IN THE FIFTH JUDICIAL CIRCUIT COURT

IN AND FOR CITRUS COUNTY, FLORIDA

CASE NO. 2012 CA-000405 A

RONALD DISHOP and CHERYL ANN BISHOP,

Plaintiffs,

vs.

CITRUS MEMORIAL HEALTH FOUNDATION, INC, d/b/a CITRUS MEMORIAL HOME HEALTH AGENCY, GULF COAST SPINE INSTITUTE, P.A., SPINE THERAPY, INC., and JAMES RONZO, M.D.,

Defendants.

_____/

DEPOSITION OF DANIEL S. HUSTED, M.D.

MONDAY, JULY 7, 2014

3:48 P.M. - 6:12 P.M.

1050 SE MONTEREY ROAD #400

STUART, FLORIDA

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Reported By:

Eleanor M. Evensen, RPR

Notary Public, State of Florida

West Palm Beach Office #148768

APPEARANCES:

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I N D E X

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E X H I B I T S

P R O C E E D I N G S

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Deposition taken before ELEANOR M. EVENSEN, Registered Professional Reporter and Notary Public in and for the State of Florida at Large, in the above cause.

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Thereupon,

DANIEL S. HUSTED, M.D.

having been first duly sworn or affirmed, was examined and testified as follows:

THE WITNESS: I do.

DIRECT EXAMINATION

BY MR. JOPLING:

Q. Tell us your name for the record.

A. Daniel Husted.

Q. And you are a medical doctor?

A. I am.

Q. Board certified?

A. I am.

Q. In orthopedic surgery?

A. Yes.

Q. Anything else?

A. No.

Q. All right. Dr. Husted, I have the benefit of

your CV and we won't belabor this, but tell us a little about your medical background and training.

A. Sure. I went to undergrad at University of Florida. I did my medical training at University of Florida.

I did my orthopedic training at Yale University and my spine training at San Francisco.

Q. And your medical degree from UF was in 2000; is that right?

A. Correct.

Q. And you have been in the private practice of orthopedic surgery since when?

A. I started here in 2006.

Q. Okay. And "here" is South Florida Orthopedics?

A. Yes.

Q. And today we are in Stuart, Florida; your group has offices elsewhere?

A. We do. We have an office in Palm Beach Gardens and we have an office in St. Lucie West.

Q. And your primary practice is here?

A. I actually have my primary practice here in Stuart and Palm Beach Gardens.

Q. Very good. And what is your address please?

A. My home address or my office address?

Q. Office will work.

A. 1050 Southeast Monterey Road, Suite 400, Stuart, Florida. Do you need a ZIP code?

Q. No. And what is your date of birth?

A. 7/25/75.

Q. I think you have told me this, you are not board certified in any specialty other than orthopedic surgery?

A. Correct.

Q. I know these days most folks I know of that are orthopedic surgeons are subspecialized, at least functionally so within that field.

Do you concentrate on one particular area of orthopedic surgery?

A. I do, it is spine.

Q. And does that include both cervical, thoracic, and lumbar?

A. Correct.

Q. I take it then that you have performed a number of bilateral laminotomies, as was done in this case?

A. I have.

Q. Any idea of the frequency of which you performed this procedure?

A. I've probably performed thousands. And I would say that I do lumbar decompressions, which is the category for which that falls into --

Q. Right.

A. -- on the order of 20 or more a month.

Q. So that we are clear here, I think I understand what you're telling me, the broader category of spinal decompressions includes laminotomies?

A. Laminotomies, laminectomies. The technique is very similar, so to distinguish between the two would be a very, it would be more clear to a spine surgeon, but the actual technique is using Kerrison Rongeurs in removing bone.

Q. Right. In the course of those thousands of bilateral laminotomies, have you ever had a patient postoperatively develop an epidural hematoma?

A. Yes.

Q. That is a recognized complication of any sort of spinal decompression?

A. It certainly is.

Q. And by that, we mean it can happen under the best of care?

A. Absolutely.

Q. It also does not necessarily, in fact does not usually, produce any sort of lasting neurological deficit, does it?

A. If dealt with in a timely fashion, and also depending on what the actual symptomatology is.

To clarify, you can have asymptomatic lumbar

hematoma or mildly symptomatic lumbar hematoma without any neurologic deficit.

Q. Right. Doctor, before we get deeper into this, I believe I have seen that you have had your deposition taken before?

A. I have.

Q. About how many times?

A. That is a difficult question to answer, because I do a lot of depositions for worker's comp.

Q. Right.

A. Very little personal injury, so when we are talking about depositions, usually for worker's comp. It is a lesser degree personal injury, and rarely for malpractice.

Q. Let's limit it to that latter category.

Can you estimate for me about how many times you have had your deposition taken in a case, as we are doing today, where you are going to be offering opinions about the standard of care of another physician?

A. Less than five.

Q. Have any of those been cases in which you were retained for the defendant physician?

A. No.

Q. So all of the testimony you have ever given by way of deposition in which you were offering medical

malpractice opinions, those were all on behalf of the plaintiff?

A. To my recollection, yes.

Q. Do you advertise your availability in any way as an expert witness?

A. No.

Q. Do you know how you came to be involved as an expert in this case?

A. I believe I was contacted by the attorney's office to review the case and to obtain my opinion, one way or another.

Q. All right. Have you worked with Mr. Kuvin, or his firm, before as an expert witness?

A. I'm quite sure I have because I do personal injury. So I think his firm does personal injury and so I'm sure I've had cases with his firm. I recognized him, so I've probably done a case with him before, but it was probably a personal injury.

Q. To the best of your recollection you have not worked on a medical malpractice case before with Mr. Kuvin?

A. To the best of my recollection, yes.

Q. The cases in which you have been an expert witness in what we are calling personal injury cases, have those been cases in which you were a treater or in

which you were offering some sort of opinion apart from your treatment?

A. Very rarely is it in a treating realm. Having said that, and are we just talking depositions or now globally when I'm asked to review a case?

Q. Let's talk globally now.

A. Globally I'm approached by both plaintiffs and defense. And I will review the cases for both sides.

So when asked to review a case, it doesn't matter to me whether it's plaintiff or defense, I do so at the request in which I render my opinion, and at some point they decide whether they want to proceed forward with the case.

They don't always like my opinion, both sides. I'm paid to render my opinion as I see it.

Q. Right. Help me out as to how that works in the nonmedical malpractice, in the personal injury section where if you are not a treater are you approached by both sides to do record reviews?

A. IMEs. And I have been approached by both sides to do an IME. And I'm equally open to either side approaching me because in the end I'm just being asked to give an opinion.

Q. Sure.

A. That's easy for me to do.
Q. How frequently do you perform independent medical examinations?
A. Not often. The vast majority, I would estimate 95 percent of my time is spent just practicing spine surgery.
So to do depositions, IMEs, narratives, things such, what I would consider to be the legal realm, is a minority of what I do.
Q. Sure, I would have expected that. You've probably been asked this question before, you know, what percentage of your professionally derived income comes from consulting work in the medical/legal field?
By that I'm including medical malpractice work, personal injury or any other.
A. Sure. I estimated it to be three percent. And I've actually never done a rough calculation until I was asked to do so. But the vast majority of what I do is just from treating and doing surgeries, etc., seeing patients in clinic, doing epidurals.
Q. You believe that the income you derive from testifying as an expert comprises somewhere in the neighborhood of three percent of your total?
A. It does, it is a small amount.
Q. Have you given testimony in trials?

A. I have.

Q. In what kind of cases?

A. There were two personal injury trials that I gave testimony in. One was a patient hit by a car, and the subsequent injuries.

The other was, oh, the other case, actually there was one personal injury case, the other was actually a malpractice case.

Q. And do you recall the names of the litigants in the malpractice case?

A. It wasn't on the list that was given?

MR. KUVIN: Here is the list, Counsel. Do you mind if I show him to refresh his recollection?

MR. JOPLING: No.

THE WITNESS: It's not on that list. It was a case in Minnesota in a screw malposition. And I'm sorry, I was only recently keeping a list because I've been asked this question now to the point where I realize I have to keep a list.

This was something I just do as, again, a minority of what I do. But now I've been asked this question enough I am keeping a list. I have to look it up, I apologize.

BY MR. JOPLING:

Q. I don't know if this is the same thing Mr. Kuvin showed me. I overlooked this; is that the list?

A. Yes, it is.

Q. I'm sorry, I may have misunderstood your answer. Was one of these the medical malpractice case you believe you testified in?

A. No, and I would have to look to see if I can recognize the attorney's name.

Q. It was in Minnesota?

A. Yes, and it was a screw malposition. It was actually a rod malposition case where the patient ultimately developed a failure to fuse because of the failure of hardware. Where the claimant in the plaintiff's position was that the rod was not properly positioned.

Q. And in that case you testified for who?

A. The plaintiff.

Q. For the plaintiff. We have talked so far about cases in which you have given depositions and testified at trial.

Approximately, how many cases do you review on an annual basis involving allegations of medical malpractice?

A. Let me actually think about that, so I can

give you an accurate number.

Q. Okay.

A. I probably review about six cases a month. So I would say ballpark of 70 a year.

Q. Med mal?

A. Med mal it might be less. It shouldn't be more.

Q. And for how long have you been doing that?

A. Three years.

Q. So in very round numbers, would you estimate then maybe you have reviewed roughly 200 cases, med mal cases in the last three years?

A. I would say so.

Q. Was there anything in particular that led you to begin doing testimonial work or reviewing work in the medical malpractice field?

A. Honestly it is the best continuing medical education you can ever do. It is the best.

I found that by reviewing cases I see the pitfalls that commonly happen in treating patients. It reiterates to me the things to be concerned about.

Q. Right.

A. And it's fascinating to me. And also, because I have been asked by my peers why would you do this. To me it is me just being asked to give the

truth as I see it.

And often I can head-off a case from even going further because I can simply say to the attorney, this is just a known complication, and he did everything right.

And that way I feel that I'm actually protecting frivolous lawsuits from going forward.

Q. You, of course, charge for your time involved?

A. I do. I do.

Q. What do you charge for your time?

A. To review a case, $650 an hour.

Q. And you have a different rate for such delightful tasks as you are doing today?

A. Depositions, yes.

Q. How much do you charge for depositions?

A. I'd actually have to review what I sent you guys.

MR. KUVIN: (Indicates)

THE WITNESS: 1200 hourly for the deposition, with 700 to review the records before the deposition. And then I also charge for the predeposition conference.

BY MR. JOPLING:

Q. So, despite the fact, that we are providing you with the best quality medical education that you do not

have to pay for, you also want us to pay you money too; is that the way it works?

A. It's have my cake and eat it too, I guess. But again, I emphasize to you it's the best continuing medical education anyone can ever have.

Q. And certainly the most cost effective, I understand.

All right. Dr. Husted, let me back up. You are obviously licensed to practice medicine in the State of Florida?

A. I am.

Q. Anywhere else?

A. No. I used to be in California, but it's expired.

Q. Have you ever been sued for medical malpractice?

A. I have.

Q. How many times?

A. Once.

Q. All right. And what was the outcome of that?

A. The case died in court, basically. The patient lost two attorneys in the process, both dropped her. And my understanding of it is because it lacked merit.

