?
20 A. She wasn't.
21 Q. So, it certainly is possible that Nurse
22 Schumacher went into the room and did her neurologic
23 assessment at times Nurse Thompson wasn't in the room.
24 Isn't that right?
25 A. Sure.

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1 Q. And you don't know whether that happened or not.
2 Do you?
3 A. I don't know that.
4 Q. Do you know anything about Nurse Schumacher's
5 reputation for truthfulness or untruthfulness?
6 A. I do not know that.
7 Q. Now, would you agree with me, Doctor, that when
8 Mr. Robinson presented and was admitted to Madeira Health
9 Care Center on July 9th of 2009, Madeira Health Care
10 Center had an obligation to independently assess
11 Mr. Robinson and decide what kind of assistance he needed
12 with his ADLs?
13 A. Yes.
14 Q. Matter of fact, they could not just simply rely
15 on what the prior records from Christ Hospital said, but
16 had to do their own assessment. Isn't that right?
17 A. Correct.
18 Q. Would you agree that the physical therapy records
19 from Madeira Health Care Center and the occupational
20 therapy records indicate that Mr. Robinson was improving
21 in terms of his ability to transfer while he was a
22 resident there from July 9th to July 18th of 2009?
23 A. Yes.
24 Q. Now, when you go in as a consultant to Villa
25 Maria do you go in and sit there and make recommendations

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1 as to what level of assistance your patients need in
2 terms of transfers?
3 A. At times I do that. We have team conferences at
4 certain times, and I will be involved in the team
5 conference as a consulting neurologist and I will make
6 recommendations in that regard.
7 Q. Do they always follow your recommendations?
8 A. Well, usually we hash them out at the meeting,
9 would be the physiatrist, the neurologist, the physical
10 therapist, occupational therapist, other people involved,
11 and reach a conclusion before we leave the room.
12 Q. Well, I want to focus just on Villa Maria, and
13 not St. Catherine's.
14 In a skilled nursing facility do you sit around
15 with the physiatrist and others and have a team
16 conference as to the level of care or assistance your
17 patients need when being transferred?
18 A. At times.
19 Q. How often do you do that?
20 A. It varies. I would say last year I must have had
21 about fifteen conferences of that nature. That would
22 include St. Catherine's and Villa Maria. I'd say five at
23 Villa Maria.
24 Q. Do you know how many patients, or how many beds
25 there are at Madeira Health Care?

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1 A. No.
2 Q. Do you know how many, what percentage of the
3 residents at Madeira Health Care Center are assessed at
4 being at a high risk for falls?
5 A. I do not know that.
6 Q. What can you tell me about June Feirl's
7 experience in assessing residents in terms of level of
8 assistance they need in transfers?
9 A. She has substantial experience.
10 Q. Now, at the time that Mr. Robinson fell on July
11 18th of 2009 the transfer was complete; was it not?
12 A. Could you repeat the question, Mr. McCartney?
13 Q. Yes. At the time that Mr. Robinson fell on July
14 18th of 2009 the transfer was complete; was it not?
15 A. Well, he was transferred into, like a shower
16 chair, and then fell from the shower chair into the wall
17 of the shower.
18 Q. He was sitting down at the time he fell?
19 A. Yes, that is correct.
20 Q. So the transfer from the wheelchair to the shower
21 chair had been completed?
22 A. That's correct.
23 Q. Do you know what size the shower room is?
24 A. I do not know that.
25 Q. Do you have an opinion as to during the course of

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1 the shower how many people needed to be assisting
2 Mr. Robinson?
3 A. Two people.
4 Q. Why did he need two people while he was being
5 showered?
6 A. Because one person would be helping to shower
7 him, could not have his hands on him to keep him steady,
8 and he was inherently unstable and clumsy, and had poor
9 cognition.
10 Q. Had he had any kind of episode of falling before
11 July 18th, 2009 while at Madeira?
12 A. Had he? Not that I'm aware of, no.
13 Q. And, can you show me where in the chart it said
14 that while he was in a sitting position he required the
15 assistance of two people?
16 A. No, but -- it doesn't say that.
17 Q. What makes you think he needed two people while
18 he was sitting?
19 A. Because, again, he was unable, ataxic, had poor
20 cognition, he could easily move on his own, and he had no
21 control of his balance, or poor control of his balance.
22 Q. Well, that's not how he's assessed at Madeira,
23 was he, that he had poor control of his balance in a
24 sitting position. Was it?
25 A. I don't think it's particular -- let me see.

