STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE
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DONNA FRESARD, as Personal Representative for the ESTATE OF JOHN M. MALONE, JR.,
Deceased,
Plaintiff,
Index No.
-against- 11-004995 NH
HARPER-HUTZEL HOSPITAL, SAFWAN SAKER, M.D., LAWRENCE CRANE, M.D., and GERALD TURLO, M.D., jointly and severally,
Defendants.
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DEPOSITION of PERRY STARER, MD, taken by Defendant, held at the offices of Fink & Carney Reporting and Video Services, 39 West 37th Street, New York, New York 10018, on Wednesday, September 26, 2012, commencing at 11:15 a.m., before Jean Wilm, a Registered Professional Reporter, Certified LiveNote Reporter and Notary Public within and for the State of New York.

APPEARANCES:

MORGAN & MEYERS
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BY: CULLEN B. McKINNEY, Esq.

Starer

PERRY STARER, MD,
called as a witness, having been first duly sworn/affirmed by Jean Wilm, a Notary Public within and for the State of New York, was examined and testified as follows:

EXAMINATION
BY MR. McKINNEY:

Q Let the record reflect that this is the deposition of Dr. Perry Starer taken pursuant to notice and agreement between counsel to utilize for any and all purposes under the Michigan court rules.

Dr. Starer, my name is Cullen McKinney. I am one of the attorneys representing the defendants in this case. We are here this morning to explore the opinions that you have relevant to the care and treatment provided to Dr. John Malone in 2008 and 2009.

I know you've given some depositions in the past. The only thing that I ask is, if I ask you a question that you don't understand, that you let me know and I will be happy to rephrase; is that fair?

A That is fair.

Starer

Q If you answer a question, then I and the record will assume you understood the question.

Is that fair?

A That is fair.

Q Could you state your full name for the record, please?

A First name Perry, P-e-r-r-y. My middle name is Jay, J-a-y. My last name is Starer.

Q Dr. Starer, have you ever been known by any other name?

A No.

Q What is your current profession?

A I'm a medical doctor.

Q Do you have a particular area of specialty as a medical doctor?

A Internal medicine and geriatrics.

Q Any other area of specialty?

A No.

Q Is geriatrics your primary medical focus?

A I view myself as an internist with a subspecialty of geriatrics.

Q What percentage of your patient base would you consider are geriatric patients?

Starer

A It will vary over the course of the year. It can be between 40 percent to 60 percent.

Q Has that been the case dating back, let's say, to 2007?

A Yes.

Q So at any given time, it could be anywhere between 40 percent and 60 percent geriatric?

A On any given day, yes.

Q The other 40 to 60 percent then would be what?

A Adult medical patients.

Q And those adult medical patients, are they patients that you are seeing in the hospital setting or in an office-base setting?

A At this time, they are in a hospital setting.

Q Are you currently working as a hospitalist, Doctor?

A I'm not considered to be a hospitalist, no.

Q The hospital-based patients that you see, are they your private patients who happen to be hospitalized?

Starer

A No.

Q Do you have a contract with a local hospital wherein you'll see patients, or round on patients, or patients will be admitted to your name?

A I don't know if a contract actually describes it, but I am employed in the hospital and patients will be seen with my name as the attending physician.

Q And what hospital is that?

A This is Elmhurst Hospital Center.

Q Do you know where Elmhurst is located?

A Yes, I do. It's in Queens, the Borough of Queens, in New York City.

Q How long have you worked or been employed by Elmhurst Hospital?

A Since approximately, I guess as an attending physician, about 1985.

Q The patients that you see at Elmhurst, are they a mixture between geriatric and general adult patients?

A Yes, that's true.

Q Tell me, Doctor, from 2000 -- let's say December of 2007 through January of 2009, so we will look at about a 13-month time frame, was your

Starer

practice essentially the same during that time frame?

A Yes. Over the time frame, it's the same, right.

Q Tell me, generally speaking, on either a weekly or monthly basis what your practice would consist of during that time frame?

A Just to be as clear as possible, we break down the year into month rotations.

Q Okay.

A So one month may be different than another month.

Q Is your current practice still the same as it was then?

A Yes. The rotations are very similar to the way it was then.

Q And when you say "we break it down," are you a member of a group of physicians who will rotate from one location to another?

A Just to be as clear as possible, this is part of a medical school, so the physicians are employed by a school of medicine, and then we are scheduled to do different rotations over the course of the year as part of training of students and

Starer

doctors and also as part of the care of patients.

Q What is that medical school?

A Mt. Sinai School of Medicine.

Q And how long have you had this arrangement with Mt. Sinai?

A I personally have had the arrangement since 1985, and the arrangement with the hospital preexists that.

Q You indicated earlier that you are employed by Elmhurst Hospital.

A I actually have two employers which both administrate Elmhurst Hospital: One is the School of Medicine, and one is the City of New York.

Q So the City of New York directly sends you a check on a weekly or monthly basis for medical care that you provide to patients?

A It's not as simple as that.

The City of New York pays the medical school to staff the hospital, so the check will have the medical school's name on it, but the money is flowing from the City of New York.

Q All right. So you only receive one paycheck on either a bimonthly basis or monthly basis?

Starer

A That is correct.

Q And that has been the case dating back to 2007?

A That is the arrangement, yes.

Q And essentially then, Mt. Sinai School of Medicine will then say, "Dr. Starer, for the month of October of 2012, you will be at X location"?

A That is correct.

Q And then you'll find out where you'll be in November at another time and you will spend a month at a time at certain facilities?

A Or certain parts of the same facilities, yes.

Q Since 2007, what facilities have you staffed on a monthly basis?

A Since 2007, I've now -- I was just based at Elmhurst Hospital Center. In the past, I've moved to other facilities, but I asked just to be placed in one of the facilities.

Q And so now, getting back to what you said earlier, there are different departments and/or floors and/or units within Elmhurst that you may spend a month at a time within?

Starer

A That's right. Different units now within the same building.

Q In which units will you, since 2007, be staffing?

A So since 2007, I will either be the attending physician for the general internal medicine unit or the director of, and attending physician of the geriatric unit.

Q Have you, in your career, done nursing-home work?

A Yes, I have.

Q Have you done that since 2007?

A No, I have not.

Q The general internal medicine unit, how many beds are on that unit?

A The unit itself has about 36 beds, but the concept of unit is not always geographical, so if it gets busy, we will have patients who are then boarded in other parts of the hospital. So we can exceed that number.

Q Just so I'm clear, if you have 39 patients, 36 will be on the general internal medicine unit and three will be somewhere else within the hospital, but you'll still be responsible

Starer

for rounding on them and overseeing their care?