Q. But your understanding is that no monies were paid on your behalf?

A. Oh, no monies were paid.
Q. You have hospital privileges at some hospitals in South Florida?
A. I do.
Q. Which hospitals?
A. The Martin system, which is in Stuart and in St. Lucie West, Tradition. And also at Palm Beach Gardens Medical Center.
Q. And are those facilities where you do the majority of your surgery?
A. I also do surgery at a surgery center, Surgicenter of Palm Beach. And between those three institutions, that's where I do all my surgery.
Q. Have you ever had your practice privileges at any hospital revoked, limited, or suspended?
A. No.
Q. More broadly, have you ever had your practice privileges revoked, limited, or suspended by the State of Florida?
A. No.
Q. Have you published in the field of orthopedic surgery?
A. I have.
Q. Tell me what you have published.
A. It was in residency and fellowship. And it

was focusing mostly on disc replacement.

I also published in regard to novel approaches to implanting pedicle screws.

Q. Any of that, any of those publications that you would consider relevant to your opinions in this case?

A. Not directly. It's spine surgery in general, and my experience and training is relevant to the case.

Q. Okay. Of those 70 or so, I understand that's an estimate of cases that you review in an average year, medical malpractice cases, what percentage of those come from plaintiffs and what percentage of those comes from defendants?

A. Unfortunately, more come from the plaintiffs than they do from defendants. And my only premise can be that, you know, it's from the same firms that became aware of me as an expert.

I obviously will review any case sent by whatever side, but it's the majority that must be aware of me are plaintiffs.

Q. Okay.

A. Again, I don't advertise, so it's just really firms that are aware of me.

Q. Right. You have obviously been retained as an expert in this case by Mr. Kuvin or his firm?

A. Yes.
Q. When did that first happen?
A. I don't know.
MR. KUVIN: I have a date.
THE WITNESS: Do you have when you first contacted me?
MR. KUVIN: This is our first letter.
THE WITNESS: January of 2014.
BY MR. JOPLING:
Q. What were you asked to do when you were first contacted?
A. To review the records.
Q. And you subsequently, I assume, received some records to review?
A. I did.
Q. Do you have those records that you reviewed with you?
A. Not physically with me, but the records I can say what I reviewed.
Q. Great, let's start with that.
Tell me what you reviewed.
A. So I reviewed the Citrus Memorial Health Systems records, the medical records from Gulf Coast Spine Institute. From Arif Sami, Dr. Sami, S-A-M-I. From the rehabilitation center, which is Citrus

Memorial Rehabilitation Services and Gulf Coast Aquatic.

Then I reviewed depositions. Deposition from Dishop, the plaintiff; from Gena Rosengrant, which is the RN; from Cheryl Bishop, who is the plaintiff's wife. And then from Dr. James Ronzo, the defendant.

Q. Do you know Dr. Ronzo professionally?

A. I don't.

Q. Are you aware from the records that you have reviewed that Mr. Dishop, and formerly Mr. Bishop, you understand those are one and the same person?

A. Yes.

Q. And that Mr. Dishop had a lengthy history of back surgery before the surgery that we are here to talk about today?

A. Yes, I am.

Q. But you have not seen any of those records, have you?

A. I don't believe I have. I believe I've only seen that referenced in the depositions.

Q. I don't want to get ahead of ourselves here, but you have got opinions regarding the standard of care regarding Dr. Ronzo?

A. Yes, I do.

Q. And you have got opinions about whether or not

anything Dr. Ronzo did or failed to do with that contributed to some injury on the part of Mr. Dishop?

A. I do.

Q. Would it be relevant to your opinions to know to what degree Mr. Dishop suffered neurological deficits related to his spine before the surgery by Dr. Ronzo?

A. It would be relevant, but to clarify what I would base, or what I have to this point based my opinion on is the baseline history from prior, from the preop evaluation to the now history of where he stands.

Q. Okay. And in regard to the latter, what is the most recent medical records you have on Mr. Dishop?

A. I'd have to review, sorry. It would be in here, I believe. Bear with me.

Q. Sure.

A. As you can see, these are very lengthy records, hence why I don't cart them around with me.

Q. Sure. Having tried to cart those records around on planes before, I'm sympathetic.

MR. KUVIN: Everyone is trying to go digital nowadays.

MR. JOPLING: Yes.

MR. KUVIN: Based upon what we provided him it appears 2010 may be the last dates, I believe,

without going through each and every record.

MR. JOPLING: That's fine.

THE WITNESS: Can I see what you say is the last followup?

MR. KUVIN: Yes. Probably going through to, that was the last, so 2007 is here. So it's actually reverse chronology.

THE WITNESS: Here is February 2011. This is a record from University of Florida Neurology, Shands. Good institution, I would think. I'm sure we can agree with that.

BY MR. JOPLING:

Q. I'm sure we can. But we can also agree that's not one of the ones you listed for us before.

A. Actually it was in the, because I referenced, I thought I referenced neurology in my list, because I've actually seen reference of his followup with neurology. I know I didn't say that, but I have --

MR. KUVIN: I may have an incomplete list.

THE WITNESS: And I have seen reference to this, but this is not a note that I haven't seen. That is a familiar note to me.

BY MR. JOPLING:

Q. That's from the UF neurology clinic, and when is that one please?

A. Yes. That's what I'm looking for the date of. It looks like it was 2011, and it was a February 22, 2011, visit. It was Dr. Annet, A-N-N-E-T.

MR. KUVIN: I see the problem, Counsel, so we are clear, he had listed what was in Volume I of what was provided, but we missed Volume II. That was the other problem.

THE WITNESS: It was the most records I've been sent at one time.

MR. KUVIN: So we are clear, Volume II is Citrus Health Rehab, Health Center at Brentwood, Citrus Urology Associates, which is Dr. Michael Desautel; Neal Lumapas at Shands Medical Center Neurology. I apologize.

MR. JOPLING: That's no problem. I'm just trying to get a general scope of the years covered, and I'll explain further.

I don't have any records for Mr. Dishop later than, I think August of 2011. And I'm trying to find out if anybody else in the room does.

THE WITNESS: I have a record here of February 2011. And I'm looking myself to see if I would call that the last one, from the chronology standpoint, and it seems to be my

initial evaluation.

BY MR. JOPLING:

Q. So you don't have any way of knowing, do you, Dr. Husted, how this patient is doing today?

A. I only can infer it from the records. I haven't examined him myself, but I have a good understanding from the note from the neurologist of February 22, 2011.

But I don't know how he is doing in 2014, if that's your question.

Q. That is my question, by today.

The last record you have is some close to three and a half years old?

A. Correct.

Q. All right. Are you able to express, prepared to express an opinion within a reasonable degree of medical probability that as of February 2011, Mr. Dishop was in a state that he was not going to improve any further?

A. I am. I mean, he had a now somewhat chronic from postoperative inability to ambulate without significant gait impairment.

He had bilateral lower extremity weakness and was utilizing an ankle foot orthotic.

Q. And are you prepared to express the opinion that no further improvement in that condition was probable?

A. It was over a year after the decompression, so, yes, I would render that opinion.

Q. And by the way, you, having not seen any of Mr. Dishop's earlier records, you don't know whether Mr. Dishop had previously complained of an inability to ambulate, or a foot drop, or any of those problems?

A. It would only be based off of his preoperative evaluation, and where he stood as preop versus postop.

Q. Okay. Would it affect your opinions in this case in any way to know that, for example, in January of 2001, Mr. Dishop, then Bishop, was claiming that he was unable to walk at that time?

MR. KUVIN: Objection to form, speculation.

THE WITNESS: It would depend on what the reason was, because inability to walk can also be inability to walk a distance due to pain.

So a patient with spinal stenosis classically has back pain, buttocks pain, or leg pain with walking. So it makes it difficult to walk any distance without leaning forward on a cart.

When I reference difficulty of walking now it's from neurologic deficit.

BY MR. JOPLING:

Q. And one of the ways that neurologic deficit is

manifested is in Mr. Dishop's foot drop?

A. Yes.

Q. In fact, that is the primary manifestation of his deficit, is it not?

A. And a wide-based gait. He has a somewhat ataxic gait now because of the motor and sensory deficit that he has, and because of his foot drop he now has to walk with a very wide-based, unsteady gait.

Q. You have not seen any records that suggest that even in September of 2007, some two and a half years before the surgery we are here to talk about, that Mr. Dishop was diagnosed with foot drop?

MR. KUVIN: Objection to form.

THE WITNESS: I would have to see those records.

BY MR. JOPLING:

Q. You have not seen them at this point?

A. I would have to see the earliest records I have provided to me, and that would be a better way of answering you.

Q. Let's take a moment to do that and see what the earliest records you have on Mr. Dishop are.

A. Can I see the first?

MR. KUVIN: Citrus, I believe started.

THE WITNESS: February, 2010.

MR. KUVIN: Ronzo records start prior to February.

Do you have the Ronzo chart with you, by any chance?

MR. JOPLING: I do.

MR. KUVIN: It was in a separate folder of mine.

MR. JOPLING: Sure.

MR. KUVIN: These are all the Ronzo records. This is most recent up top, I believe. So we can go back to Ronzo's beginning.

THE WITNESS: Physical is September 2007, there. Bear with us, sorry about that.

MR. KUVIN: Counsel, I can stipulate it would be the oldest record for Dr. Ronzo with this patient. We are just looking for it.

MR. JOPLING: Those go back, I believe, to 2007, is my understanding.

MR. KUVIN: It looks like the earliest date is 2007.

THE WITNESS: Do you have a note I can look at?

BY MR. JOPLING:

Q. If you are looking at me, I'm looking at a medical chronology prepared by my office, but I'm looking

at a particular note from Citrus Memorial Home Health on September 24th of 2007, if that's any help at all.

A. Not all this is in order.

Q. Also a record from the Gulf Coast Spine Institute of September 25, 2007.

A. We are getting there. I see December of 2007, October of 2007, wonderful.

MR. KUVIN: Sorry. Just to cut to the chase I can tell you Dr. Lumapas' records start on June 6th of 2005, and he has been provided those records.

THE WITNESS: If you can show me those?

For instance, I'm looking at a record from Dr. Ronzo's office when he saw him December of 2007, and he did not have foot drop at that point.

MR. KUVIN: Okay. Here is the first record that I'm aware of you have been provided, and this is dated June 6, 2005.

MR. REICHERT: Is that Lumapas?

MR. KUVIN: Yes.

THE WITNESS: That is Dr. Lumapas, I would be more particularly looking for a spine specialist. So, my best answer to him would be reviewing Dr. Ronzo's office, because I would believe

Dr. Ronzo's preoperative evaluations.

And I have a September 2007, and in September of 2007 he had normal reflexes and a normal lower extremity exam.

BY MR. JOPLING:

Q. Okay. Do you find that in September of 2007 that he uses a walker for assistance when walking and walks with a wide, unsteady gait?

A. Sure, he had just had a cervical surgery. So he had the laminoplasty, and remember he did have a neck injury at that point where he was doing, where he had just had the laminoplasty.

And so he's seen two weeks postoperatively after neck surgery, which it's not uncommon to have, just for a stability standpoint, the patient using a walker.

Q. All right. And you likewise think that his wide, unsteady gait would be attributable to his spinal surgery?

A. I would attribute it to his immediacy of his postoperative care of his neck surgery. But again, I would opine that his lower extremity exam was normal.

Q. All right. Will you be offering opinions in this case, Dr. Husted, about the functional impact of Mr. Dishop's neurological deficits?

A. Functionally it affects his ability to ambulate. And to, I mean, obviously he had a preoperative history of stenosis. And to further elucidate, the wide-based gait that does go with spinal stenosis.