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1 The balance, they say not able to perform
2 function, whatever that means.
3 Q. I'm looking in the physical therapy records,
4 including the note from July 18th, which said sitting
5 balance is fair.
6 A. Well, fair is not good.
7 Q. Fair is not poor either?
8 A. No.
9 Q. You said poor.
10 A. Okay. Fair is still not adequate. He needs
11 help.
12 Q. Well, what level of help does someone who has a
13 fair balance with sitting need?
14 A. Well, one person to shower him, one person needs
15 to stabilize him.
16 Q. Why do you say that? On what do you base that?
17 A. I think I said it before, Mr. Robinson had very
18 poor -- had impaired balance, Mr. Robinson had impaired
19 cognition. That could enable him to fall easily from a
20 seated position without someone supervising him.
21 Q. And what in your experience leads you to have the
22 knowledge as to what is required when someone is sitting
23 in a nursing home on a day-to-day basis?
24 A. Having had thousands of patients who were
25 neurologically impaired, seeing the repercussions of

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1 inappropriate lack of supervision.
2 Q. When was the last time that you went into a
3 nursing home and sat there and evaluated and told the
4 nurses how many people needed to be assisting a resident
5 while they were being showered?
6 A. I don't know about showering particularly in the
7 last few weeks, but I've done that in the past, and I
8 usually discuss with the nurses a particular patient's
9 needs based on my neurological assessments. We do this
10 on a regular basis in these committee meetings we talked
11 about, in these group sessions.
12 Q. Were you aware that the occupational therapist
13 evaluated Mr. Robinson as only needing the assistance of
14 one while being bathed?
15 A. Yes, I saw that.
16 Q. And you're saying that's incorrect?
17 A. Yes.
18 Q. Well, certainly if the occupational therapist
19 assessed that person as the assistance of one, you can
20 understand why the nursing staff, or the nurse aides,
21 would only provide assistance of one during bathing.
22 Wouldn't you?
23 A. That's open to interpretation. One person to
24 assist, one person to bathe. In other words, if one
25 person's bathing him, putting water on him, you need

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1 someone else to stabilize him. He would need two people
2 to do that function.
3 Q. Well, how many people did he need to assist him
4 while he was toileting?
5 Not based on the records, but based on your view.
6 I'm asking your opinion.
7 A. If he's toileting, it doesn't require anything
8 hands-on of the assistant to do. They can be watching
9 him while he's toileting. When he's moved from the
10 toilet to someone place else, you need two people.
11 Q. Have you ever worked as an occupational
12 therapist?
13 A. No.
14 Q. Ever worked as a physical therapist?
15 A. No.
16 Q. Any training in either of those two
17 professions?
18 A. No.
19 Q. Would you disagree with the physical therapist's
20 assessment on July 15th that Mr. Robinson only needed
21 contact guard assist while ambulating?
22 A. That's what that person stated at that point.
23 That's his or her assessment.
24 Q. I understand. I'm asking whether you would agree
25 with it or not.

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1 A. Well, that's okay.
2 Q. That would only be one person assisting him while
3 he's walking. Isn't that true?
4 A. Let me see -- can I see the note you have in
5 front of you, or can I find mine?
6 Thank you.
7 It's the 15th, you said?
8 Q. Yes.
9 A. Yeah, but with a walker -- on a walker that would
10 be accurate, yes.
11 Q. That would only be one person; would it not?
12 A. That's right.
13 Q. So you're saying that he needed only one person
14 to ambulate, but he needed two people while he was
15 sitting in the shower?
16 A. That's right. Add to the fact ambulating with a
17 walker.
18 Q. What about the physical therapist's assessment on
19 the 15th that he only needed contact, Mr. Robinson only
20 needed contact guard assist for sitting to standing?
21 A. Let me find that.
22 Okay. Thank you.
23 Maybe I misheard your question. Could you repeat
24 it, please, sir?
25 Q. On July 15th the physical therapist notes that he

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1 only needed contact guard assist from sitting to
2 standing.
3 Do you see that?
4 A. Yes. It doesn't say one person.
5 Q. So you think that you might have two people
6 contact guard assist?
7 A. That's right.
8 Q. And where do you get that contact guard assist is
9 two people?
10 A. Doesn't have to be. It could be one or two. I'm
11 saying he needed two based on his particularities.
12 Q. Would you be surprised to know that in the long
13 term care industry that contact guard assist means only
14 one person's assisting rather than one to two, or more?
15 A. I'm not sure I agree with that statement. It can
16 be one, but it can be two.
17 To be clear, some other things I received and
18 reviewed after my letter, including some statements by
19 Defense experts, namely a neurosurgeon and a nurse.
20 Q. Mel McMannis?
21 A. McMannis is a nurse and --
22 Q. Dr. McCormick?
23 A. Yes.
24 Q. Would you agree that largely the decision as to
25 what kind of assistance an individual needs with ADLs,

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1 such as transfers in a nursing home, rests with the
2 nursing home staff and not physicians?
3 A. Typically, that's true.
4 Q. I think when we started this exercise, Dr.
5 Fischer, you were telling me that Mr. Robinson was a high
6 risk for falls. Is that correct?
7 A. Yes.
8 Q. And that you were talking about what that was
9 based on, and one would be the prior records?
10 A. Yes.
11 Q. And then secondly, I assume it would be based on
12 their own evaluations and assessments?
13 A. Correct.
14 Q. What else would it be based on?
15 A. History of any other falls he had, or actually
16 the whole -- they would do the assessment, they would
17 look at the various past records, look at his current
18 state, a composite of that.
19 Q. Did you see any history of prior falls?
20 A. No.
21 Q. Do you have some criticisms of the evaluation and
22 assessments they did of Mr. Robinson in terms of his
23 needs?
24 A. In terms of the fall risk assessment, yes.
25 Q. What are those?