A If they're admitted to our service, then we're responsible no matter where they are located within the building.

Q The geriatric unit, how many beds in the geriatric?

A It's the same. Units have roughly about 36 beds.

Q And the same arrangement there, if you need more beds then the patients may overflow to another department?

A Or if we don't have 36 geriatric patients, other patients may come in, so it may fall below.

Q If five of those beds in the geriatric unit are being used for postsurgical patients, you will not be responsible for those five patients?

A No, unless they are admitted under my name for some other reason, I would not be responsible.

Q Let's talk about since 2007 your experience with outpatient care wherein you would see a patient in an office base where they would schedule an appointment to come in and see you, but

Starer

are not inpatients.

Have you had the occasion since 2007 to serve within that capacity?

A No, only to the extent that I would admit patients sent to us from an outpatient setting.

Q So they would be, for example, sent from an office base where it was felt that the patient needed to be admitted?

A Right. Either from outside the hospital or from one of our own clinics. And there are times, if it's in the building itself, we may actually go to the clinic just to start the process.

Q Have you, during your career, worked in a -- I will call it traditional -- that may not be the right word, but I will call it the traditional office base where patients will schedule appointments and come in and see an internal medicine physician for whatever it is that may be ailing them?

A I have worked in offices, but they were always located within a hospital or within a medical school's faculty practice program.

Q And when was the last time that you

Starer

did that?

A Probably in maybe the 1990s.

Q So is it fair to say that you have been a hospital-based internist/geriatric specialist seeing inpatients since 2000 to the present?

A I don't remember exactly when I switched over. I may have actually done a little bit of it in the early part of the century, but not recently.

Q Since 2007, 100 percent of your practice has been seeing patients on an inpatient basis?

A That is true.

Q Do you have the opportunity to consult other specialists, such as infectious disease specialists or podiatrists or vascular surgeons?

A Yes.

Q That is part of your everyday practice?

A That is true.

Q And as an internal medicine or an internist, you have to, to some degree, rely upon those specialists' recommendations at least as it relates to their particular area of specialty?

Starer

A Well, certainly we collaborate in the care of patients.

Q Has your number of hours worked essentially been the same on a per week basis since 2007?

A I think it might have actually increased.

Q Approximately how many hours would you say that you worked a week since 2007 on average?

A Total or how much during the week?

Q During a given week.

A It would be eight to ten hours a day at least five days a week and then there are weekends in there which may be an extra eight hours.

Q How often would you work a weekend? Would that be something you do every other weekend or once a month?

A Certain months, I will do it two or three times a month. Other months, I may not do it at all. Over the course of the year, maybe ten weekends a year.

Q You have been reviewing medical malpractice cases for some time; is that true?

A Maybe about 14 years.

Starer

Q During the time that you have been reviewing cases as an expert, have you ever held yourself out as an expert in the field of infectious diseases?

A No, I don't believe I have.

Q Have you ever held yourself out as an expert in the field of podiatry?

A No, I don't think I have.

Q In this case, Doctor, are you intending to offer testimony with respect to either causation or damages?

MR. MEYERS: He will be called with regard to both causation and life expectancy issues.

I will indicate for the record with regard to the deposition that we took recently of the attending physician, whose name is escaping me --

MR. McKINNEY: Dr. Farber?

MR. MEYERS: No. The attending physician in the hospital.

MR. McKINNEY: Saker?

MR. MEYERS: The second admission. The intensivist who took care of

Starer

Dr. Malone in the hospital. We don't have a deposition transcript yet.

I planned on providing it to the doctor, but he is planning to give opinions as to both life expectancy and causation. He will only be called with regard to the actions of Dr. Turlo, if that saves some time, as opposed to Saker and Crane.

BY MR. McKINNEY:

Q That is your understanding of your role in this case, Doctor, is to comment on standard of care applicable to Dr. Turlo, give causation opinions, and give life expectancy opinions?

A That is what I focused on.

Q Do you have any titles at the medical school?

A I have the title of assistant professor at the medical school.

Q I'm going to hand you, Doctor, what I have been provided as a copy of your curriculum vitae.

If you would, let me know if this is current and up to date?

Starer

A Yes, it is.

Q Do you know when this was prepared? Anyway for us to know that?

A It was probably prepared within the last year. I made no additions to this since 2009.

Q What I am going to do quickly here administratively before I forget, I'm going to have that marked as Deposition Exhibit A and a copy of your affidavit of merit marked as Deposition Exhibit B.

(CV was marked as Deposition Exhibit A for identification, as of this date.)

(Affidavit of Merit was marked as Deposition Exhibit B for identification, as of this date.)

BY MR. McKINNEY:

Q I will have you take a look at what will be marked as Deposition Exhibit B on page 4 and tell me if that is your signature.

A That is my signature.

Q Now, as far as the notary is concerned, do you remember who it was that notarized this document?

A Well, it's Christian Lee.

Starer

Q Who is Christian Lee?

A This is a gentlemen who works at a Mailboxes Etc. store.

Q And you recognize this document as a document that you signed relative to at least initial opinions you had in this case?

A Yes.

Q Any other materials, Doctor, that need to be added to your CV that are not currently on here?

A As far as publications and credentials, I think this is complete.

Q According to your CV, you are, and I believe you just indicated, an assistant professor in the department of geriatrics and adult development at Mount Sinai School of Medicine?

A That's correct.

Q You are also the chief of the geriatrics section of the department of medicine at City Hospital Center at Elmhurst?

A That's correct.

Q How many geriatric physicians are there on staff at Elmhurst?

A Well, there are physicians who have

Starer

geriatric credentials, but within the geriatric section of the inpatient service, right now it's only me.

Q Have you written any articles or publications that you believe to be germane to the issues in this particular case?

A I don't believe there is any publications here which specifically would reference the issues in this case. There might be some articles in here which in general will touch upon some of the issues in this case.

Q Any that come to mind as you are looking through the list?

A Only insofar as there are articles which may reference infections and that might be 12 and 19, but these are articles about patients who actually were in nursing homes at the time and Dr. Malone was not in a nursing home.

So that's why I said maybe in general there might be some discussions of infections, but nothing specifically addressing the issues in this case.

Q Have you had the occasion, Doctor, during your career to treat a patient who was a

Starer

physician?

A Yes, I think I have.

Q Approximately how many times have you done that?

A Maybe two or three times, we've had patients who have been physicians.

Q Any of them direct colleagues of yours?

A There was one who I had worked with, yes.

Q How long ago was that?

A I just saw him briefly once maybe two years ago.

Q Was that the last time that you saw a patient who was actually a physician?

A That I'm aware of, yes.

Q And that patient two years ago, do you remember what his specialty was?