But then his gait obviously has greatly worsened, because now the bilateral leg weakness, which was not present preoperatively.

Q. Are you aware from reading the materials that you reviewed that as early as 1993 Mr. Dishop, then Bishop, was found to be 100 percent permanently disabled as a result of his spinal condition?

MR. KUVIN: Objection to form.

THE WITNESS: I saw that in the depositions.

BY MR. JOPLING:

Q. Does that affect your opinion, in any way, as to how he's functionally impacted, if at all, by any sequelae of his surgery in February of 2010?

A. Yes, it was taken into consideration with my opinion. And he still has worsened function because of his weakness.

Q. Okay. So even though he was 100 percent disabled before, he is more disabled now?

MR. KUVIN: Objection to form.

THE WITNESS: Correct.

BY MR. JOPLING:

Q. Let me go back, just briefly before we get to your opinions, about the initial contact you had with this case in January of 2014.

You told me that you were asked to review records, correct?

A. Correct.

Q. Who was that initial contact by? Who made that contact with you?

A. I believe it was with Mr. Kuvin.

Q. Did Mr. Kuvin tell you anything at all about the case then?

A. Generally they say I have a case. They make sure it actually fits within the context of what I do. And the general question is also if I know the defendant, to make sure I have no problems with reviewing the case.

Q. So that we are clear, you have answered my question by telling me what generally happens; do you have a recollection that's what happened in this case?

A. I don't. But that's typically all there is.

Q. In addition to the materials that you have told us you reviewed, have you done any sort of medical literature search, any kind of research on your own beyond review of just the materials that have been

provided to you?

A. No.

Q. Do you intend to do so?

A. Not typically.

Q. All right. You have formed some opinions regarding the standard of care as applicable to Dr. Ronzo; is that correct?

A. Correct.

Q. We have been provided, as I'm sure you're aware, with some answers to expert witness interrogatories. And let me, I want to give you every opportunity to tell me fully every opinion you have in this case, but I also know the parameters we are working with.

Let me do it this way. Am I correct in my understanding, Dr. Husted, you have no standard of care criticism of Dr. Ronzo in terms of his election to perform this procedure on this patient?

A. I don't. I don't feel, from what I've seen, that the actual procedure itself fell below the standard of care.

Q. So we are clear about that, that means it was within the standard of care to elect to do this procedure on Mr. Dishop?

A. Yes, he had pathology in his low back consistent with that.

Q. And the performance of the procedure itself was technically within the standard of care?

A. As far as I can tell, yes.

Q. How about the decision to discharge Mr. Dishop when he was discharged, was that within the standard of care?

MR. KUVIN: Objection to form.

THE WITNESS: It is again, based off all the records I could review. To speak frankly, patients having urinary hesitancy postoperatively is not completely uncommon. It happens with a male who has undergone surgery and been under anesthesia.

BY MR. JOPLING:

Q. It's not completely uncommon or even at all uncommon, is it?

A. It's not uncommon.

Q. Right.

A. So it also depends on the degree of difficulty in voiding. Obviously a patient who can't void is a clear cut, should not be discharged.

A patient who has hesitancy, it becomes a little bit more gray, because then: Can he void? Is he voiding completely? How much post void residual is there?

So there are questions that arise when one just says simply "urinary hesitancy." But it's common.

Q. And you, of course, saw Mr. Dishop's IO's in the hospital record?

A. Yes.

Q. And certainly, you can tell from that it certainly was not the case that he was not voiding at all?

A. Right, he is voiding. And as far as I can tell I wasn't criticizing his initial discharge.

Q. Okay. Do you have any standard of care criticisms of Dr. Ronzo's response once Mr. Dishop presented himself to the emergency room on February 4th?

A. No, ultimately he responded. And the key word I would say is ultimately, he responded in the manner that he should.

Q. Okay. We'll obviously explore the ramifications of that in a little more depth in a moment.

A. Yes.

Q. Where I was going specifically with that, you don't have any criticism of Dr. Ronzo's timing of showing up in the emergency room once the patient is there?

A. Right.

Q. You don't have any criticism, from a standard of

care point of view, of how Dr. Ronzo responded to his patient once he saw them in the emergency room on the evening of February 4, 2010?

A. No, he did what he was required and should have done.

Q. Okay. Now, do I understand correctly from the answers to interrogatories that I have received that your single standard of care criticism of Dr. Ronzo is his failure to have a 24-hour a day answering service?

MR. KUVIN: Form.

THE WITNESS: Yeah, I felt it was below the standard to not be available after hours. That was my concern.

And I'm not aware of any surgeon, particularly a spine surgeon, and the degree of possible deficit in a patient's life that doesn't have a means of being contacted after hours.

BY MR. JOPLING:

Q. You read Dr. Ronzo's deposition?

A. I did.

Q. In it's entirety?

A. I did. I'd like to have it in front of me again, if you are going to ask me particular questions about it. Again, there are lots of records here.

Q. Sure. Of course. You saw that Dr. Ronzo

testified that the way his office operated was that if his spinal surgery patients called after office hours, they were instructed to go to the emergency room; is that correct?

A. I see that response, yes.

Q. Okay. You think that's inappropriate?

A. I do, and I'll elucidate.

Q. Okay.

A. The problem that this case had for the eventual deficit the patient suffered, was that we are dealing with patients and not all patients are medically savvy. So we are dealing with patients that really were in the hands because they had no other options, in my opinion, in the hands of the home health agency.

So they were not medically savvy, and they were listening to what, to them, was the only medical practitioner they were discussing things with, and that was a nurse, and the secretary, as far as I can tell, of Dr. Ronzo's office.

And to cut to the chase here, they were being told that this was likely a medication and that this could be dealt with by a straight cath. The concern I have is that no one actually was diving beneath the surface for what it could be because a doctor such as

Dr. Ronzo, or me, we spine surgeons would take the inability to void or overflow incontinence much more seriously than that in the context of what the patient just underwent.

So I look at the records, I read the series of missed cues because that's how I see it, a series of missed cues, and I feel that you have a medically unsavvy patient who is somewhat stoic, from what I can tell; a patient's wife, who all she knows is that she was straight cath'd once and that helped the symptoms; and a nurse who says, yeah, this is probably just medication; and a secretary who says, yeah, this is probably just medication.

And the patient and his wife didn't know any better, so they thought they were okay, and all they wanted to do was get him to be able to pee. But there was nowhere in there that someone such as Nurse Rosengrant in the middle of the night, how is she, or in the evenings or after office hours, how is she going to be able to contact the physician?

In every practice I know of we get called all the time from home health or from a patient's family or from the patient themselves asking simple questions. And I feel that if that call had made it to Dr. Ronzo, he would have made the call to go to the

E.R. and he would have explained why, because a blanket statement of go to the E.R. doesn't resonate with the patient unless you say go to the E.R. because if you don't go to the E.R. you are going to have a spinal cord deficit or nerve deficit or weakness, and this is why I'm worried, and you need to go to the E.R.

So it was a failure to communicate, and it was preventable.

MR. REICHERT: Excuse me, I need to put a motion to strike on there, the nonresponsive portion of that answer.

THE WITNESS: I apologize. Was it nonresponsive? I thought I was just cutting to the chase, so I do apologize.

BY MR. JOPLING:

Q. Let me explore that with you a little further.

A. Sure.

Q. First of all, you gleaned from somewhere in the materials you reviewed that Nurse Rosengrant did not consider Mr. Dishop's complaints of urinary difficulty voiding, that she didn't consider that to be a serious problem?

A. From what I gleaned from the records, her notations, and then the deposition, what they seem to

be attributing it to was likely a response to Flexeril. And the seriousness was simply that the patient couldn't void.

And what was baffling to me, and I hope I'm answering your question and not being nonresponsive, the baffling thing to me is that even when the patient was straight cath'd for a large amount, there still wasn't concerns about bladder injury and other things.

So I felt like there was actually a naivety of medical knowledge, or at least it wasn't alarming them the way it should alarm them.

Q. You read all of Nurse Rosengrant's deposition, right?

A. I'd like to see it again, and yes, I did.

Q. You are welcome to do that. I'm not going to ask you for page and line because I don't know I could do that, but you saw in her deposition, did you not, that she instructed Mr. and Mrs. Dishop on several occasions that they should go to the emergency room; did you see that?

A. Yes. Let me find that, please.

Q. Sure.

A. Yes, I see on page 12. Actually it is page 42.

Q. I don't have the transcript with me.

A. Would you mind if I read it?
Q. Please.
A. Okay. "So I called Mrs. Dishop, Bishop, back and let her know that Kitty had said to go to the E.R. She wanted to wait until Dr. Ronzo arrived at his office to see if he would give the order first." And this is in reference to straight cathing.
"And so we waited a while, and then I called Dr. Ronzo's office again, spoke to Kitty again. They had arrived and I got the order to go out to see the patient to do a straight cath on him."
So again my answer would be it is a mixed message.
Q. When is that conversation taking place?
A. That was the daytime after he was unable to void, with only a little bit during the whole night. And so Mrs. Dishop had called during the daytime, I believe on the Wednesday, I could be wrong, but it's on the Wednesday to Nurse Rosengrant.
Q. Did you see in there, Dr. Husted, that the night before however, Nurse Rosengrant had specifically recommended to this family they get themselves to the emergency room?
MR. KUVIN: Objection to form.
THE WITNESS: Sure, I'll even go farther back

here.

The question: "Okay, do you recall getting a call this particular morning to go out to Ms. Dishop's house? Yes."

I'll keep reading.

"Tell me about that. What do you remember?

I was on call the night before and I got calls all throughout the night from Mr. Dishop's wife. And then this was the morning of she called again, calling again, stating he was still unable to void."

Now I'll skip forward because I already read part of it.

"Okay," is the question. "And you said that Mrs. Bishop called you in the evening. How many times did you recall her calling?"

The answer: "Quite a few times. I think three, I think three times during the evening. And what was she explaining was the problem? Was it just a urinary issue? Yes. Or were there other problems?

All she was says was he having was urinary issues."

So the answer to your question is that she does say she had said at some point, well, you

should go to the E.R., but if you read throughout the deposition from what, obviously I wasn't there, but from what I read from the deposition and what I read from the notes was it was a mixed message.

Well, I guess you can go to the E.R. because they can straight cath you -- again, this is my impression -- but maybe I can just get the order from Kitty at Dr. Ronzo's office to straight cath.

And I have a concern about that, because Kitty on one hand says go to the E.R. On the other hand says, oh, Dr. Ronzo said yeah, you can straight cath.

Now, if you are looking at those facts there, basically one can infer, especially if you're a medically naive patient, Kitty wanted you to go to the E.R. so you can get straight cath'd. But oh, Dr. Ronzo just came in, oh, we can do the straight cath at your house.

Now, what is concerning to me is why did Dr. Ronzo not say, wait a minute, why does the patient need to be straight cath'd. Wait a minute, oh, the patient was unable to void all night long? And then put two and two together,

that there might be a postoperative hematoma, that's what would ring that bell for me.

So I have major reservations that not only is he not available, his office says he was contacted day of, and still said, yeah, go straight cath.

BY MR. JOPLING:

Q. Let me ask you in that regard: Are you prepared to tell a jury in this case, Dr. Husted, that a patient with Mr. Dishop's history as of eight o'clock on the morning of February 4th, that is of urinary retention without any complaints of leg weakness, numbness, or lower extremity problems, that urinary retention alone in that patient required that he be seen in the emergency room?