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1 A. It was incorrect.
2 Q. The fall risk assessment was incorrect?
3 A. Yes. Yes.
4 Q. And that was, I can speed this up, that there was
5 a blank for the ambulation elimination status?
6 A. That's one.
7 Q. They assess vision status as normal when it was
8 not?
9 A. Yes.
10 Q. Incorrectly assessed the systolic blood pressure
11 as zero?
12 A. Right.
13 Q. And they didn't give a high enough score for meds
14 because he was on more meds and should have had, I think
15 a 4 instead of a 2, or something like that?
16 A. That's correct, sir.
17 Q. Do you know if the fall risk assessment had been
18 done differently, whether that would have led to any kind
19 of change in the care plan for Mr. Robinson?
20 A. Not necessarily. He was at high risk. I mean,
21 he was at high, high risk. I mean, there are higher than
22 he, but he was definitely a significant risk patient.
23 But apparently, from what the depositions state, if
24 you're over 10, 10 or more, they give you a certain level
25 of care. I think it just demonstrates a lack of

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1 proficiency in these evaluations.
2 Q. Do you have an understanding that if someone has
3 a score, say of 12, that they have certain interventions,
4 if you have a score of 13 you have certain
5 interventions?
6 A. Well, according to the deposition by Ms. Feirl,
7 the risk -- the expenditure was not greater with 16 than
8 it would have been at 10, so in that regard it would not
9 have made any difference in his care. It just
10 demonstrates, as I said, a lack of efficiency in the
11 evaluation itself.
12 Q. Well, he was assessed at high risk. Is that
13 right?
14 A. He was assessed at 10, which is a high risk.
15 Yes.
16 Q. And then once a patient's assessed at high risk,
17 the facility must then individually do an individualized
18 plan of care for that risk. Isn't that right?
19 A. That is correct, sir.
20 Q. So, whether he was at a 10 or a 16, it didn't
21 really matter in the sense they still had to come up with
22 a care plan appropriate for him?
23 A. Agreed.
24 Q. And you're also critical for them deciding that
25 he was only one to two person assist with transfers and

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1 things. He should have been two or more at all times?
2 A. Yes, sir.
3 Q. Anything else, prior to the fall on July 18th of
4 2009 that you're critical of the staff for?
5 A. Okay. There was some assessments that were done
6 at the time which weren't completed. In other words,
7 they were -- I think Ms. Wolford did an assessment at
8 time of admission and it was not completed for some
9 period of time during the early stage of his care. I'm
10 not sure why exactly.
11 Q. Well, have you seen her deposition?
12 A. No.
13 Q. So you don't know what her explanation is for
14 that?
15 A. No, I do not know that.
16 Q. Do you know whether, if she had filled out all
17 those things, whether that would have changed what the
18 care plan was for Mr. Robinson in terms of transfer,
19 sitting, etcetera?
20 A. I don't know that. It may or may not have.
21 Q. Any another criticisms you have of the staff at
22 Madeira, before the fall on July 18th of 2009?
23 A. No.
24 Q. And, it's a little cryptic in your report, at
25 least it's cryptic to me, I should say, about precisely

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1 what you have reviewed, and I just want to make sure I
2 know precisely what you have reviewed.
3 A. Okay. Sure.
4 Q. You reviewed the Christ Hospital records for the
5 admission immediately prior?
6 A. Yes, sir.
7 Q. The entire chart or just what's within Madeira's
8 chart?
9 A. Just within the latter.
10 Q. Okay. You obviously reviewed Madeira's records
11 for the July 9th, 2009 admission?
12 A. Yes, sir.
13 Q. And I assume you saw the Jewish Hospital records
14 for the ER visit on July 18th, 2009?
15 A. I do.
16 Q. University Hospital records for the July 18th
17 admission?
18 A. Yes, sir.
19 Q. And, at least subsequently you had the autopsy
20 report, but I think you had the death certificate
21 before?
22 A. Yes.
23 Q. And then we've talked about the three depositions
24 that you reviewed?
25 A. Three depositions, Ms. Schumacher, Ms. Thompson,

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1 and Ms. Feirl.
2 Q. Okay. Any other materials that you've reviewed
3 relative to this case?
4 A. No, sir.
5 Q. Now, you are critical of the response of the
6 staff at Madeira after the fall too. Is that correct?
7 A. Yes, sir.
8 Q. And, what are your criticisms there?
9 A. Based on Mr. Robinson's particular medical
10 situation, as soon as he fell the physician should have
11 been notified indicating exactly what had transpired, and
12 the patient should have been transferred at that juncture
13 to an acute care facility for an evaluation.
14 The reason for that is, Mr. Robinson was a man
15 who sustained acute head trauma, had external trauma
16 about his right brow, was on three different
17 anti-coagulants simultaneously, those being Coumadin,
18 aspirin, and Plavix, and was accordingly at high risk for
19 having intracerebral, or extradural bleeding, and
20 required immediate neurological evaluation and brain
21 imaging.
22 So therefore, where ever he fell at 7:45 a.m., at
23 that point Rescue should have been called, they should
24 have notified the attending physician of what
25 transferred, specifically, and the patient should have