A Pulmonary.

Q Would you agree, Doctor, that, in general, a patient who is also a medical doctor would have more general information with respect to general medical issues than an average lay witness off the street?

Starer

A They may or may not.

Q Would it depend on their specialty?

A It depends on their specialty, how long ago they were in practice, and also their current state of well-being.

Q If they are alert and oriented, they are currently practicing -- well strike that and let me back up.

Would you agree that in this case John Malone likely had more general medical information and/or knowledge than a patient who is off the street and does not practice as a physician?

A I can only speculate, because I had no records which actually would have given me that information.

Q What types of records would give you that information?

A Records in which there were discussions of medical standards of care. What I see, there is only discussion of his illness, not of his ability to converse concerning medical issues.

Q Is it your belief that Dr. Malone had some sort of cognitive deficits at the time of his inpatient stay from December 21 of 2008 through

Starer

January 9 of 2009?

A No, I had no reason to believe that.

Q Would you agree, Doctor, that as an expert witness the majority of the cases that you reviewed and/or consulted on were about nursing home issues?

A I'm uncertain. I know there's been hospital cases in there, but I wouldn't be surprised if there were more nursing home cases.

Q And would you agree that nearly 100 percent of the reviews that you have done over the years have been on behalf of the patient, or the plaintiff pursuing the case, as opposed to a defendant/physician or a defendant/facility?

A I would agree that a hundred percent of the depositions and trials I participated in were on behalf of the plaintiff.

Q How many cases have you reviewed on behalf of a physician or a healthcare facility?

A I don't recall the exact number, but it's probably 5 percent or less where I've discussed or looked at cases on behalf of defense.

Q How many cases, Doctor, have you reviewed as a medical expert over the last 14 years

Starer

or so?

A I'd have to estimate. Maybe about 70.

Q How many times have you given a deposition as an expert?

A Once again, it's an estimate. Probably more than 45, maybe 50.

Q When was the last one that you gave?

A I did give one last week.

Q On behalf of a patient?

A Yes.

Q Do you know where the care arose out of in that case? I mean, the state.

A Florida.

Q When is the next scheduled deposition that you have after today?

A I have nothing on the schedule right now.

Q How many times have you testified in a trial where you served as a medical malpractice expert?

A I think about 12 times.

Q Ever in Michigan?

A No.

Q With respect to the state of Michigan,

Starer

have you reviewed cases out of the state of Michigan prior to this one?

A I'm not sure that I have. I might have, but I don't really remember.

Q Have you ever reviewed for Mr. Meyers or anyone from his firm before this case?

A I don't believe I have.

Q Do you know how it is that Mr. Meyers came to know of your availability as a potential expert witness?

A I'm not certain.

Q Do you review for medical-legal review companies? MedScape or MedQuest or Sapanelli?

A I have been contacted by one of those entities, yes.

Q Do you know if your name is published as a potential expert by any of those entities?

A That I don't think happens, no.

Q The reviews that you receive, are they by word of mouth where the attorney or attorney's office contacts you directly as opposed to some intermediary?

A That is usually what happens. I'll get a phone call or an e-mail. I don't really

Starer

question how they found me.

Q How is it that you started reviewing these cases?

A I got a phone call about 14 years ago from a lawyer who asked me if I review cases and I said no. He started telling me about something that happened in a nursing home and I said, "Look, I don't really do this. If you want to send me the records, I will look at it and tell you what I think," and that just started it.

Q So it's your testimony that over the last 14 years, you have not had your name placed out there as an individual willing and/or capable of reviewing medical malpractice cases?

A I've done nothing to put my name out there. I don't know if somebody has my name out there, but I'm not paying anybody to put it out there.

Q And you are not aware of any entity that publishes your name as a potential expert for attorneys to call?

A I didn't think that was happening.

Q Now, I asked you earlier if you work as a hospitalist. Do you know what a hospitalist

Starer

is?

A I know we have hospitalists in our hospital and I'm not classified as one. And these are doctors without subspecialties whose full-time job is to deliver direct care to inpatients in the hospital.

Q You would agree that you are employed by the medical school to provide care and treatment to inpatients at Elmhurst?

A That is correct.

Q Besides the responsibilities and titles we talked about from your CV, do you have any other responsibilities at Elmhurst or at the medical school besides treating patients?

A Well, teaching is also one of my responsibilities.

Q Who do you teach?

A I teach anybody who wants to be taught and they have sent us medical students, pharmacy students, nurse practitioner students. I've done teaching for the nurses. I've done teaching for the social workers. There has been a podiatry student every once in a while. So teaching is just part of the day.

Starer

Q You do not teach any didactic classes at the medical school?

A In the past, I've gone over to the school itself and stood in the classroom, but right now, I do prefer the bedside for teaching.

Q Essentially, these are students who will be assigned to your service and follow you around for the day? Is that how that works?

A That's one of the ways it works, that students will be assigned a rotation and they're going to either follow me or be sent off to do something and then come back and report to me.

Q That is not something that happens with regularity as far as every day, but it happens from time to time; is that your testimony?

A There are times that it seems like it's happening every day. There are months that they're just everywhere.

Q Are you teaching clinically geriatric medicine residents in a clinical setting?

A We don't specifically have a geriatric medicine resident. We have internal medicine residents who are going to learn geriatric.

Q At some point later?

Starer

A Just an ongoing thing. But it's an internal medicine residency. We don't have a geriatric medicine residency.

Q Any other responsibilities with either the medical school or Elmhurst that we haven't talked about yet this morning, Doctor?

A Well, there's other kinds of administrative things that go along, of course, during the day and during the year. I don't know if you want me to try and list them all.

Q Well, I'd like to know, professionally, the responsibilities that you may have that contribute toward who Dr. Starer is as a physician.

A Well, I'm interfacing with the team of healthcare professionals, so they'll be rounding with an interdisciplinary group.

I'm keeping an eye on the unit as far as aspects of preventing falls, adverse medication reaction, pressure ulcer development.

But this sort of becomes such a natural part of the day that I don't really split it out.

Q Fall prevention, from what I have

Starer

gathered at least in the information that I have with respect to you, seems to be one of your areas of interest; is that fair?

A This is an area of interest, yes.

Q Anything else that goes to who Dr. Starer is professionally as a physician that we have not at least touched on?

A I mean, I've done some publishing in the past and I will help others if they want to write a paper. Once again, it's just sort of part of the day. Then I guess advising people as far as careers. People will ask me questions. You know, you try and be helpful. And then paperwork, you know, which is required, is a small part of the day as well.

Q "Paperwork" meaning writing progress notes or policies and procedures?