A. I disagree with that statement. He was having complaints of leg numbness and weakness. So what I'm saying --

Q. When?

A. Not only was he having issues when he was discharged, it was progressive through that portion.

Q. Where do you get that from?

A. Again, through all the depositions.

Q. All the depositions?

A. Yeah, when you read the deposition of the

wife, of the husband, when you read the deposition of the -- Nurse Rosengrant, what you see is a global picture. How I see it as an expert is a global picture of a slowly worsening exam.

Q. Let's take this one at a time, if we may.

Can you tell me where in Nurse Rosengrant's deposition you find she noted any problem with lower extremity weakness or pain in the evening of, any time before Mr. Dishop appeared in the emergency room?

A. Well, it would be firstly on her initial evaluation of him, which was a piss-poor, excuse my language, piss-poor evaluation.

She references that a patient has weakness in his legs, does not do a good exam. And then states that this is his baseline from discharge.

Now, I feel as any medical practitioner, a nurse or doctor, if you are going to state weakness, you need to actually do an exam and say what is weak, because for her to say this was his baseline is poor care.

How does she know that's his baseline from when he was discharged? So then we already have in the records that a patient has some weakness postoperatively, now we also start having worsening ability to void.

The worst case scenario is that he has a worsening hematoma. Whenever these symptoms are found in context together, and they are in the records, it's there, black and white, I am just baffled no one actually said, maybe he has a hematoma, and actually did something about it.

Q. Is some degree of leg weakness a common and expected symptom following this sort of surgery?

A. Sure.

Q. Okay. So let me go back to my question a moment ago, that I think I must not have been clear on, Doctor.

A. Okay.

Q. And let me try it again and see if you can answer the question as I ask it.

A. Okay.

Q. My question to you is: Can you point out to me where in either the medical record or in Nurse Rosengrant's testimony you find some evidence that she noted a worsening problem with lower extremity pain in Mr. Dishop during the period of her care of him at home?

A. Yes, I'll actually find that, if I can see the timeline too, please.

MR. REICHERT: While you're looking I need to put a motion to strike from the previous question. Motion to strike nonresponsive

testimony.

Can you clarify what timeline he is looking at?

MR. KUVIN: It's just chronology. I can provide you a copy, if you want.

MR. REICHERT: Yes, I would like a copy of that.

THE WITNESS: With extensive records a chronology is helpful.

MR. REICHERT: I have one myself here.

THE WITNESS: So on 2/3 in her start date evaluation, this is the nurse, she notes that there is urinary hesitancy, but he is voiding. And the patient has lower extremity weakness, on 2/3.

MR. REICHERT: Before anymore answer is given, can you just read back the question for me?

(A portion of the record was read by the reporter.)

MR. REICHERT: Thank you.

MR. KUVIN: Counsel, you're looking for just post or after 2/3?

MR. JOPLING: I'm looking for any time from after the patient was discharged on 2/2 through

the time of his return on 2/4.

MR. KUVIN: Gotcha. Here is her initial eval, which is 20 pages out, which has her summary and then the 2/3 note.

THE WITNESS: So, on the initial evaluation on 2/3/2010, I will read the nurse's handwritten words.

BY MR. JOPLING:

Q. Right.

A. "Patient assess complete. Patient with lower extremity weakness. Patient states has not changed from status before leaving hospital. Patient having urinary hesitancy, but voiding."

Q. Okay.

A. So to answer your question specifically --

Q. Yes.

A. -- we are trained to look for signs for the worst possible consequences, and to look for subtle signs sometimes. And you're right, urinary hesitancy, even inability to void can happen postoperatively. But in the context of the patient with also concomitant weakness, it is a concern.

MR. REICHERT: Let me move to strike, nonresponsive.

MR. JOPLING: Join that.

BY MR. JOPLING:

Q. And actually, respectfully, Doctor, my question didn't have anything to do with what you're trained to look for.

My question was, and let's take that assessment you just read to me. Do you see anything in that assessment that suggests at the time this nurse is assessing Mr. Dishop that his lower extremity weakness has worsened since the time of his discharge?

A. No, specifically the patient says it's the same. That's all I have to go on.

Q. Okay. Do you find anything else in the language of Nurse Rosengrant in her deposition, or anywhere else in the records that she created regarding her care, that documents a worsening problem with leg lower extremity weakness during the period of Nurse Rosengrant's care?

A. I will review her deposition now.

Q. Okay.

A. Yes, I do.

Q. Where would that be?

A. On the nurse's handwritten notes, February 4, 2010. Details related to emergent care and/or hospitalization/nursing home.

Q. Does that look like this?

A. Yes.

MR. REICHERT: Does it have a little number at the bottom? The Bate stamps you put on it.

MR. KUVIN: No.

THE WITNESS: Care summary including Oasis Element 4, that is February 4, 2010.

MR. REICHERT: Got it.

THE WITNESS: Care summary with Oasis Elements 4. Oh, that's for the admission.

BY MR. JOPLING:

Q. Is that what you're looking at?

A. Yes. Bear with me, I'm still looking.

Actually I was stating something that was somebody else's written notes, so I don't want to confuse the response.

Q. Sure.

A. Can I see the deposition?

MR. KUVIN: Uh-huh, that's what I'm looking for. So here is the call for that morning, starting here.

BY MR. JOPLING:

Q. By the way, just so we can cover these one at a time, Dr. Husted, the second note that we are looking at, nursing note that is a nursing assessment, says: Skilled intervention/teaching?

A. Yes.

Q. And it's dated lower corner 2/4/10 and signed by Gena Rosengrant?
A. Yes.
Q. And visited at 9:30?
A. Yes.
Q. And then I guess that's visit complete at 10:30?
A. Yes.
Q. In that note Nurse Rosengrant does not document any worsening problem with lower extremity weakness, does she?
A. Correct.
Q. Okay. Sorry to interrupt, you were looking elsewhere.
A. Sure.
MR. KUVIN: Starts here.
THE WITNESS: I'm currently reading in her deposition.
MR. REICHERT: Page number?
THE WITNESS: Starts on page number 41 and I'm reading through, and you're correct in saying that in her deposition she testifies to that she wasn't told about any numbness in the legs or paresthesia in any way. She was not told about any numbness or tingling in the feet.
So if I was having the question specifically

stated to me: Was Ms. Rosengrant told, per her testimony, about worsening weakness or numbness?

Not according to her testimony.

BY MR. JOPLING:

Q. All right. So that's sort of where I was going with this. It's your opinion that, it's your opinion that Mr. Dishop was suffering worsening lower extremity weakness during this period of time?

A. Yes.

Q. And that opinion is based upon Mr. Dishop's testimony and that of his wife?

A. Yes.

Q. And why is it that you assume that they're being accurate in their testimony and Nurse Rosengrant is not?

A. Because the facts are that he was ultimately found to not be able to ambulate. And that I see such a lack in the records on the part of the home health nurse of a depth of understanding of what the concern can be.

And to even further state, she states the patient has lower extremity weakness. If you asked her any particular questions about lower extremity weakness, her answers would be none. She has no idea what his lower extremity weakness is.

So how can we go off of the records of a

nurse that doesn't even bother to examine the patient and can't give any details of the lower extremity weakness?

MR. REICHERT: Move to strike the nonresponsive answer.

BY MR. JOPLING:

Q. Let me back up and ask you a little more broadly.

In your own practice, Dr. Husted, do you send patients home with home health nurses postoperatively after this kind of surgery?

A. Absolutely, I do.

Q. And why do you do that?

A. I want them to be able to alert me if there's a wound problem or a weakness problem or a voiding problem.

Q. Right. That practice in general, I assume you would agree is within the standard of care to have such home health provided?

A. Absolutely.

Q. All right. And when you are employing that in your practice, do you rely upon the accuracy of what the nurses report to you?

A. Certainly.

Q. And do you rely upon them to report to you

findings that would be of concern to you about possible postoperative complications?

A. Absolutely.

Q. So would Dr. Ronzo have been acting appropriately to assume that if Nurse Rosengrant, or whoever is assigned to this patient sees trouble, some issues suggestive of postoperative complications, she will report those to him?

A. Yes. Can I further?

Q. Absolutely.

A. But I feel that the two weren't really talking, that's my concern. And I agree with you, absolutely, she is his soldier on the ground. She's there stating the facts.

But as far as I can it is through Kitty, who is a nonmedical practitioner, and I don't play the telephone game. The telephone game being you say one thing to one person and it changes a little bit along the course.

I like to talk to the home health nurse directly if they're calling to ask for an order. I'm concerned in this case that Dr. Ronzo, you're right, was not necessarily clearly told all the facts, if that's what your question was.

But I'm also concerned that he gave an order

so he knew there was postoperative urinary retention, but it doesn't seem that he asked any further questions.

MR. REICHERT: Same motion to strike.

BY MR. JOPLING:

Q. And Dr. Husted, to sort of expound on Mr. Reichert's objection, and I made the same, you said several times during the course of your deposition, and we all understand and can appreciate the perspective, you have made comments about what you would do, or what troubles you, or what is baffling to you.

And while we respect those opinions, I'm sure that you understand, having testified as an expert before, that the issue in these cases is not going to be what Daniel Husted would have done or what baffles --

A. It's the medical standard.

Q. It's what the standard of care requires.

A. Okay, I'll start using the standard of care.

Q. I'm not belaboring that or castigating you for that but I do need to know --

A. It's below the standard of care. I feel that not having to be specific, not having a means of contacting him after hours is below the standard of care.

I feel that ordering a straight cath on a

patient, without knowing any further details, that just had a decompression, is below the standard of care without finding out more details.

I believe that Ms. Rosengrant also rendered care below the standard of care.

Q. My question was going to be if you assume that Dr. Ronzo is informed that Nurse Rosengrant, with whom he's worked before on these patients; do you see that Doctor, that Nurse Rosengrant was experienced in this field? Do you not? Did you find that?

A. I, I'm, I guess she's been in this field for a while, it doesn't mean she has great experience. It's not evident.

Q. Did you find any reason anywhere in this record to make you say Dr. Ronzo knew or should have known that Nurse Rosengrant wasn't competent to make this assessment?

Did you find anything in there that would lead you to that conclusion?

A. At the time he probably was unaware that she was incompetent.

MR. REICHERT: Object to the form, move to strike.

BY MR. JOPLING:

Q. I think we have covered this, but to make sure

you told me, I believe that it's your opinion that Dr. Ronzo was within the standard of care in relying upon information provided to him by Nurse Rosengrant during this time period of February 3, 4?

A. Certainly he relies on, but he should also ask questions.

Q. I understand. My very specific question to you is this: If Dr. Ronzo is advised by Nurse Rosengrant that the patient has difficulty voiding, but does not have worsening signs of lower extremity weakness, it is your opinion and you would tell a jury that Dr. Ronzo would breach the standard of cared by simply ordering a straight cath without further investigation?

A. Yes.

Q. Okay. If Dr. Ronzo had had a call system where he could be reached directly at midnight the night before, you would have expected him to have been told by Nurse Rosengrant directly of what was going on with this patient at that time?

A. Actually I would have expected that the patient himself would have been able to get a hold of the Doctor, that's how it should be.

Q. And knowing what you know about it, you would have expected Dr. Ronzo to then tell the patient: You need to go to the emergency room?