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1 been transferred to an acute care facility for
2 evaluation. Anything less would be below the standard of
3 care.
4 Instead, he was not transferred for a period of
5 two hours and 45 minutes, and that allowed the subdural
6 hematoma to evolve to a state which was not treatable.
7 Q. If he had been transferred immediately following
8 the fall, do you know what hospital he would have been
9 transferred to?
10 A. I don't know that. I mean, he eventually went to
11 Jewish Hospital, but whether it would have made a
12 difference or not, I don't know that. I assume that's
13 the closest hospital to their facility.
14 Q. Do you know whether at Jewish Hospital they have
15 the capability of doing any kind of neurologic surgery?
16 A. I don't know that for a fact. I suspect they
17 didn't because in the case when he came there he was
18 transferred to University Hospital shortly thereafter.
19 Q. And let's say he gets transferred right away
20 following the fall at 7:45. Is that a transfer that had
21 to be by calling 911 versus calling an ambulance
22 service?
23 A. 911, yes.
24 Q. And when he gets to the hospital at that point in
25 time what would be done?

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1 A. He would get a stat brain CT scan.
2 Q. And how long would that take?
3 A. Typically, it takes -- from time of the admission
4 to the hospital to CT, fifteen to twenty minutes.
5 Q. Did you look to see how long it took when he
6 actually went to Jewish Hospital later in the morning
7 from the time he arrived till it was done, until it was
8 interpreted?
9 A. Well, let's see. They call Rescue some time
10 after 9 -- after 10:30. I see the scan was interpreted
11 at 11:22. So actually -- I'm not sure exactly what time
12 he arrived at the hospital. I'm trying to find the --
13 Q. I think he arrived at the hospital at 10:37.
14 A. So it was interpreted within 45 minutes, but I'm
15 not -- at least the dictation was within 45 minutes.
16 Typically when the radiologist looks at it, he or she
17 will call the emergency room doctor, tell him or her the
18 results and then dictate it, and the dictation occurred
19 11:22.
20 Q. How long does the CT take?
21 A. CT takes five to ten minutes.
22 Q. And then, so let's say we play out the same
23 scenario at 7:45 that was played out at 10:30. So we're
24 talking then it was eight minutes shy of an hour after
25 the fall, so at 8:37 a.m. the radiologist is dictating

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1 his report. Is that correct?
2 A. Right.
3 Q. During that time, now 40 -- 52 minutes?
4 A. Yeah.
5 Q. Is there anything medically being done for
6 Mr. Robinson?
7 A. Well, it would take -- they would check his blood
8 pressure, they would monitor, examine him neurologically.
9 Probably call -- if they had a neurologist available,
10 call that neurologist in to consult on him. As soon as
11 the scan is done, that's when things really get
12 expedited.
13 Q. Do you know what the situation was at Jewish
14 Hospital that morning at 7:45, 8:00 o'clock in terms of
15 the number of people in?
16 A. No, sir, I do not know that.
17 Q. Do you know how quickly they could have done a
18 stat CT at that point in time?
19 A. I do not know that. Well, we do know a time --
20 yeah, the answer's no, I don't. I mean, usually earlier
21 is better, but they did it pretty quickly when he came in
22 at 10:30, 10:37.
23 Q. And, do we know anything, or do you have an
24 opinion as to what his neurologic status was from 7:45 to
25 8:37 a.m.?

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1 A. Yes. According to Ms. Schumacher, he was alert,
2 responsive, had unchanged from his previous state.
3 Q. And they would still order a stat CT even if he
4 was alert and responsive, and having no focal neurologic
5 deficits?
6 A. Oh, absolutely, sir.
7 Q. Okay. So they get this interpretation back at
8 8:37, the radiologist has to speak to the ER doctor, and
9 I think in this case that whole process took a few more
10 minutes when it occurred later in the morning. Do you
11 remember that?
12 A. Yes.
13 Q. And how long was it, do you remember, till he was
14 sent out to University Hospital? I could tell you if
15 you'd rather have me tell you.
16 A. Sure, go ahead. I'll see if I can agree with
17 that.
18 Q. I think it was 12:28, the final nursing note
19 indicating that he's being transferred.
20 A. Yes. That sounds right to me.
21 Q. And so, what would have been done then after they
22 got the CT done, back, say in the morning at 8:37 a.m.?
23 Would they have done anything medically, other than
24 arrange for a neurologic consult and a transfer?
25 A. Yes. Likely they would have given him fresh

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1 frozen plasma to reverse the effects of the Coumadin.
2 Q. Did they give him fresh frozen plasma at Jewish
3 Hospital?
4 A. No.
5 Q. Why wouldn't they have given him fresh frozen
6 plasma later that day when he was there, after they got
7 the CT results back?
8 A. I think -- because looking at the reports of Dr.
9 Frappier, F-R-A-P-P-I-E-R, at that point he was too far
10 gone. He already had substantial amounts of bleeding and
11 uncal herniation, and they basically felt that his only
12 course was comfort measures. That would have been
13 different two and a half hours earlier.
14 Q. How long does it take for the administration of
15 fresh frozen plasma to reverse the effects of Coumadin?
16 A. Fifteen to thirty minutes.
17 Q. And, of course the flesh frozen plasma is not
18 reversing the effects of the aspirin; is it?
19 A. That's correct, it's not.
20 Q. Nor does it reverse the effects of the Plavix?
21 A. It would not.
22 Q. And would that, if they had been able to just
23 administer the fresh frozen plasma, would that have
24 prevented the subdural hematoma from progressing like it
25 did?