A Well, the progress notes are definitely in there. There is also an ongoing program of maintaining credentials and in-servicing, you know, staying up to date on the policies and procedures.

Q I know in the past that you have brought medical literature with you to depositions.

Starer

Have you done that today?

A No, I have not.

Q Have you done any medical literature review as part of your review of this case?

A I didn't do anything formally. I did make some notes based upon some aspects of this case as it pertains to medications and infection, but I didn't actually rely on any specific article or textbook chapter.

Q You said you have some handwritten notes that you've prepared?

A Yes.

Q Can I take a look at those?

A Yes, you can.

Q I have 11 pages of notes that you just handed me. Do you believe this encompasses all the notes that you have written in this case?

A Yes, I think that is it.

MR. McKINNEY: We will mark this 11-page set of records as Deposition Exhibit C.

(Eleven-page set of records was marked as Deposition Exhibit C for identification, as of this date.)

Starer

BY MR. McKINNEY:

Q I will hand this to you, Doctor, and you can make sure before we leave today we get copies of it.

Tell me generally what is contained within those 11 pages.

A These are notes that I write as I'm reading the records, so it's really just recopying facts from the records onto a piece of paper. So some of it pertains to hospitalization. Some pertains to the certificate of death and the autopsy report. Some of it is the deposition of Dr. Turlo, and then there is a page where I was just making some notes on medications and sepsis as I was thinking of it.

Q Any specific opinions contained within those notes?

A No.

Q Those are obviously facts that you feel are relevant and germane to your opinions or your role as an expert in this case; is that true?

A Well, when I start writing, I'm not always sure what is going to be pertinent or not, so there might be some things here which are not.

Starer

Q Other than Mr. Meyers or someone from his office, have you spoken to anyone else about this case?

A No.

Q The opinions that you have here this morning, do you consider them to be full and final?

A They are full as far as the information I received to date.

Q Can you tell us just for the record, Doctor -- I think we may have already established this, but just for the record -- just what you were asked to do in this case?

A My recollection is that I was asked to look at the treatment of Dr. Malone by Dr. Turlo following the first hospitalization.

Q This next question may pertain to you and you may not be able to answer it, or you may be able to answer it.

Do you know why it is that you are not going to be giving opinion testimony with respect to care and treatment provided by Dr. Saker in this case?

A All I can say is, I've not been asked to.

Starer

Q That is probably more something for Mr. Meyers.

You've just been asked to render testimony with respect to Dr. Turlo?

A That is correct.

Q Tell us, Doctor, what it is that you have reviewed leading up to the deposition this morning.

A I have the records here, and I reviewed records from Harper University Hospital. I reviewed the records that were labeled the records of Dr. Gerald Turlo. I reviewed an autopsy report. I reviewed a certificate of death. And I've reviewed the deposition of Dr. Turlo.

Q Have you reviewed any other depositions?

A No. That's the only deposition that I was provided.

Q I would assume you have not reviewed any films or pathology slides?

A I have not reviewed those.

Q Is there material in this case that you have asked for and not received?

A No.

Starer

Q Is there material in this case that you believe you need to look at before giving final opinions in this case?

A I believe I have enough information to give an opinion.

Q You signed an affidavit of meritorious claim in this case and we have marked that as Deposition Exhibit B signed March 7 of 2011, and within that affidavit at paragraph 13, there are two subparagraphs A and B which purport to outline your opinion what the standard of care required of Dr. Turlo; is that correct?

A That is true.

Q Have your opinions changed in any way since you signed this affidavit?

A Only in as far as that since signing this affidavit, I have seen the deposition of Dr. Turlo and that I have received information about Dr. Saker stating that he informed Dr. Turlo about the discharge of Dr. Malone.

And with that new information, I would be able to now say that, with that advisory, and that discussion with Dr. Saker, that Dr. Turlo was now obligated to obtain laboratory studies on

Starer

Dr. Malone earlier than January 15th.

Q Just so I'm clear, you have not reviewed Dr. Saker's deposition?

A No, I have not.

Q You have been provided with some information that Dr. Saker allegedly testified that he spoke with Dr. Turlo at the time of Dr. Malone's discharge?

A As was represented to me, yes.

Q You have not read in context specifically what his testimony was in that regard?

A No, I have not.

Q Based upon information provided to you, I'm assuming by counsel, you have expanded your opinions beyond your affidavit of merit in this case to add another breach; is that what you're saying?

A Yes.

Q And that breach is that studies, specifically blood studies, should have been obtained relative to this patient prior to January 15th?

A That is true.

Q What, specifically, is your opinion that the standard of care required of Dr. Turlo

Starer

assuming hypothetically that Dr. Turlo was notified of something by Dr. Saker at the time of discharge on January 9th?

A Based on the dialogue that would take place, the standard of care would require Dr. Turlo to continue to monitor Dr. Malone's renal function on a timely basis and while at the hospital, the renal function was not being monitored any less than every two days and that should have been continued until it had normalized.

Q Give me your definition of standard of care.

A Standard of care is what an ordinary and prudent physician would do in the same or similar circumstances.

Q So it's your testimony that the standard of care required Dr. Turlo to ensure that additional lab studies were done relative to the patient's kidney function on an every-other-day basis?

A No less than every other day, yes.

Q The standard of care would not have allowed for blood draws three times a week? It would have required more than that?

Starer

A Three times a week -- I mean, every three days -- I think initially it should have been within two days.

Q Now you say you think. Is that what you are testifying here today the standard of care required?

A Yes.

Q What specifically needed to be checked every two days?

A Well, it needed to be checked at least initially within two days and then based upon the result, a decision would be made as to when the next one should be obtained, but the blood urea nitrogen and creatinine should have been checked within two days.

Q And when you said until it normalizes, what would normal for a patient like John Malone be of BUN and creatinine?

A The normal for John Malone is his own normal, and we would have seen that in early January of 2009, he had a BUN between 16 and 18 and a creatinine between 1 and 1.2. So that actually is his normal.

Q Now, those are just levels taken from

Starer

the hospital chart and you are referring to a page within what we have marked as Deposition Exhibit C?

A I am referring to a page of my notes which is copied over from the records, yes.

Q And those are two numbers that are taken from that list from early January?

A Well, there's actually more numbers there, but I was giving you a range.

Q Are you basing your range on what the averages were between December 21, 2008, and January 9 of 2009, or are you just picking two numbers out that you believe look like they fall within the normal range?

A Well, to be accurate, between and including December 31st, 2008, and January 4th, 2009, the values were within the normal range.

Q Which was? What were the values during that time frame?