A. I would have.

Q. All right. You expected that the resulting communication, if Dr. Ronzo had had a system whereby he could be reached directly by the patient, would be the exact same instructions to this patient as the patient received from Nurse Rosengrant, but from a different source, correct?

MR. KUVIN: Objection to form.

BY MR. JOPLING:

Q. Correct?

A. It would be, but with a more clarity of why. Because, again, my opinion from reading these records, is that the reason they were being referenced to go to the E.R. was to deal with the superficial problem of his inability to void.

In other words, go get a straight cath in the E.R., they can take care of you there. I can't get anyone there overnight to do a straight cath.

It wasn't why they should go to the E.R. as in you might have resulting neurologic deficit. I strongly believe if Dr. Ronzo had talked to the patient he would have said, as any spine practitioner should say, and the standard should be and is, you have lower extremity weakness, you have difficulty voiding, you need to go to the E.R., you might have a

hematoma, you might need surgery because you might ultimately have urologic and neurologic deficit. And that wasn't explained.

MR. KUVIN: Counsel, so I'm clear, you're asking him to look at Rosengrant's depo in a vacuum and ignore the plaintiff's and his wife's depo for the purpose of your questions, or do you want those included?

MR. JOPLING: I hear you and I'll try to address that in future questions, if I need to.

BY MR. JOPLING:

Q. Dr. Husted, you said several times, the sort of overall inference you have drawn from the totality of what you have read, including Mr. and Mrs. Bishop's testimony, is somehow the message being conveyed to them is the reason Nurse Rosengrant was telling them to go to the emergency room was to deal with the urinary problem; that's been your overall impression?

A. Correct.

Q. But you would agree with me though, Ms. Rosengrant didn't say that's why she told them to go to the emergency room?

A. I would agree that she didn't say any other reasons other than that. She's being told they're having difficult voiding. She's saying you need to go

to the E.R. She's not saying go to the E.R. because you might have an underlying impending neurologic deficit. She's saying go to the E.R. so you can get straight cath'd, and/or we can get you a straight cath order from Kitty. Which is what ultimately happened.

Q. Really? She says somewhere in her deposition that she told them you need to go to the emergency room to get a straight cath?

A. Let me answer that with a simple statement then.

Q. Okay.

A. If it was you need to go to E.R. because you might have a spinal cord deficit, why did the order of a straight cath mean he didn't have to go to the E.R. after all?

So if your inference was she was saying you have an impending doom here, then why did that impending doom magically disappear once the order from Kitty for the straight cath occurred?

Q. I know you have done this enough, Dr. Husted, to know, however unfair it may be, I get to do the questioning, you get to do the answering.

A. I'm sorry, I was saying logic infers.

Q. I know that you believe that.

My question to you, however, was: Do you find

anywhere in Nurse Rosengrant's deposition where she indicates that she told these folks they need to go to the emergency room only because of the problem of urinary retention?

Do you find she said that?

A. No, if we are just looking at her deposition, no.

Q. Do you, in fact, find in her deposition where she expresses in the deposition that she had concerns about the patient's overall status, beyond just urinary retention?

A. I'd have to look to answer that question.

MR. KUVIN: You just want him to look at Rosengrant's?

MR. JOPLING: I do.

THE WITNESS: Could you clarify what you mean by that question, sir?

BY MR. JOPLING:

Q. Yes. Do you find in Nurse Rosengrant's deposition the idea, expressed by her, that one of the reasons she was telling them they need to go to the emergency room was not just limited to a urinary problem, but his overall condition?

A. You would have to reference that specifically, because from everything I see here it is

in regard to his urinary problem.

Q. But you don't find anyplace in there where she says to them: Go to the emergency room to get a straight cath or go to the emergency room to deal with your urinary problem?

A. No. I see that she did say she had told them to go to the E.R., but it doesn't specify why.

Q. And your premise is that -- strike that, I'll try it again.

You find some discrepancy between what the Dishops describe happened that evening and what Nurse Rosengrant described?

A. I do. If what you're specifically asking, yes, I see kind of a different slant in the deposition for the plaintiff and his wife.

Q. Did you find Mr. and Mrs. Dishop's testimony about the events of that previous evening, that evening of February 3rd, 4, did you find them consistent with each other?

A. I'd have to reference that again. I agree that if my memory is that the wife had problems in terms of times, determining what was happening the night and the day, if there was somewhat of a timeline issue, the overall slant of what they were saying is that he was weak and that he couldn't void. But the

timeline can be somewhat, there can be discrepancies because I think it was a back and forth -- was this the daytime, was it the night before, and I think there was confusion in that regard.

Q. Okay. Your opinions overall in this case are premised on the notion that the plaintiffs, if they had been told to go to the emergency room by Dr. Ronzo, would have done so?

A. Yes.

Q. Although you acknowledge that they were told by Nurse Rosengrant and did not do so.

A. Correct.

Q. I ask it that way to say this: Do you have some doubt based on reading the Dishop's deposition that maybe they weren't even told to go to the emergency room?

A. No, I will believe that Ms. Rosengrant did tell them to go to the E.R.

Q. Although they deny that, don't they?

A. They do. But I believe she probably did because it's even their policy, regardless of whatever, to go to the E.R.

I agree with the premise everybody states if you have any issue, whatsoever, you go to the E.R.

Q. All right.

A. My problem with all of that is you're dealing

with very medically dumb patients, who didn't realize what the consequence could be, and didn't have it actually stated to them.

Q. Help me understand your opinion. If you read Mrs. Bishop's and Mr. Dishop's depositions, and you find them saying or denying they were told to go to the emergency room, which is what you find, correct?

MR. KUVIN: Are you saying both Mr. and Mrs.?

THE WITNESS: I'd have to look through because I don't want to say they both said no, that they were never told that.

MR. KUVIN: Here is Mister.

THE WITNESS: Okay. So Mister says -- can I quote?

BY MR. JOPLING:

Q. Sure.

A. The question is: "And so, just so we cover this thoroughly, your testimony here today is that the home health nurse never suggested to you that you ought to go to the emergency room?"

The answer: "If she did I would have went." That was Mr. Dishop's response. So I understand that he is saying that he was not told to go to the E.R. And I am going to read now Mrs. Bishop.

Q. You are welcome to do that, but let's stop with

Mr. Dishop for a second, he is the patient.

A. Right.

Q. Mr. Dishop says, I don't remember, but if I had been told by the nurse to go to the emergency room, I would have gone, or would have went, correct?

A. Right, that's what he is saying.

Q. All right. Yet, you are assuming that he was told to go by the nurse, he still didn't go, but he would have gone if told by the doctor?

MR. KUVIN: Objection to form.

BY MR. JOPLING:

Q. Is that right?

A. The records are showing that the nurse said she told him. He says, I would have gone if I was told, and particularly if a doctor says go, you go. Quote, unquote.

And obviously it is a he said, she said. He said she never told him. She said she did tell him. And my opinion is if the doctor had explained to him why he needed to go, he would have gone.

Q. Help me understand what you base that on. If the patient says, if the patient didn't go when the nurse told him, although the patient says I would have gone if the nurse had told me.

A. Correct.

Q. Tell me on what basis you conclude that the patient would have gone if the doctor told him.

MR. KUVIN: Objection to form.

THE WITNESS: Firstly, we have to conclude this is the premise that the patient is lying and was told to go to the E.R. but chose not to go to the E.R.

BY MR. JOPLING:

Q. I thought that was what your perception was.

A. Again, this is an assumption, because obviously now we have two parties saying absolutely different from the one party is saying he was never told, the other party is saying he was told.

Now you're asking me to speculate. If I'm speculating that Mr. Dishop is indeed lying, again, that's a speculative statement, then it would make it harder for Mr. Dishop to be able to say, well, if I had gone, if I had been told by the doctor to go.

What I'm saying is that I believe that Mr. Dishop would have gone if the doctor had explained to him that he should go, and why he should go.

And I also can't tell you with any degree of certainty who is telling the truth though.

Q. You don't know Dr. Ronzo?

A. I don't.

Q. You don't know Mr. Dishop?
A. No, I don't.
Q. You never met Mr. Dishop?
A. No.
Q. Do you have patients who sometimes decline to follow your medical advice?
A. Absolutely.
MR. KUVIN: Form.
BY MR. JOPLING:
Q. Do you have patients where you have said: Go to the emergency room, and they say: I would rather wait?
A. Certainly.
Q. Tell me then what is the factual basis of your opinion, Dr. Husted, that Mr. Dishop would have done something different if addressed by Dr. Ronzo?
MR. KUVIN: Form, asked and answered.
THE WITNESS: Because, again, the patients that will decline to follow my medical advice when it's something that is significant, impending doom, that's usually if I haven't explained to them what that significant, impeding doom would be.
So, in other words, if a nurse says that, and this is time and time again, then I actually get on the phone and explain to the patient why I

feel they should go. And then they go.

So I haven't had that actually happen, to my knowledge, of where I have a significant concern for a significant impending deficit that a patient has declined to follow my advice when I explain that. I'm sure that exists somewhere.

BY MR. JOPLING:

Q. I was going to say, you are really prepared to tell a jury --

A. I'm sure it exists somewhere.

Q. You are prepared to tell a jury in this case that any time a patient fails to follow a doctor's advice, it can only be because the doctor hasn't explained himself well enough?

MR. KUVIN: Objection to form.

THE WITNESS: No. I'm prepared to tell the jury that you have a much higher percentage of likelihood of the patient following the advice of a medical practitioner if it was given by a doctor with a good explanation of what the consequences might be.

The odds are greatly increased that the patient is going to at least follow that. If your blanket statement is go to the E.R. and you don't give an explanation of why to go to the

E.R., most patients are going to sit there and say, I don't want to go to the E.R., it is a long wait, six hours.

And particularly in this case, to be specific here, if it's all about you need to have your bladder decompressed, you need to have a Foley put in, you are having urinary retention. The patient might say, well, I'm not going to go to the E.R. for six hours to have a Foley put in if Kitty might order it in the morning, which is what happened.

MR. KUVIN: If we can, so we are not misrepresenting any testimony, I want to show him Mrs. Bishop's testimony.

MR. JOPLING: If you don't mind, I'd respectfully ask that you save that for redirect, or for cross if you need to, for the sake of time, because right now my questions are related to Mr. Dishop.

MR. KUVIN: Fine.

BY MR. JOPLING:

Q. Dr. Husted, again we were talking logic earlier, when you say the chances are better. Well, if chances of something occurring go from 1 percent to 20 percent, that's a huge increase in the chances of it occurring,

correct?

A. Correct.

Q. But it's still less than 50 percent, correct?

A. Sure.

Q. We are talking hypothetically.

A. Right.

Q. Help me understand, if you can, again, what is the factual basis of you being able to say that you can predict that in an interaction between Dr. Ronzo and Mr. Dishop that a sufficient explanation by Dr. Ronzo let's you tell a jury there is a more than 50 percent likelihood that Mr. Dishop would have responded by going to the emergency room?

MR. KUVIN: Objection to form, asked and answered.

THE WITNESS: Okay. The facts, as I've been explained, are that the patient was never explained why by the nurse he should go to the E.R., other than to get a straight cath.

That Dr. Ronzo had no way of knowing what the problems were, including weakness. That if the patient and his wife had talked to him, he would have been very alarmed. And I would be surprised if he wouldn't have been alarmed by the context of weakness and urinary retention.

And I really do believe that the likelihood would have been greater than 50 percent that they would have gone. And it's the testimony of the patient and the testimony of his wife that they would have gone if the doctor had said so.