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1 A. It would have helped. In other words, he would
2 have had a much smaller lesion and he would have been a
3 surgical candidate.
4 Q. Now, you don't actually do neurologic surgery.
5 Do you?
6 A. You're correct. I do not.
7 Q. Would he still have ended up with a subdural
8 hematoma even if he had been sent to Jewish Hospital
9 earlier?
10 A. Yes.
11 Q. How much smaller would the subdural hematoma have
12 been?
13 A. Substantially.
14 Q. Are we talking 50 percent smaller, 75 percent
15 smaller?
16 A. Now we're -- I don't want to speculate. It would
17 have been much smaller. In other words, this is a
18 progressive problem. It's usually venous bleeding. It
19 goes in a linear manner. So, I would suspect if he would
20 have been two and a half hours earlier, again, it would
21 be much smaller. I couldn't say 80 percent smaller or 70
22 percent smaller, but substantially smaller.
23 Q. And how do you know it would have been small
24 enough that they could have operated?
25 A. At that point in time he was alert, had an

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1 unchanged neurological state.
2 Q. Well, he didn't arrive to University Hospital
3 till 1:05 p.m., two hours and 35 minutes after he was
4 found to have a change in neurologic status. Is that
5 correct?
6 A. Say that again, sir.
7 Q. He did not arrive to University Hospital until
8 1:05 p.m.
9 A. Yes.
10 Q. Two hours and 35 minutes after he was found to be
11 in an unresponsive state at Madeira.
12 A. Yes.
13 Q. How quickly would they be able to get him to
14 surgery?
15 A. Well, that's -- you mean at University Hospital?
16 Q. Yes.
17 A. Typically, if they told them, look, he has a
18 subdural hematoma, he had been on Coumadin, had fallen,
19 they would have been poised to receive him as soon as he
20 arrives there and have an operating room ready. They can
21 even drill burr holes in the emergency room in some
22 cases.
23 Q. Well, he'd have to be evaluated first by the
24 neurosurgeon; would he not?
25 A. Oh, sure. Of course.

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1 Q. So, it would take at least some time before he
2 could be taken to surgery?
3 A. Yes.
4 Q. He wouldn't have been to surgery in ten
5 minutes?
6 A. Well, again, if he really -- if the scan were
7 showing early herniation, and he started decompensating,
8 they can do a drill, burr hole right in the emergency
9 room within ten minutes. That does happen.
10 Q. Now, it's also possible that the neurosurgeon
11 might have decided he was not a surgical candidate even
12 earlier. Isn't that right?
13 A. Well, if he were only mildly affected and the
14 subdural was small, and was reversing -- and he was
15 getting fresh frozen plasma, they might just watch him in
16 ICU and do sequential scans. That's a possibility. He
17 might not even have required the surgery if he had been
18 treated more promptly.
19 Q. Well, it's possible they might have watched him
20 in the intensive care unit and he still would have
21 continued to bleed, and then he still wouldn't have been
22 a surgical candidate?
23 A. I think that's unlikely because he would have
24 been -- at the time he could have been transferred he
25 would have been much less involved with the radiographic

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1 lesion and he would -- the answer is no to your question.
2 He would have likely been a surgical candidate.
3 Q. Now, the decision whether or not to operate, that
4 rests with the neurosurgeon; does it not?
5 A. Surely.
6 Q. And you, as the neurologist, do not get to make
7 that decision. Isn't that correct?
8 A. Well, I can suggest it, but obviously I can't do
9 surgery.
10 Q. Now, you know from the notes that Sandra
11 Schumacher made that she did notify, or have contact with
12 Dr. Frecka, or made attempts to have contact with Dr.
13 Frecka, I should say, shortly after the fall. Is that
14 right?
15 A. Yes.
16 Q. And you know from her deposition that she would
17 have told him about the fall and what happened?
18 A. She states that in the deposition. It's not
19 documented in the contemporaneous notes.
20 Q. Well, do you have some reason to disbelieve Ms.
21 Schumacher?
22 A. Well, typically if one indicates to a doctor what
23 transpires, that's documented. She did not say. She
24 mentions the blood sugar being where it was, and then she
25 says she called Dr. Frecka and notified him. She does

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1 not say she notified him of the fall, the trauma, the
2 bruise on his head, or anything like that.
3 Q. Well, do you have any reason to believe that
4 Sandra Schumacher wasn't telling the truth when she was
5 deposed?
6 A. I don't know that, sir. I mean, as I said, a lot
7 of inconsistencies in her behavior. I'll leave it to
8 others to decide whether she's telling the truth or
9 not.
10 Q. Well, there's often inconsistencies in behavior
11 in charts. Isn't there?
12 A. Not as glaring as I see here.
13 Q. And, what do you know about, or what do you
14 recall about Sandra Schumacher's experience as a nurse?
15 A. She was a registered nurse. She had worked for
16 some years. I don't know anything more than that. Just
17 what she discusses in her deposition.
18 Q. Was she an experienced nurse?
19 A. She had experience, yes.
20 Q. Would there have been any other reason for her to
21 attempt to notify Dr. Frecka, was it 7:45 or 8:00 o'clock
22 in the morning on July 18th, other than to tell him about
23 the fall?
24 A. Just the blood sugars being low, and then giving
25 sugar and it came up to normal.