A On January -- let's start with December 31st 2008, the blood urea nitrogen was 20, the creatinine was 1. On January 1, 2009, the blood urea nitrogen was 20 and the creatinine was 1.1. On January 2nd of 2009, the blood urea nitrogen was 18, the creatinine was 1. On

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January 3rd, 2009, the blood urea nitrogen was 16, the creatinine was 1. On January 4th, 2009, the blood urea nitrogen was 18 and the creatinine was 1.2. Following that, there started to be increases.

Q Why, in your opinion, did the patient's creatinine and BUN levels need to be checked on an every-other-day basis?

A I said no less than every other day. Well, the reason it needed to be checked is beginning on January 6th, 2009, there is evidence that the values are starting to increase. Two days later, it increases even further. So they were checking it in the hospital every two days, and this is where I saw that you shouldn't wait any longer than two days before you check the next one.

Q Do you have an opinion as to specifically why those values were increasing?

A Well, more likely than not, the reason the values are increasing is a medication effect.

Q Any particular medication?

A There is a medication he is receiving called Bactrim, which is an antibiotic. It's a combination medication of two things: One is sulfur

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methoxazole and the other one is trimethoprim.

Q When did he start taking Bactrim?

A I know that the Bactrim was given on January 2nd, 2009, and then continued until the time of discharge on January 9th, 2009.

Q Tell me that date again. I'm sorry.

A It was given on January 2nd, 2009, January 3rd, January 4th, January 5th, January 6th, January 7th, January 8th and January 9th.

Q For discharge planning, to continue orally at home?

A That is correct.

Q Is it your opinion, Doctor, that Bactrim has a nephrotoxic effect?

A That has been reported with the medication, yes.

Q What is your opinion of whether or not Bactrim has a nephrotoxic effect?

A I do believe that is true.

Q Would you agree that vancomycin also has a nephrotoxic effect?

A Yes.

Q Are you able to give expert testimony

Starer

with respect to the degree of nephrotoxicity between vanco and Bactrim?

A I'm not sure what you mean by "the degree."

Q Is there a difference in nephrotoxicity between those two drugs?

A Well, there are the variables that take place and it has to do with the exposure to each drug. I don't know if I can say that one is more nephrotoxic than the other in isolation.

Q Dr. Malone began taking vancomycin for his infected big toe on December 22nd of 2008. Is that your recollection of your review of this case?

A Vancomycin was given on December 23, 2008, and the 24th and 25th and continued to the 28th of December.

Q The patient was also taking Unison?

A That is true.

Q Does Unison also have a nephrotoxic effect?

A I don't -- there may be some nephrotoxic effect, but not to the extent of the other medications.

Q The patient was taking clindamycin?

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A This is true at some point, the patient was taking clindamycin as well.

Q Does clindamycin have a nephrotoxic effect?

A It may have an effect.

Q The patient was taking Zosyn during the admission?

A There was a notation in the records of Zosyn, but it doesn't actually say -- I don't have the records saying when it was actually given.

Q Assuming for the sake of argument -- and the records can bear this out one way or another -- does Zosyn have a nephrotoxic effect?

A It may have a nephrotoxic effect.

Q What is your opinion, Doctor, as to what monitoring the kidney function via the BUN and creatinine would have resulted in as far as lab results between January 9th and January the 15th?

MR. MEYERS: Could you read the question back, please?

MR. McKINNEY: Let me rephrase it. It's not a good question.

Q If Dr. Malone goes home on

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January 9th, Doctor, it's your opinion that the first blood draw at home should have been the 10th or the 11th?

A The 10th.

Q Then continuing on, for example, the 10th, then the 12th and then the 14th, moving forward?

MR. MEYERS: Form.

A Well, depending on what the results were on the 10th that would have then informed when the next study should have been done.

Q Based on your review of this case, your review of the fact that the patient was on some sort of nephrotoxic antibiotic dating back into December of 2008, can you map out what you believe the creatinine and/or BUN levels would have been had labs been drawn on the 10th, the 12th, and the 14th?

A Yes, and I'm basing that on what they were on January 8th and what they were on January 14th and the creatinine level, more likely than not, would have been elevated on the 10th and the 12th.

Q Can you create some sort of a graph as

Starer

far as what numbers you believe that the creatinine level would have been on the 10th or the 12th or the 14th?

A Could I draw a picture? Yes, probably.

Q And what would the basis of you drawing that picture be?

A What I would do is, to draw the picture, I would make a graph. One axis would be time and the other would be creatinine levels. I would plot in the values that we have and then I would extrapolate to connect the dots.

Q How far back would you begin that graph based upon the information that you have there in Exhibit C which appears to me to be the creatinine and BUN levels during the admission?

A I can do it as far back as you want because it's a graph.

Q I'd like, Doctor, for us to take a quick break and during that break, I would like you to draw a graph of what you believe the creatinine levels would have been and the BUN levels would have been from the time of the record that you have in front of you until the time that John Malone came

Starer

back to the hospital on January 19th.

A Okay.

(Whereupon, a recess was taken from 12:15 p.m. to 12:27 p.m.)

PERRY STARER, MD, called as a witness, having been previously sworn/affirmed, was examined and testified further:

BY MR. McKINNEY:

Q Doctor, during the break, you have prepared for me a graph of what you believe the creatinine levels would have been had lab draws been done between January the 10th and January the 19th; is that fair?

A Yes.

MR. McKINNEY: And for the record, we will mark that as Deposition Exhibit D.

(Graph was marked as Deposition Exhibit D for identification, as of this date.)

BY MR. McKINNEY:

Q Tell us, Doctor, just for the record, what it is that you have done there.

A I created a graph, as you asked me to, with two axes: One is creatinine and the other is

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time. Taking the variables that we already know the answers to, and that is the lab tests that we have for creatinine, I put them onto the graph. Then from the information that we have, I extrapolated what I believe is the trajectory of the lab values.

Q And you've created this graph, so I'm assuming that you believe with reasonable medical probability that had draws been done on the dates corresponding, that would have roughly been what the creatinine levels would have been; is that a fair statement?

A That's right. Since the creatinine levels were not actually drawn on those dates, based on my experience, more likely than not, they would have been very close to where I drew the lines.

Q Your graph begins at December 31st of 2008, and the creatinine level on that date was 1.0?

A That is true.

Q And if we extrapolate out to the 14th, it is 1.66?

A That's true.

Q So, therefore, there would be a rise over that 14-day or two-week period a little over --

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well, approximately two-thirds of a gram?

A Yes, you could say that, yes.

Q And it's your opinion that the rise is only secondary to antibiotics being given during that time frame, or are there other contributing factors from your perspective?

A I think to say it more accurately, based on my review of the entire case, that although there might be other contributing factors, it is the Bactrim that was the significant contributing factor.