BY MR. JOPLING:

Q. What time do you understand the order permitting a straight cath was given?

A. In the morning at 8:00 a.m. on February 4th.

Q. All right. If Dr. Ronzo had at that time, at 8:00 a.m., at the time he first learns of this problem with urinary retention, if he orders, if he tells the patient then: You know, I'm concerned there may be a problem here that's more serious than we thought. You need to go to the emergency room now.

If he had that conversation with Mr. Dishop at 8:00 a.m., would he be in full compliance with the standard of care in this case, as far as you're concerned?

A. Yes. Actually the surgery, if I'm understanding, happened that evening, correct?

Q. No, I'll straighten it up. Surgery is on February 1st.

A. No, the subsequent surgery.

Q. Yes.

A. The hematoma evacuation happened the evening of February 4th.

Q. Correct.

A. So if he had the discussion at 8:00 a.m. with the patient and performed the hematoma evacuation, it would have been the same day as what he ultimately did; am I saying that correct?

Q. Yes.

A. So he would have been within the standard of care because if he is aware on the morning of February 4th and he is operating within that day, then absolutely.

My concern is really that he should have been aware the evening before.

Q. Okay, that's what I'm trying to understand.

A. I think there was a greater than 24-hour delay.

Q. Okay. My question is this: Let's assume for the moment that he doesn't have the ability to be contacted directly himself during the night hours, but that at 8:00 a.m. the next morning he gets word about the urinary retention.

He gets on the phone with the patient then and says: I need you to come in and here is why. This can be serious. And the patient comes in at 8:00 a.m.

If that were the facts of this case, would you find Dr. Ronzo to have acted fully in compliance with the standard of care?

MR. KUVIN: Objection to form, incomplete hypothetical.

THE WITNESS: I now understand your question. No, because the ship sailed. He should have been aware the evening before.

So there is a delay because of the fact that he wasn't able to be made aware.

BY MR. JOPLING:

Q. I'm a wanna-be sailor. I'm very interested in the "ship sailed" concept.

By "ship sailed" are you prepared to tell a jury at eight o'clock in the morning it was too late to repair this problem?

A. No, I'm prepared to tell the jury, obviously, the outcome is better if you act sooner rather than later.

The literature is somewhat, I hate to use the word divided, but it's a little bit debatable on what the exact timeline should be and how soon you should act.

But the standard is to act within 24 hours.

Q. Within 24 hours of what? I'm sorry.

A. With any onset of the symptoms you should actually start the process of evaluating.

So this is a patient who, at a baseline, was found to have weakness, per the report, and urinary hesitancy. And over the course of the day and evening now becomes straight forward, can't void.

He should have been starting the process of working it up at that point. He should have been notified. He should have been into the E.R. that day/that evening. This would have been something they should have been dealing with overnight rather than the next evening.

Q. My question was somewhat different. Are you prepared to tell a jury, within a reasonable degree of medical probability, that if Mr. Dishop had shown up in the emergency room at midmorning on the 4th, instead of midafternoon on the 4th, that his outcome would have been different here?

A. Not if you are asking me the question, which I think the question is very misleading, midmorning versus midafternoon, no, there is not a difference.

I'm talking he should have been shown in the E.R. on the 3rd.

Q. I understand that.

A. But to answer your question, which I think

doesn't really state the facts as they should be stated, yes, there would be no difference or less of a difference if you are between the morning or the afternoon.

But to me it's just not a medically relevant question, it is a legal question.

Q. Okay.

A. It is a lawyer practicing medicine. Medicine states that he should have been in the E.R. as soon as possible.

There is a delay, and, yes, if he had been aware, if Dr. Ronzo had been aware the morning of the 4th, absolutely that he would have said, okay, come in.

The answer to your question is sure, there would only have been a seven hour difference. Seven hours is not what I'm talking about, I'm talking about a 24-hour delay.

Q. If I didn't ask the question clearly enough, I apologize. I'm trying to ask what I believe to be a purely medical question. It may not be one that is answerable medically.

A. Yeah.

Q. Well, there are some questions doctors can't answer, right? Even doctors --

A. No, and I apologize if I'm getting frustrated because I think you and I are doing a two-step dance.

Q. I think it is pretty straight forward, honestly, Dr. Husted.

I'm simply trying to find out, do you agree that if Mr. Dishop had come to the hospital at, say, 9:00 or 10:00 on the morning of February the 4th, instead of coming there, what, late afternoon I think he showed up; is that right?

A. Right.

Q. And Dr. Ronzo had immediately begun the process of setting up and doing the surgery he eventually did. I'm simply trying to find out are you going to tell the jury under those hypothetical facts that Mr. Dishop, more likely than not, would have avoided the neurological deficit he had --

MR. KUVIN: Objection to form, incomplete hypothetical.

THE WITNESS: Under those hypotheticals, no.

BY MR. JOPLING:

Q. And in fairness to you, because I understand your answer, you are willing to say that if Mr. Dishop had showed up, let's say, 8:00 or 9:00 p.m. the previous evening, and had showed up, and Dr. Ronzo had proceeded to this surgery, then the result would have been

differently; is that correct?

A. Correct.

Q. That's all I'm trying to make sure that I understand.

A. Thank you.

Q. Are you able to tell a jury at what point you think that line is crossed between 8:00 or 9:00 the evening of February 3rd and 9:00 or 10:00 the morning of February 4th?

A. Sure. Bear with me.

Q. Sure.

A. I'm looking at the actual timing of the ultimate surgery.

Q. It was 11:00 or 11:30 p.m., I think.

MR. KUVIN: That's what I'm looking for. It was very close to midnight. The call report is here.

THE WITNESS: It's unfortunate because it's dictated a month later. Do we have the actual?

MR. REICHERT: Do you have the perioperative nursing record there? Page 59 in my numbering system, or might be Bate stamped, I don't know.

THE WITNESS: That's the 5th, so that's after surgery.

MR. REICHERT: Here it is. (Handing)

BY MR. JOPLING:

Q. Anesthesia start time 0:19, operation start 0:43.

A. Yeah, patient in room 0:19. So it actually happened technically on the 5th, the surgery was February 5th.

Q. Right.

A. And thank you for providing this. And the start time, ultimately the procedure started at 12:43 a.m. on the 5th --

Q. Right.

A. -- of February. And the symptomatology was really worsening over the evening, the course of the after hours, and daytime of the 3rd.

And so between February 3rd and the morning of February 4th, over the course of that evening is when he should have gone to the E.R.

Q. And when you said just a moment ago the symptomatology was worsening during that time, that is based on what Mr. and Mrs. Dishop say?

A. Correct, but it's also based off of the deposition of the nurse, that she was getting multiple phone calls in that evening.

MR. REICHERT: Object to the form. I mean, move to strike, that was nonresponsive to the

question.

THE WITNESS: Sorry again.

BY MR. JOPLING:

Q. That last answer, Dr. Husted, assumes the patients are calling frequently because the condition is getting worse?

A. Correct.

Q. Have you ever had experience as a surgeon taking care of people in the hospital who called and had lots of complaints when they, actually their condition was not getting worse?

MR. KUVIN: Objection to form.

THE WITNESS: Correct, yes, I have.

BY MR. JOPLING:

Q. Regardless of the exact hour that the surgery started, the repair surgery if we can call it that, exploratory surgery started in the very wee hours of February 5th, it remains the case that you are not charging Dr. Ronzo with any breach of the standard of care in terms of the responsiveness once the patient shows up, correct?

A. Correct.

Q. You have read Dr. Ronzo's operative report from that surgery of February 4th/5th?

A. Yes.

MR. KUVIN: The surgery is here. (Indicates)

BY MR. JOPLING:

Q. I'll turn to that as well. You see the description in that operative note where Dr. Ronzo describes it as a small epidural hematoma firmly coagulated and found resting between the lamina of L-3 and L-4 at the laminotomy site?

A. Yes.

Q. By the way, is that a description of a -- I think we touched on this earlier -- a fairly common postoperative complication in these patients?

MR. KUVIN: Form.

THE WITNESS: Yes.

BY MR. JOPLING:

Q. All right. Can you explain to a jury how a hematoma of that size and in that position would have produced a neurological deficit in Mr. Dishop?

A. He documents it as being small, but if the canal itself is a narrow canal to begin with and there is a degree of pressure on the nerves, that can be enough to cause a deficit.

Not all hematomas have to be very large. Having said that, on the MRI it was a fairly sizeable hematoma. 3.9 centimeters, I believe was what was documented on the MRI.

Q. You read Dr. Ronzo's deposition, of course?
A. Yes, I did.
Q. And wasn't he questioned about his specific operative findings during this procedure?
A. He documented them in his op notes, sure, he dictated it.
Q. And this really isn't a rhetorical question, because it's been a while and I can't really remember: Did Dr. Ronzo explain in his deposition why he believed that this hematoma was not likely the cause of Mr. Dishop's neurological deficit?
A. You will have to excuse me while I review his deposition.
Q. I don't remember myself or I would direct you to it.
A. While we are looking through his, the size, which it was still a fairly sizeable hematoma, is such the corollary would be the size of herniations.

We can have significant nerve root deficit from a smaller herniation, and then I've seen the largest of herniations and patients are neuro-intact.

So I hesitate to correlate size with ultimate pathology because that's not really a great corollary.

Are we still looking through the deposition?

Q. You know what, don't bother. For the sake of

time we'll forego that.

Just explain to the jury, and I'm very close to finishing, Doctor --

A. That's okay, I'm enjoying this, I guess.

Q. How very perverse.

A. That was sarcasm.

Q. I thought I recognized it as such.

Explain to the jury, just briefly, Dr. Husted, how you believe this particular hematoma produced a neurological deficit in Mr. Dishop?

A. Because the hematoma resulted in nerve compression such that he had a neurological deficit.

Q. And you believe that neurological deficit involves what nerve distribution?

A. Well, it's in the canal itself. So again, it can affect the L-3, 4, 5 nerve roots, and below. So S-1, S-2, it can affect all nerve roots that are actually from the L 3-4 segment and below.

Q. I've forgotten my neurology 101, so I would have to have you educate me.

Would you typically expect to see, with that involvement at that level, problems with urinary or fecal incontinence?

A. You can have urinary or fecal incontinence, but again, remember it is the contents of the canal

and below. So at L 3-4 you have the sacral nerve roots.

Q. Right. Mr. Dishop has not suffered any sort of incontinence, has he, as a result of this?

A. He has not suffered any fecal incontinence. I don't believe he has any ultimately, I have to look through any ultimately urinary issues.

Q. Okay. Do you know, we touched on this earlier, but the manifestations of his neurological deficit are foot drop, and is that just on the left?

A. I'd have to go back to the Miami records; do we have the Miami records over there?

MR. KUVIN: From?

THE WITNESS: 2007. No, 2011, the last one. Shands. While we are waiting, in the E.R. obviously he has significant weakness in both ankles and both gastrocs. And then he had fairly sizeable deficits in his quadriceps bilaterally, too.

MR. KUVIN: I found the section in Ronzo's depo, if you want him to read it to himself while I'm looking for the other record.

MR. JOPLING: Sure.

MR. KUVIN: It starts here and goes to the next page on the causation issue.

THE WITNESS: Yeah, he basically references it was only a small blood clot that he saw. And he put a drain in just to prevent a bigger hematoma.