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1 Q. Do you know whether that's something a nurse
2 would normally notify the doctor about?
3 A. They could. If the patient had low sugar and it
4 was rectified, they might tell him about that, yes.
5 Q. But do you know whether that's something they
6 would normally notify the doctor about?
7 A. They may or may not.
8 Q. So would you agree that it's more likely than not
9 that the reason why she attempted to contact Dr. Frecka
10 the morning of July 18th was to inform him about the
11 fall?
12 MR. POOLE: Objection.
13 THE WITNESS: I'd be speculating to answer that
14 question.
15 BY MR. McCARTNEY:
16 Q. And correct me if I'm wrong, Doctor, but wasn't
17 there an order to give a certain amount of insulin
18 depending on what Mr. Robinson's blood sugar was?
19 A. Sliding scale, yes.
20 Q. And if but for the fall, if he had a low blood
21 sugar and they gave him insulin, and it was corrected --
22 A. No, no, no, there you're wrong. They wouldn't
23 give insulin. In other words, that sliding scale is when
24 you have high glucose, it tells the nurse how much
25 insulin to administer. If the patient has low blood

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1 sugar, that may be a reason for the nurse to contact the
2 doctor regarding the patient.
3 Q. His fasting blood sugar was 113. Is that
4 correct?
5 A. Yes, it had been.
6 Q. And that would be below normal?
7 A. No. That's fine. That's a little high, but not
8 anything dangerous. It was 63 in the time after the
9 fall, that's a low blood sugar, it may occasion the nurse
10 to contact the physician.
11 Q. And the giving of OJ when someone has a low blood
12 sugar is a normal nursing response; is it not?
13 A. Sure. That's fine.
14 Q. And one of the reasons why the thought process of
15 Ms. Schumacher may have been that with a fasting blood
16 sugar of 63 he might have been dizzy, or whatever, and
17 that might have been what contributed to the fall?
18 A. That was probably her thought processes, yes.
19 Q. So, let's play this out. Let's rule out, take
20 out a fall having occurred. A nurse finds a blood sugar
21 of 63, gives orange juice and it comes to 113. That
22 ordinarily would not result in the physician being
23 notified immediately; would it?
24 A. It might because they may want to change the
25 standing insulin orders based on that occurrence.

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1 Q. But it might not also?
2 A. That's right. I'm not saying it necessarily
3 would have caused a call, but it might.
4 Q. So the one thing we know that did happen that
5 necessitated Dr. Frecka being notified was the fall?
6 A. Say that again, Mr. McCartney.
7 Q. The one thing we know that did occur that would
8 require Nurse Schumacher to notify Dr. Frecka was the
9 fall?
10 A. Correct.
11 Q. Aspirin, is that an anti-platelet medication?
12 A. Yes, sir, it is.
13 Q. It's not typically considered an anti-coagulant.
14 Is it?
15 A. It's an anti-platelet medicine, yes. It has
16 anti-coagulant effects as an anti-platelet agent.
17 Q. And what about Plavix?
18 A. Same. It's a different kind of anti-platelet
19 agent.
20 Q. So, regardless of the whole issue about whether
21 or not they notified Dr. Frecka, it's your opinion that
22 that really was secondary, they should have called 911
23 regardless?
24 A. Yes. I mean, as a courtesy let him know they
25 were calling 911 because it's his patient, they should

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1 let him know something transpired with him. Nonetheless,
2 you're correct, immediately upon his fall 911 should have
3 been notified.
4 Q. And they did do that at 10:30, they called 911
5 first and then notified Dr. Frecka?
6 A. That's right.
7 Q. And that was appropriate?
8 A. It was.
9 Q. You're just saying that based on the fall, the
10 bleeding, and being on an anti-coagulation it should have
11 resulted in an immediate transfer?
12 A. Correct.
13 Q. Without even consulting the doctor?
14 A. Correct.
15 Q. Have you formulated any opinions as to
16 Mr. Robinson's life expectancy?
17 A. Yes.
18 Q. What opinions have you formulated relative to
19 that?
20 A. It was reduced compared to his expected life
21 expectancies for his age detainment at the time of his
22 demise.
23 Q. Do you know by how much?
24 A. Fifty percent.
25 Q. Fifty?

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1 A. Fifty.
2 Q. How did you arrive at a fifty percent number?
3 A. Just as to his profile that was applied from the
4 previous Christ Hospital records.
5 Q. And that's based on your experience and
6 training?
7 A. Yes.
8 Q. I assume that there is not some place that you
9 can go and look up and plug in his diagnoses, etcetera,
10 and everything, and have them pop a number right out?
11 A. Right. There's no -- I can imagine that being
12 done, but that's not been done as yet. That would be
13 nice.
14 Q. No statistical analysis, I guess.
15 A. No, sir.
16 Q. Any other opinions you have formulated that we
17 have not discussed?
18 A. No, sir.
19 Q. Are you still a volunteer faculty member at the
20 University of Miami?
21 A. Correct.
22 Q. And is it the three months a year that you spend
23 Wednesdays over there, or something like that?
24 A. That's right.
25 Q. What do you do when you go over there on