Q So, therefore, you are making the assumption that in Dr. Malone's case the Bactrim had a greater nephrotoxic effect than the vancomycin that he had been taking back earlier in December of 2008?

A I would say based on my review of the records and based on the clinical condition that at that time the Bactrim is having the greater impact.

Q And just so that I'm clear, you are not prepared to testify in this case pharmacologically why that is the scenario with Dr. Malone?

A Well, there may be a pharmacological

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discussion in there, but I'm also basing it on his clinical conditions and the impressions of the other physicians who were caring for Dr. Malone at the time.

Q Would you agree, Doctor, that septic shock is something that can cause a patient's creatinine level to rise?

A Septic shock certainly can cause renal failure. Insofar as there is renal failure, there will be a rise in creatinine.

Q Do you have an opinion as to why it is on this graph that we have such a significant rise between the 14th and the 19th in comparison to the graph between December 31st and January 14th?

A Just to be clear, I don't have any values between the 14th and the 19th, so somewhere between there, there is a rise but because the labs were not checked, I can't tell you if it occurred on the 15th or the 16th, but the reason that there is a rise is that he is going into renal failure.

Q You will agree that, aside from a causation argument, from a medical doctor's

Starer

perspective, a creatinine level of 4.1 means that the patient is in renal failure?

A Well, there may be other reasons for creatinine levels to go up, but in this particular case, it means he is in renal failure.

Q What are other reasons why a creatinine level would rise?

A The creatinine level could rise if the gentleman had ingested something that has a lot of muscle material in it, if he is having breakdown of his own muscles, but that is not the case here.

Q Why?

A There is no evidence of it and, more likely than not, the reason his creatinine is going up is because of renal failure.

Q Can a patient suffering from pneumonia go into renal failure?

A Yes. In general, yes.

Q Are you saying, Doctor, just following up on your testimony here, that he could have continued on the same course up to, for example, the 17th or even the 18th before the significant rise in the creatinine level up to 4.1?

A There's a possibility that it may not

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have been 4.1 on as late as the 18th.

Q Based on your review in this case, based upon the evidence that you have available to you, based upon your knowledge, training and experience as an internist, is it your opinion that the rise in his creatinine level between the 14th and the 19th was as it appears on your graph, or do you believe that it continued on the same course it had been until a certain date at which time it then jumped to 4.1?

A Based upon my clinical experience, I can say that I cannot tell you with certainty if it jumped on the 18th or the 19th, but more likely than not, seeing what his clinical condition was, it probably went up to such an elevated level closer to the 19th than it did to the 14th.

Q So the reality is, with respect to a medical degree of certainty, that line likely continued on closer to the 19th as opposed to rising the way that it is currently drawn?

A More likely than not, it was elevated and it wasn't going down. As to when it actually went up, I can only extrapolate between the two points.

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Q Do you have any evidence as to his clinical condition changing between the 14th and the 19th?

A The evidence I have is that on the 15th of January he was still hemodynamically stable. He was seen by a visiting nurse. He wasn't hypotensive and he wasn't febrile. I do know on the 19th, he was seen by Dr. Rubin at which time he was sick. There is no information that I have available right now for the intervening days.

Q So we can agree then at least with respect to the 15th that his creatinine level is probably closer to what it was on the 14th?

MR. MEYERS: Form and foundation.

A Oh, yes.

Q And if his condition continued, if he was continually hemodynamically stable until the 19th, then that significant rise likely did not occur at least with a reasonable degree of medical certainty until the 19th; is that fair?

MR. MEYERS: Form and foundation.

A Well, the way I actually do the graph, on the 18th, the creatinine is still 2.5 or less, so it doesn't really go up on my graph until the

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last day.

Q So you believe with a reasonable degree of medical certainty that the graph that you have drawn as Deposition Exhibit D is most likely the course that the creatinine levels took during the time that we're discussing?

MR. MEYERS: Form and foundation.

A Yes, based on the information that we have and based on my clinical experience, this is the closest I think I can give you.

Q Have you heard of something, Doctor, that is referred to as creatinine clearance?

A Yes.

Q What does that mean?

A The idea of creatinine clearance is to measure kidney function based upon how it is able to filter out certain entities.

So the idea of creatinine as it pertains to kidney function is, this is a material which the kidney is supposed to clear from the body. If it doesn't function well, then the creatinine will accumulate and this is why the creatinine level is elevated.

So if there is a decreased creatinine

Starer

clearance, there will be an increased serum creatinine.

Q Would you agree that relying on BUN and creatinine levels are actually more reliable than relying on creatinine clearance levels?

A I think you have to look at the full picture and you can use the creatinine and the BUN and then do a calculation of creatinine clearance.

I think in this case they were using GFR or glomerular filtration rate. I would look at them in combination. I would also look at the trends.

Q Based upon your review of this record, do you believe that the BUN and GFR would follow a similar course to the graph that you prepared as Deposition Exhibit D reflecting creatinine levels?

A The BUN does go up, but it probably will not follow as closely here. If we were to track the GFR, it probably would be similar, but be going in a different direction.

Q But it would be interpreted the same?

A Yes. They're consistent with each other.

Q Is it your opinion, Doctor, more

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likely than not, that something in John Malone's condition changed on the 18th or 19th, resulting in the condition with which he presented on the 19th to the hospital?

MR. MEYERS: Form.

A Well, in general, I'd say something is changing. Something's getting worse.

Q What would be explanations for why the kidney function would take a much more drastic route here resulting in a significantly more elevated creatinine level as opposed to continuing on the course that it was on as created on that graph?

MR. MEYERS: Form and foundation.

A A couple of explanations. You want explanations?

Q Yes, please. Thank you.

A An explanation, and we may find there is going to be a combination, is one, the continued exposure to a nephrotoxic agent finally overwhelms the burdened organ and it can no longer function well. So say like, in simple language, the kidney is struggling for days and then gives up.

Now, this can also be explained by an infection superimposed on top of an impaired kidney

Starer

further burdening Mr. Malone's organ system and this is probably more likely than not what is happening here.

You have a nephrotoxic agent which is not discontinued and on top of that, he has a source of infection and this combination of events leads to a downward spiral.

Q Any evidence of any other contributing factor as it relates to John Malone specifically?

A There may be other conditions, but none that would explain this acute change in condition as well as what I've just mentioned.

Q Would you agree that a patient who has cirrhosis of the liver would be at increased risk for this scenario?

A A patient who has cirrhosis of the liver would, but without a sudden decline in liver function, I wouldn't expect to see this change in renal failure that we have here.

Q Physiologically, how would cirrhosis of the liver or what role would cirrhosis of the liver play in this scenario?