And when asked: Do you believe his neurological profile improved because he removed the blood clot. He said: You know, I don't know, I really don't know. I would hope so.

MR. KUVIN: Here is the 2011 record.

THE WITNESS: So the subsequent weakness in 2011 is left more than right. And the exam demonstrates a weakness of knee extension on the left with a flail ankle. So completely flail ankle on the left. A complete deficit on the left, with some weakness of right plantar flexion pushing down, and eversion at the ankle on the right.

BY MR. JOPLING:

Q. All right. And I'm sorry, the date of that examination you are looking at?

A. Is in 2011, February 23rd.

Q. That's done where?

A. At Shands, University of Florida Neurology.

MR. KUVIN: The Doctor referenced Miami before when we are talking about Gainesville,

just to be clear.

THE WITNESS: That's what I meant, sorry.

BY MR. JOPLING:

Q. You regularly confuse the University of Miami with the University of Florida, do you, Doctor?

A. That would be sacrilege.

Q. Just one second, Doctor, I'm very close to finishing.

Doctor, do you have any other standard of care opinions regarding Dr. Ronzo that we have not talked about?

A. No.

Q. So the standard of care opinions for Dr. Ronzo all relate to his failure to be in communication with the patient earlier than he was, and to direct the patient back to the emergency room?

A. Correct.

Q. And further, based on your assumption that had Dr. Ronzo communicated directly with the patient and explained the situation, the patient would have actually gone to the emergency room sooner than he did?

A. Correct.

MR. JOPLING: I think that's all I have.

MR. REICHERT: Do you need a break?

(Break in the proceedings)

CROSS EXAMINATION (Dr. Husted)

BY MR. REICHERT:

Q. All right, Doctor, when we were off the record I understand we have been talking -- strike that.

During your direct examination here today by Mr. Jopling you expressed some opinions about care rendered by Nurse Gena Rosengrant, correct?

A. Correct.

Q. Okay. Are you going to be testifying at trial that she breached the nursing standard of care in any way?

A. Yes.

Q. All right. Before I get to what those actual breaches are or breach, would you tell me what is your understanding of the nursing standard of care? Define it for the jury please.

A. That's a good question. I would, my understanding of what the standard of care is that the nurses should follow the orders that are given to them by the physicians. The home health orders that would be typical would be to evaluate the wound and do dressing changes and to follow the neurological status, at least that's what would be expected on a postoperative spine patient.

And then to report these or any concerning

findings or changes to the physician's office for further orders on how to actually interact or what to do as a consequence.

Q. Okay. In answer to my question you gave me a very specific answer based on the type of patient that we are dealing with in this case, correct?

A. Correct.

Q. All right. My question was more general than that.

A. Okay.

Q. Tell me what you understand a nursing standard of care to be.

A. Well then, I'm not sure that I understand what you mean by that then, because my general response would be to follow doctor's orders and to report any findings of concern to the doctors for further orders.

Q. Okay. And are there any other, you have defined standard of care in terms of practices by nurses, correct?

A. Correct.

Q. That you would expect?

A. Correct.

Q. Does that comprise what the standard of care is, in your opinion?

MR. KUVIN: Objection to form, asked and answered.

BY MR. REICHERT:

Q. Or is there anything else?

A. I've stated as best as I can what I consider to be the standard of care and how it would relate to this case particularly.

Q. All right. Where does the nursing standard of care come from?

A. I don't know.

Q. You know, when we start using terms like standard of care for physicians, which Mr. Jopling asked you about, you have a sense of that because you are a physician, correct?

A. Correct.

Q. Are you a nurse?

A. No, I'm not. No, I'm not.

Q. Have you been to nursing school and not completed it?

A. No, I have not.

Q. Have you ever taken any nursing continuing education credits?

A. No, I have not.

Q. Have you ever written any nursing policies at any of the facilities that you perform surgery at?

A. No, I have not.
Q. Do you belong to any nursing organizations?
A. No.
Q. I have your CV here, I don't see any nursing articles or nursing publications.
A. No, I have not.
Q. Have you submitted to any nursing publications for peer review any articles that didn't make it into publication?
A. No, I have not.
Q. Have you ever written anything on nursing?
A. No, I have not.
Q. And why do you think you are qualified then to comment on a nursing standard of care?
A. Because for thousands, many thousands of postoperative patients I have dictated and followed and completely formed how the nurses should follow those patients, both from my training and my experience.

And in every institution that I have worked at I have observed and interacted with, and seen how nurses treat postoperative spine patients with the concerns that they follow, the way that they follow out the orders, and the communications that they then have with the physicians.

This is something that I've been doing for, since residency, including residency and fellowship, we are talking 15 years.

Q. Have you ever taught nurses in a nursing school?

A. I have taught nurses on the floor. We constantly are doing updates of care and we are doing lectures on spinal pathology and care of spine patients.

We have formed an orthopedic center for excellence at the hospital that I work with and I have been a part of that. But as I stated, I have observed and interacted with, and been intimately involved with nurses and in the care of spine patients for the last 15 years.

Q. Are you familiar with what they're taught in school in the courses that they take?

MR. KUVIN: Objection to form.

THE WITNESS: I must admit, I don't look at their course literature, so I don't know.

BY MR. REICHERT:

Q. Now, for a little bit of time you were asked some questions about what Gena Rosengrant told the Dishops, either Mr. Dishop or Mrs. Bishop, about going to the emergency room; do you remember that?

A. Yes.

Q. And that was during the evening or afternoon to the next day of February 3rd to February 4th; is that correct?

A. Yes.

Q. Okay. Do you know point-for-point based on what you have read in the medical records and in the depositions, exactly what Ms. Rosengrant told them each time she communicated with them about that issue?

A. It would be that, the discussions that were back and forth with the urinary retention and the need for a Foley, the interaction with the wife that yes, a Foley or straight cath is a possibility.

The discussion on the nursing standpoint that she would have told them, she did tell them to go to the E.R. The patient and the patient's wife stating they discussed the patient was significantly weak.

So as we stated back and forth, there was a discussion to go to the E.R., but then there was a further discussion that the E.R. might be avoided if they just got a straight cath order.

Q. Where did you get that information that the E.R. could be avoided?

A. Again from the depositions. It would be the wife's deposition.

Q. Excuse me, maybe I can cut to the chase and save

some time. You are going back to Mrs. Bishop's deposition?

A. Yes. I'm using all three depositions to try and get a discussion back and forth, because I guess the discussion, it obviously involves two parties. So I'm trying to put the discussion of what happened back and forth by just using the two parties and what they say happened.

Q. You don't know whether they discussed anything beyond the points you just gave me back?

A. Right, I can only say what they say they talked about.

Q. That's all you have?

A. That's all I have.

Q. You would have to ask them, correct?

A. I would have to ask them.

Q. And you haven't done that?

A. No, I haven't.

Q. In fact, you haven't met Mrs. Bishop or Mr. Dishop yet, have you?

A. No, I have not.

Q. You have never examined Mr. Dishop, have you?

A. No, I have not.

Q. Everything you know about this case are in those papers sitting in front of you; is that correct?

A. Absolutely.

Q. You don't know anything else? You haven't talked to Mr. Kuvin about anything beyond what is in those records, correct?

A. Absolutely.

Q. So let's talk about, I need to put it down, I've got little things scattered in my notes about Nurse Rosengrant.

Let me start with this: Other than Nurse Rosengrant, do you have any criticisms of the care rendered by any other home health employee?

A. No, other than her.

Q. So when we talk about nursing standards of care, we are only talking about Gena Rosengrant; is that correct?

A. Correct.

Q. Can you list for me what your opinions are as to how she failed to meet the nursing standard of care?

A. My opinions would be that she documented that the patient had lower extremity weakness, couldn't state why she said that. Basically it seemed like she just had it as a history rather than a confirmation. She didn't examine the patient in any way.

She then again, inferring that the correct, the truth is being stated from the deposition, was

told that he had worsening weakness and inability to void, and didn't, and had no means of communicating with the physician, but also didn't instruct them that there was nothing else that should be done other than him going to the E.R., that instead stated that, yes, this might be secondary to the medication. Stated that's the only possible cause.

And then allowed them a means to avoid going to the E.R. by just arranging for a straight cath, rather than, again, insisting that they go to the E.R. and sticking with that.

Q. So you have given me what I've written down as four general areas where she breached the standard of care.

Number one, having to do with the lower extremity weakness, and on her initial assessment, and some specifics as to that. That's number one, correct?

A. Uh-huh.

Q. Is that a "yes"?

A. Yes.

Q. Thank you. Number two, was told of worsening weakness and along with difficulty voiding, increase in difficulty voiding, right?

A. Right.

Q. And again, I think we have been through this, I

don't have to beat a dead horse.

The worsening weakness does not come from Rosengrant, correct?

A. Correct. But it also states in a way, for lack of a better word, had the ring of truth.

For instance, in the wife's deposition she states that the nurse had suggested that she stand the patient up to go stand in the shower and that might actually help him urinate. A running stream I guess would help him want to urinate with him standing, which makes sense.

The wife said that he wouldn't even be able to walk to get into the shower. These are major concerns if I were discussing this with the nurse. This would be a major concern that the patient is expressing weakness, and that has a ring of truth.

Q. Again, Doctor, that comes from the wife's deposition?

A. Absolutely.

Q. Whether it's not credible or credible to you, it comes from the wife's deposition; is that correct?

A. Correct.

Q. It does not come at all from Gena Rosengrant's deposition?

A. No, it doesn't.

Q. So, as far as if we just, if we set aside the wife's deposition and we look at Gena Rosengrant, what she had to work with and what she said she had to work with, we have urinary difficulty; is that correct?

A. Correct.

Q. We don't have worsening lower extremity weakness, correct?

A. Correct, if you are just looking at the nurse's deposition.

Q. That's right.

Okay, that's the second point. The third point was that, and I can't even read my writing here, but something about that Ms. Rosengrant did not instruct them other than go to the E.R., that she did not discuss with them the reason that you want to go to the E.R. is because there is doom involved if you don't; is that correct?

A. Correct. She didn't have enough of a concern, or maybe even understanding what the concern should be. But also was able to be talked into an alternative path by the medically naive wife of, well, can we have a straight cath order.

And I feel, as a nurse, she should have been more instructive and insistent of the patient going to the E.R. rather than waiting all night for an order

for a straight cath the next morning.

Now, I can further elucidate that. The nurse knows that you should void. If you wait a long time to void you can have significant amounts in the bladder. Significant amounts in the bladder can result in bladder damage.

I know that nurses know this. I know that they, at certain amounts, they will actually ask the physician can I just keep the Foley in. This is something that is common knowledge.

This knowledge is not demonstrated by Ms. Rosengrant. She doesn't talk about keeping the Foley in. She even doesn't, at 1700, doesn't strike her as a large amount, which it should have.

Again, this to me underscores the lack of knowledge that she has.

Q. Okay. Let me back up a little bit.

If you take Gena Rosengrant's testimony, which is that he was experiencing, well, she received telephone calls explaining that he had difficulty voiding, increased difficulty voiding; you agree with that based on what you saw in her deposition?

A. She had telephone calls, yes.

Q. Was he going at all; do you recall?

A. According to her testimony there was some

voiding. And according to the wife or the husband there was dribbling which sounds like overflow incontinence. But yes, was there urine coming out in some form? Yes.

Q. And you do agree that urinary hesitancy is a common problem after surgery?

A. Absolutely.

Q. Not only this type, right?

MR. KUVIN: Objection, asked and answered.