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1 Wednesdays?
2 A. I instruct the residents and the students, and
3 the, I guess -- they used to call them interns, I guess
4 the PG1 people who are rotating through neurology, and in
5 neurology. But specifically, we have, it's a large
6 clinic, there are about a dozen residents. There's
7 usually two regular faculty people, and there may be one
8 or more volunteer faculty people, and we alternate taking
9 patients that the residents see. They'll see the
10 resident first. Resident will come out, present the case
11 to us verbally. We will go in there with the resident,
12 and the students, we will examine the patient, discuss
13 the patient, and make suggestions in terms of whether
14 they need admission, what kind of diagnostic evaluation,
15 what kind of therapy should be provided them.
16 I will be there Wednesdays during the course of
17 the month. I was there in April. My next rotation is in
18 August.
19 Q. When you're not doing that, you're otherwise
20 spending five days a week in your office practice?
21 A. Plus every weekend day as well working, seeing
22 patients in the hospital.
23 Q. How many patients do you typically have in the
24 hospital at a given time?
25 A. I'd say minimum, rarely goes below five. Usually

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1 it's not more than ten, although more recently it's been
2 as high as fifteen.
3 Q. So the weekends you're rounding in the hospital
4 on your patients?
5 A. That's correct. And also the extended care
6 facilities and the skilled nursing facility, and the
7 rehabilitation facility.
8 Q. What extended care facility?
9 A. Over at St. Catherine's or Villa Maria.
10 They have an extended care facility.
11 Q. How much do you charge to travel to testify for
12 your time?
13 A. If it's in South Florida it's $800 per hour. If
14 it's the Kentucky/Cincinnati area, it would be per diem
15 rate of $5,000 for the trip, plus expenses.
16 Q. Have you worked with Mr. Poole before?
17 A. I have, yes.
18 Q. On how many occasions?
19 A. I think I had one case with his firm before.
20 Q. What about Chip Goff, have you worked with him
21 before?
22 A. I think it was the same -- I mean, I think
23 Mr. Goff was involved in that same case as well.
24 Q. What percentage of your reviews currently are for
25 the plaintiff versus defendant?

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1 A. It depends on the nature of the case.
2 Negligence, medical negligence, it's primarily for the
3 plaintiff. In other cases it's majority for the
4 defense.
5 Q. I was talking about med mal. So you did
6 rightfully clarify my question.
7 When you say the majority for the plaintiff, what
8 percentage would you --
9 A. I'd say in the last five years it's been 90
10 percent for the plaintiff. There's one exception to
11 that. In the maritime cases, which are tried in Miami
12 often, typically there will be a contention by the
13 plaintiff's attorney that the shipboard company failed to
14 provide the passenger, or the crew member adequate
15 service, and most of those cases I'm on the defense side.
16 But it's not true medical negligence case, or it's a
17 medical negligence case in disguise. In those cases I'm
18 primarily for the defense. Other actual clear-cut
19 medical negligence cases like this is 90 percent for the
20 plaintiff.
21 Q. I take it you disagree with Dr. McCormick's
22 opinions that he issued in his report?
23 A. Yes, sir, I do.
24 Q. Do you disagree this was a mild closed head
25 injury by definition prospectively?

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1 A. Well, the injury itself was relatively mild
2 in the sense the patient did not have a skull fracture,
3 did not lose consciousness. But it's not mild in the
4 sense in the setting this man was in, it's a substantial
5 injury, it's a very dangerous injury.
6 Q. Do you disagree with Dr. McCormick's assessment
7 that his baseline Glasgow coma score remained at 14 after
8 the fall?
9 A. I do not disagree with that statement, no.
10 Q. Why was Vitamin K given at Jewish Hospital?
11 A. Well, Vitamin K does reverse, to a certain
12 extent, Coumadin. However, it takes a while. It takes
13 24 hours. So it's really -- doesn't speak to the issue.
14 Q. So the only way to expeditiously reverse Coumadin
15 would be to give the fresh frozen plasma?
16 A. Well, the common therapy. There are some newer
17 materials out, which were out in 2009, I'm pretty sure,
18 which can reverse Coumadin as well.
19 Q. And Dr. Frappier, F-R-A-P --
20 A. Yes, he was the ER physician at Jewish
21 Hospital.
22 Q. Now, at that time he had not had the benefit of
23 having a neurologic consult. Is that right?
24 A. He did not.
25 Q. And he did not know at that point in time whether

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1 or not Mr. Robinson was a surgical candidate or not. Is
2 that true?
3 A. He felt the patient was not, based on his on
4 appraisal of the patient.
5 Q. He still sent him down to University Hospital to
6 be assessed for possible surgery?
7 A. He said that just -- basically he suggests,
8 mainly he said for comfort measures. He did not think
9 surgery was going to be practical.
10 Q. He didn't know that yet, though. Would that be
11 fair?
12 A. He suspected that, but he's not a surgeon. He
13 was going to give the patient the benefit of the doubt by
14 having him seen.
15 Q. And, certainly until the surgeon had ruled out
16 the possibility that Mr. Robinson was a surgical
17 candidate, efforts should have been made to prepare him
18 for possible surgery?
19 A. Well, it's debatable. He was not -- the way he
20 appeared to Dr. Frappier he was not a -- he had already
21 herniated, he was comatose, and it was unlikely any
22 measure would be helpful to him.
23 Q. Now, Dr. Frecka was Mr. Robinson's attending
24 physician. Is that right?
25 A. He was, yes.