MR. MEYERS: Form.

A If it does at all, we would have to

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postulate that somehow the liver is shutting down, you know, which is setting off a cascade of events, but I don't think that is happening. Or perhaps due to portal hypertension, the patient starts bleeding, dropping the volume which impacts upon the kidney, but this is not happening here either.

Q What do you base that opinion on, Doctor, when you say "this is not happening here either"? We do have evidence of portal hypertension; isn't that true?

A Well, we don't have evidence of portal hypertension as far as him having bleeding esophageal varices, so if he even has portal hypertension, it's not suddenly manifesting itself on January 18th or January 19th of 2009. There's a better explanation as to what is happening here.

Q Let me ask you this, Doctor: Can we agree that platelets are affected by portal hypertension and/or cirrhosis?

A We can agree that low platelets, thrombocytopenia, can occur in a patient with a portal hypertension, yes.

Q And John Malone had thrombocytopenia

Starer

when he presented back to the hospital on January 19th; isn't that true?

A Yes, he had it for a while.

Q Do you have an explanation for low platelets other than either portal hypertension, cirrhosis, or a combination of those two?

A No. My understanding of the low platelets is that it had existed for a while and was secondary to splenomegaly. There is a possibility that Bactrim may have contributed to the thrombocytopenia as well.

MR. MEYERS: Form and foundation to the last.

Q We can agree, Doctor, that the most likely scenario to the low platelet count would be secondary to portal hypertension and/or cirrhosis?

A Yes, if it's a chronic condition that would be the best explanation.

Q You saw the autopsy report? I think you testified to that earlier.

A Yes, I did.

Q You saw the spleen was 610 grams? While you look for it, if it were 610 grams, you would agree that is severely

Starer

congested?

A I would agree that it is enlarged, yes.

Q Can we agree that a normal spleen is approximately 155 grams?

A I would agree that it is an enlarged spleen, yes.

Q It's severely enlarged; isn't it, Doctor?

A Yes, yes.

Q You would agree that a severely enlarged spleen in a patient with a history of alcohol use, the most likely explanation for that would be cirrhosis?

A In a patient who has cirrhosis, yes.

Q Is it your testimony that you do not believe, with a reasonable degree of certainty, that John Malone had cirrhosis?

A No. I was just answering the previous question where you said the patient drinks alcohol. You didn't say that they had cirrhosis.

Q Can we agree that John Malone most likely had cirrhosis?

A Yes.

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Q Let me circle back for one second, Doctor, and then we will continue on this course. With respect to that criticism of Dr. Turlo, can we agree that if the facts bear out that Dr. Saker did not speak with Dr. Turlo with respect to the patient's lab results, that the standard of care would then not have required Dr. Turlo to be involved in the discharge planning with respect to blood draws on creatinine and BUN?

MR. MEYERS: Form.

A Not necessarily.

Q My understanding of your prior testimony, and I may be wrong, was that you were told that Dr. Saker said in his deposition that he told Dr. Turlo, "We're discharging Dr. Malone. Here are his lab results," and based upon that communication between Dr. Saker and Dr. Turlo, Dr. Turlo then was required under the standard of care to ensure that creatinine and BUN at a minimum were followed on an every-other-day basis?

A Yes, if he was told that the patient was being discharged, yes.

Q My question, my follow-up to you is: You've added that to your affidavit based upon

Starer

representations from Dr. Saker's deposition?

A That is correct.

Q If Dr. Saker did not communicate that information to Dr. Turlo, then you would agree that would no longer be a criticism of yours with respect to Dr. Turlo?

A Specifically, as it applies to repeating the lab test within two days of discharge.

Q That's right.

A Yes.

Q Okay. Did you see anything in Dr. Turlo's deposition that would suggest to you that he was armed with specific information relative to this patient as of January the 9th that you believe would have required him under the standard of care to be involved in the discharge planning on BUN and creatinine level draws?

A I don't see anything specifically referring to January the 9th.

Q So there was nothing in Dr. Turlo's deposition that changed your opinions with respect to your original thoughts on his breaches of the standard of care?

A As put forth in my affidavit, that's

Starer

correct.

Q So based upon direct evidence that you, yourself, have reviewed in this case as of the start of the deposition today, aside from any information you have been provided by plaintiff's counsel, your position with respect to Dr. Turlo's alleged breaches of the standard of care continue to be limited to paragraph 13, subparagraphs A and B of your affidavit?

MR. MEYERS: Form.

A And paragraph 14, too.

Q Well, essentially paragraphs 13, 14, and 15 all sort of work in conjunction with one another; isn't it true?

A That is true.

Q Have we talked, Doctor, about the opinion you have with respect to Dr. Turlo assuming that he was told by Dr. Saker about the creatinine and BUN levels at the time of discharge?

A I'm not sure I understand that. My criticisms?

Q Well, we haven't gotten into the other two specifically yet. We can agree that when you walked into the deposition here today, you felt that

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Dr. Turlo had breached the standard of care in three ways, two of which are codified in your affidavit and one of which was based upon information that you were provided relative to what Dr. Saker allegedly said in his deposition about contacting Dr. Turlo and discussing the labs; is that fair?

A Yes.

Q That latter criticism, that was a new criticism, have we talked about that, or is there anything else that you would like to add to that that we have not yet talked about?

A No, I believe we have covered it in general.

Q Let's talk about paragraphs 13, 14, and 15 in your affidavit.

A Uh-hum.

Q First of all, you saw Dr. Turlo's deposition testimony with regard to questions Mr. Meyers asked him relative to the care and treatment provided to Dr. Malone; isn't that true?

A That is true.

Q You saw that Dr. Turlo testified that he did not ever see that lab result at least until after John Malone came back to Harper Hospital on

Starer

January 19?

A I'm not sure if he said it that way or he wasn't certain whether he had seen it or not.

Q Let me ask you this way: If Dr. Turlo never saw that document until after John Malone came back on January 19th, we can agree that Dr. Turlo had no information available to him with which to do anything relative to Dr. Malone?

MR. MEYERS: Form.

A Well, he wouldn't have had any information as it pertains to laboratory studies, that's true.

Q Your affidavit says, "Upon receipt of the laboratory report dated January 15, 2009, Dr. Turlo was required to contact Dr. Malone and instruct him to immediately present to the hospital for admission."

An inherent assumption in that paragraph is that Dr. Turlo had that lab result at some point. That's fair?

A That is true.

Q When you generate this criticism of Dr. Turlo and suggest that he breached the standard of care, when are you assuming that he saw that lab

Starer

result?

A Dr. Turlo should have seen the lab result on January 15th when it was available.

Q Now, you understand that lab result was prepared at a facility other than the facility where Dr. Turlo was working?