THE WITNESS: Absolutely.

BY MR. REICHERT:

Q. Okay. Then I can't read the fourth one. Something about?

MR. KUVIN: You wrote it.

MR. REICHERT: I know, I was writing really fast.

BY MR. REICHERT:

Q. Something about the E.R. and then arranging for something?

A. She had no means of actually contacting the physician's office, but, which obviously is not her fault, that's the physician's office. But she actually then arranged the next morning for the Foley.

And my point was she should never have made that an alternative to wait until the next morning for

a Foley.

Q. What should she have done?

A. She should have said you need to go to the E.R. or you can have bladder damage.

Q. She told them to go to the E.R., you agree with that?

MR. KUVIN: Objection, asked and answered.

THE WITNESS: Right. But then she said, she basically said you need to go to the E.R., but when the wife says can we do a straight cath, and she says we'll have to wait until morning to get a straight cath order. And then she's at a crossroad, she could have insisted, no, you have to go to the E.R.

Instead she said, yeah, we can also get an order in the morning. Which, to a medically naive patient, that ambivalence gives you alternatives. Alternatives means you can make the wrong decision.

BY MR. REICHERT:

Q. She said she offered the E.R. or a straight cath as an alternative in her deposition testimony?

A. In the testimony, again, this is a discussion, unfortunately, we are dealing with three people and the discussions between them.

Q. I want to know what Gena Rosengrant said.

MR. KUVIN: Just strictly Gena Rosengrant, 41 onto 42.

THE WITNESS: Yes. "I was on call the night before and I got calls all through the night from Mr. Dishop's wife." And then this was the morning of she called again stating he was still unable to void, only a little bit during the whole night and she wanted me to come out and insert a catheter. So then I called Dr. Ronzo's office.

So again this is, she doesn't fully state what, at least from what I'm seeing now, what she was actually telling her through the night. She says what she says during the day, which is: "I called Ms. Bishop back and let her know that Kitty said to go to the E.R. She wanted to wait until Dr. Ronzo arrived at his office. So again we are on February 4 to see if he would give the order first.

Then I called Dr. Ronzo's office again, spoke to Kitty again and got the order to straight cath basically.

BY MR. REICHERT:

Q. Did you get the impression from anywhere in Gena

Rosengrant's deposition testimony that she offered them an alternative between going to the E.R. and having a straight cath at some point?

A. No, she actually doesn't talk at length about what happened over the night. No, the answer is no. If you are looking specifically at her deposition, which has a paucity of information about that nighttime, the answer would be no, because I have a paucity of information from her deposition.

Q. And that's because you haven't talked to her, correct? All you have is the answer to the very question that was asked.

A. Correct.

Q. You would have asked different questions, I understand that, Doctor.

A. I agree, yes.

Q. Okay.

A. There is a statement here from her, by the way: I let her know that they had called several times during the night, he was unable to void fully, that he was having a lot of pressure from the feeling of having to go. And they wanted me to go out and put a catheter in to relieve his bladder.

And then the question: Did Kitty express any concerns to you that might be something other than

normal complications postoperatively? The answer: No.

So the discussion basically between her and Kitty was this was, again, superficial discussion of the problem being urinary retention. The solution being getting the urine out. Nothing done to actually look underneath that.

Q. Was it appropriate for a nurse to try and get an order for a straight cath in order to relieve her patient's pain?

A. Correct, it is appropriate. Can we go off the record?

MR. REICHERT: Sure.

(Break in the proceedings.)

THE WITNESS: Go on.

BY MR. REICHERT:

Q. You don't see a problem with Gena Rosengrant calling Dr. Ronzo's office in an attempt to get an order for a straight cath, do you?

A. I don't have a problem with that.

Q. Okay. I want to get back to the first one, where you talked about her initial assessment. And you talked about, well, you know, you read it and it's right here. This is an assessment form, correct?

A. Correct.

Q. And you have you seen forms like that before?
A. Yes.
Q. Do you read them, as a physician?
A. If they're sent to me, yes.
Q. Okay. Do they contain important information for you?
A. They contain information that can be important, yes.
Q. Okay. Being here today talking about nursing standards of care, are you familiar with the standards of care for a nurse who is filling one of these out to document her assessment?
A. I can't say that I'm absolutely familiar with what her standard would be, no.
Q. Or a standard for any nurse?
A. I can't say that I'm absolutely certain of that.
Q. Well, can you say within reasonable nursing probability what the standard of care is for a nurse doing an assessment what to document?
A. Specifically what you're referencing, if there is a standard that you are referencing specifically that's out there, I don't know what that standard is. I only know what should have been done for this patient.

Q. You are talking about what a nurse should have done for this patient?

A. Any nurse that I would have worked with should have been done for this patient.

Q. But you are a physician?

A. I hear you. I agree I'm a physician.

Q. And I don't think you are an expert on nursing standards, but we can take that up with the judge.

MR. KUVIN: Objection to form, move to strike.

BY MR. REICHERT:

Q. She writes: Patient assessment complete. She writes: Patient with lower extremity weakness.

And you saw in her testimony Mr. Dishop himself said, I'm weak in my lower extremities, correct?

A. Correct.

Q. And you also see that she documented that Mr. Dishop told her that that status, that weakness had not changed at all since he left the hospital, correct?

A. Correct.

Q. Then she assessed him for whether he was voiding. And he wrote that he was having urinary hesitancy, but was voiding.

What is your criticism of the way she documented the lower extremity weakness, and how did that deviate

from the nursing standards of care?

A. Sure. That she doesn't say anything other than he has a baseline of lower extremity weakness from postoperative.

She doesn't clarify what the weakness is and she can't clarify what the weakness is. From what I see from the records, and in her deposition, she didn't have a recollection, she couldn't even say for certain that he had any strength in his legs. There is no information whatsoever, other than weakness.

Q. And you saw her deposition that was taken several years after the fact, correct?

A. Correct.

Q. Would you expect her to remember exactly what the weakness was?

A. No, that's not a criticism of her memory. The problem is there is no documentation, that's what the criticism is.

Q. And you are saying then she breached the standard of care because she should have quantified the weakness in some way?

A. Yes, she should have had some motor examination.

Q. And have you seen nurses document motor examinations before?

A. Absolutely.
Q. Okay. Tell me how they go about doing that and how they chart it.
A. So they would chart whether they have knee extension, whether they have ankle dorsal flexion, whether they have ankle plantar flexion.
Q. Did you see anyplace on the chart to do that on the assessment form?
A. I don't see anything on there that she would actually do that.
Q. Does this form meet standards for the types of documentation in patients like this? Or is that form --
A. I would be unhappy with this form, but I don't know what standard you are referencing it, but I would be unhappy with this form because I don't feel it adequately deals with a neurological examination of a postoperative spine patient.
Q. By a nurse?
A. By a nurse, who is doing home health.
Q. Do you know who makes that form? Does it say on there?
A. I don't. It's Briggs Medical Service Company, 2007.
Q. You do not believe that is adequate for this type of patient?

A. I don't.
Q. Have we discussed every type of criticism that you have of the nurse in this case?
A. Yes.
Q. Trying to get us out of here.
A. I appreciate that.
Q. To tell you the truth, I'm kind of confused. Just give me a moment to think, and if you want to take a break and run down the hall and tell her I'll be done in five minutes.
A. That's okay. I can text her that.
MR. JOPLING: One question, can I ask that?
MR. REICHERT: Yes.
REDIRECT EXAMINATION (Dr. Husted)
BY MR. JOPLING:
Q. I'm sorry, Dr. Husted, I meant to ask you this.
A. Sure.
Q. Was it unreasonable for Mr. and Mrs. Dishop, Mrs. Bishop and Mr. Dishop, to fail to go to the emergency room when the nurse taking care of them told them they should?
MR. KUVIN: Form.
THE WITNESS: If the nurse insisted that they go, and there was no other alternative given to them, I feel that they should have gone.

BY MR. JOPLING:

Q. All right. You would agree that patients have some responsibility for cooperating in their care?

A. Absolutely.

Q. And for generally following the directions of their health care providers?

A. Absolutely.

Q. Including nurses?

A. Sure.

RECROSS EXAMINATION (Dr. Husted)

BY MR. REICHERT:

Q. You agree that health care practitioners and nurses, they can't figuratively hold a gun to a patient's head and make them go and do something?

MR. KUVIN: Objection to form.

THE WITNESS: Absolutely.

BY MR. REICHERT:

Q. That's paternalistic, isn't it?

MR. KUVIN: Form.

THE WITNESS: Right, and you can lead a horse to water, but you can't make them drink.

BY MR. REICHERT:

Q. You agree with that?

A. Yes.

MR. REICHERT: I think I'm done.

COURT REPORTER: Did you want this typed, Mr. Jopling?

MR. JOPLING: Yes, please.

MR. REICHERT: You don't have any questions?

MR. KUVIN: No, you covered what I was going to ask when he was able to talk about what she said in her deposition.

COURT REPORTER: Anybody want copies?

MR. REICHERT: I'd like a mini, with whatever exhibits. I would like to attach a copy of Defendant's Exhibit 1, which is the timeline.

(Defendant's Exhibit No. 1 was to be marked for identification)

MR. KUVIN: Sure, I'll get you a copy. I don't have a clean copy but I'll provide it to the court reporter. And while we're doing this, let's attach a copy of his CV as Plaintiff's 1.

(Plaintiff's Exhibit No. 1 was marked for identification)

(Discussion held off the record.)

MR. REICHERT: A mini script, E-Tran in mini format. I need it to come in like that, and I need it to come in with a word index.

(Discussion held off the record.)

COURT REPORTER: How would you like yours? Do

you want a hard copy? What do you want?

MR. KUVIN: I would like an E-Tran only for Kuvin.

(Witness excused.)

(Deposition was concluded.)

DEPOSITION ERRATA SHEET

Assignment no: 148768

Case Name:

Dishop v Citrus

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my deposition/examination under oath taken in the captioned matter or the same has been read to me, and the same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

Signed on the _____ day of _____, 20___.

_____

DANIEL S. HUSTED, M.D.

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DANIEL S. HUSTED, M.D. #148768

C E R T I F I C A T E O F O A T H

STATE OF FLORIDA

COUNTY OF MARTIN

I, the undersigned authority and Notary Public in the State of Florida, certify that DANIEL S. HUSTED, M.D. personally appeared before me and was duly sworn on July 7, 2014.

DATED this 16th day of July, 2014.

_____

ELEANOR M. EVENSEN
NOTARY PUBLIC, STATE OF FLORIDA
My Commission Expires: 10/27/2016
Commission No. EE 835802
148768

REPORTER'S CERTIFICATE

STATE OF FLORIDA
COUNTY OF PALM BEACH

I, ELEANOR M. EVENSEN, Registered Professional Reporter and Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did report said deposition in stenotype; and that the foregoing pages are a true and correct transcription of my shorthand notes of said deposition.

I further certify that said deposition was taken at the time and place hereinabove set forth and that the taking of said deposition was commenced and completed as hereinabove set out.

I further certify that I am not an attorney or counsel of any of the parties, nor am I a relative or employee of any attorney or counsel of party connected with the action, nor am I financially interested in the action.

The foregoing certification of this transcript does not apply to any reproduction of the same by any means unless under the direct control and/or direction of the certifying reporter.

DATED this 16th day of July, 2014.

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ELEANOR M. EVENSEN
148768