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1 Q. And he had already seen and examined Mr. Robinson
2 by July 18th of 2009. Is that right?
3 A. Right.
4 Q. And he had given orders in between relative to
5 Mr. Robinson's anti-coagulation. Isn't that right?
6 A. Yes.
7 Q. He had signed the orders for Mr. Robinson to
8 receive Plavix, Coumadin, and aspirin. Is that right?
9 A. Yes. He did.
10 Q. Do you remember when it was that Mr. Robinson had
11 last received Coumadin?
12 A. That probably would have been on the 17th.
13 Q. What is the effect of, or I guess the half-life,
14 I should say, of Coumadin?
15 A. It's at least twelve hours.
16 Q. Well, how long would Mr. Robinson have to have
17 been off of Coumadin for the anti-coagulative effects to
18 have been reduced?
19 A. Well, reduced -- it's reduced every day that
20 you're off it. To become subtherapeutic would probably
21 take 48 hours. In other words, one attempts to obtain an
22 INR between 2 and 3. If you don't give Coumadin for one
23 day, typically the INR will still remain in the
24 therapeutic range. It takes at least 48 hours just by
25 stopping the Coumadin to reduce below the therapeutic

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1 range.
2 Q. What happens if he had not received Coumadin
3 since July 15th?
4 A. His INR may be in the range of, like 1 and a half
5 to 2, but may not be therapeutic.
6 Q. And so we don't mislead you here, I believe his
7 INR was still in the therapeutic range on the 18th.
8 A. So it could have been the high range. In other
9 words, as I say, one tries to attain 2 to 3, so it could
10 have been 2.8, let's say, just pick a number, and when it
11 was finally taken his range, it was over 2.
12 Q. It was 2.3 at Jewish.
13 A. Yeah.
14 Q. So, if he had been off of Coumadin for 48 hours,
15 would you still give fresh frozen plasma?
16 A. Yeah. Oh, absolutely.
17 Q. And, of course, if he had been off Coumadin for
18 that long, the effectiveness of giving fresh frozen
19 plasma would be reduced too?
20 A. No, no, it would not. He still would have had
21 the effective therapeutic effect of Coumadin on him at
22 that point in time.
23 Q. Have you ever heard the phrase that the physician
24 who's in the best position to make a diagnosis on the
25 patient is the physician who actually sees the patient?

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1 A. Sure.
2 Q. Would you think that sort of a corollary to that
3 would be the person who's in the best position to
4 evaluate someone's needs with ADLs is the person who
5 actually assesses the person?
6 MR. POOLE: Objection.
7 THE WITNESS: Typically, that would be true, yes,
8 sir, assuming the qualifications of the person were
9 appropriate.
10 BY MR. McCARTNEY:
11 Q. Any other opinions we have not discussed?
12 A. No, sir.
13 Q. Would you be disappointed if I told you I thought
14 I was finished?
15 A. No. You're very efficient.
16 MR. McCARTNEY: Well, thank you.
17 I am finished. Thank you for your time,
18 Doctor.
19 THE WITNESS: Thank you, sir.
20 MR. POOLE: No questions.
21 THE WITNESS: Okay. Would you like me to read,
22 Mr. Poole?
23 MR. POOLE: We can waive, if you want to waive.
24 THE WITNESS: Okay.
25 MR. McCARTNEY: I'm going to order, if you can

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1 send me an etran, please.
2 MR. POOLE: I'll have an etran.
3 (Deposition concluded at 2:27 p.m., reading and
4 signing having been waived.)
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1 CERTIFICATE OF OATH
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3 STATE OF FLORIDA
4 COUNTY OF MIAMI-DADE
5
6 I, JANINE P. CARROLL, Notary Public, State of
7 Florida, certify that KENNETH C. FISCHER, M.D. personally
8 appeared before me on July 5, 2012 and was duly sworn.
9
10 Signed this 16th day of July, 2012.
11
12 ______________________________
13 JANINE P. CARROLL
Notary Public-State of Florida
Commission No.: EE 070619
14 Expires: March 28, 2015
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1 CERTIFICATE OF REPORTER
2
3 STATE OF FLORIDA
4 COUNTY OF MIAMI-DADE
5
6 I, JANINE P. CARROLL, do hereby certify that I
7 was authorized to and did stenographically report
8 the deposition of KENNETH C. FISCHER, M.D.; that a review
9 of the transcript was not requested; and that the
10 foregoing transcript is a true record of my stenographic
11 notes.
12 I FURTHER CERTIFY that I am not a relative, employee,
13 or attorney, or counsel of any of the parties, nor am I a
14 relative or employee of any of the parties' attorney or
15 counsel connected with the action, nor am I financially
16 interested in the action.
17
18 DATED this 16th day of July, 2012 at Miami,
19 Miami-Dade County, Florida.
20
21
22 ______________________________
JANINE P. CARROLL
23
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