A I understand it was prepared in a laboratory.

Q At a different healthcare facility completely from the one within which this patient was being seen?

A That's okay. That happens.

Q We can agree that you have not seen any evidence that suggests that Dr. Turlo knew that there was a lab draw being done on the 14th?

MR. MEYERS: Form.

A I think he, in his deposition, page 79 he is asked a question "When you took it upon yourself to order the labs, did you have an expectation it was going to fall on your shoulder this obligation to monitor Dr. Malone's status?" He answered "yes," so based on that, it seems he ordered the laboratory tests.

Q My question is a little bit different

Starer

than that.

Did Dr. Turlo know based on evidence that you reviewed that labs were being drawn on January the 14th?

A My understanding is that he ordered the labs. Whether he knew whether they were actually drawn or not, I can't say, but more likely than not, if a doctor orders the labs to be drawn, he would understand that they are going to be drawn.

Q But, again, my question is more specific than that.

We can agree that you have not seen any evidence in this case that says to you, Dr. Starer, that Dr. Turlo knew that labs were being drawn on Dr. Malone on January 14, 2009?

A Well, based upon Dr. Turlo's deposition, there seems to be a lot of stuff that he doesn't know.

Q Was Dr. Turlo involved in the admission from December 21st of 2008 through January 9th of 2009 as far as you can tell from the records?

A As far as the records, I can tell he is listed as the primary-care physician. According

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to his deposition, he wasn't involved in the care in the hospital aside from what he describes as social visits.

Q So he was not involved as far as you can tell in any of the management decisions that were made relative to this patient?

A As far as I can tell, he was not.

Q Have you seen any paperwork that would tell you that Dr. Turlo ordered these lab draws?

A Aside from the lab itself where he is listed as the physician, I do not see any other paperwork.

Q It's not uncommon for the patient's primary-care physician to receive a courtesy copy of labs or other diagnostic testing relative to their specific patient; is that true?

A Although that is not uncommon, in this particular case, Dr. Turlo is the only physician's name on the final report of the lab results. There is no indication that anyone else was involved in obtaining this study.

Q So how is it that Dr. Turlo would become involved in obtaining that study if you have not seen any evidence that he was involved in the

Starer

care and treatment during the admission at issue? Are you making certain assumptions in this case?

A No, this is actually obtained -- it's collected on January 14th, 2009. This is after the hospitalization. This is when the patient is -- when the patient, Dr. Malone, is an outpatient.

Q We can agree that likely what happened is that the visiting nurses went to his home, they were treating him, and as part of their protocol for that particular day, they drew lab tests?

A In order to agree with that, that means that the visiting nurses were providing care under the supervision of Dr. Turlo.

Q Why do you assume that they were providing care under his supervision?

A Because the visiting nurse needs to be directed by a physician, needs to collaborate with a physician, and Dr. Turlo's name is the only name which appears on this laboratory report.

Q In your experience, should any additional names be contained on that lab report?

A The name of the physician who submits the request needs to be on the report. Additional names could be put on there if you want to send

Starer

courtesy copies, but the only name on this report is Dr. Turlo's.

Q So are you saying that in your experience typically the only name that appears on an outpatient lab report is the physician who specifically orders that lab?

A I'll say the main name is because, one, the lab has to be ordered by a physician; two, there is a billing aspect, and other names could be put on if you want to send copies, but the submitting physician is listed as Dr. Turlo, and they actually list his physician -- his doctor's code on here as well. There is no other doctor's name or identifying doctors here.

Q And what lab was that blood tested at?

A St. John Clinical Pathology Laboratories.

Q Do you have any idea as to whether or not Dr. Turlo has any affiliation with St. John Clinical Laboratories?

A I don't know whether a doctor is affiliated with a laboratory or is just contracting out. I can't tell you what his relationship is aside from it seems, in this particular case, that

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that is the lab that he is using to obtain laboratory tests for his patient.

Q Now, based upon your affidavit -- and I'm assuming that your testimony today is consistent -- Dr. Turlo was required to contact Dr. Malone and instruct him to immediately present to the hospital for admission. Based on what?

A Based on the fact that Mr. Malone is at risk for renal problems and based on the fact that we have evidence of renal problems and that this needs to be addressed in a timely fashion before it gets worse.

Q It's your position that a creatinine level of 1.66 in light of the fact that the patient's discharging creatinine level was 1.4 requires under the standard of care that the patient come back to the hospital immediately for readmission?

A Either that or that the patient is evaluated by a doctor in another setting.

Q Based on your experience, Doctor, what is a reasonable turnaround time for a lab result that is drawn on the 14th and a report is generated on the 15th to make its way to the

Starer

ordering physician?

MR. MEYERS: Form.

A Well, it's very general, lab studies turnaround times, but in a case like this where you have a patient who is at risk of serious consequences, the results should be reviewed as soon as they become available.

Q The standard of care required that it be obtained by that physician, for example, within one to two business days based upon lab mail turnaround?

A No, no. This shouldn't be put in the mail.

Q Would the standard of care have been met had this information been made available to Dr. Turlo on January 16th and he called Dr. Malone on that date?

A No. The standard of care required that when the results became available the doctor should be made aware of the results. Two days would have already passed between when the labs were drawn and when the doctor had the results.

Q I didn't quite understand your last answer. Does that mean by the 16th, it would have

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been reasonable time for the doctor to have been notified?

A I'm sorry. I wasn't clear.

If the test was drawn on the 14th and the results are available on the 15th, by waiting for the 16th, the results were already two days old and that that's not acceptable.

Q So it's your testimony, based upon your knowledge and training and experience, that the lab should have notified Dr. Turlo on the 15th of these lab results?

MR. MEYERS: Form.

A Well, I think Dr. Turlo, based on my experience and the standard of care, Dr. Turlo should have established a relationship by which he would be able to get these results.

Now, whether he sets up a system in which the lab is going to call him, fax him, he is going to have somebody from his office pick it up or call them, that is up to Dr. Turlo how he is going to manage his practice.

Q Again, you are making certain assumptions here that Dr. Turlo was the actual ordering physician for these labs; is that true?

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A I see no evidence of any other ordering physician.

Q I understand that is your position, but my question is a little different.

You are making an assumption here based upon the evidence you reviewed that Dr. Turlo was the ordering physician for these labs?

A Yes, under that scenario, the assumption is that Dr. Turlo ordered the labs.

Q If another physician were the ordering physician for these labs and Dr. Turlo's name was provided as the patient's primary-care physician, would your position change with respect to what the standard of care required of Dr. Turlo?

MR. MEYERS: Form.

A If Dr. Turlo is not ordering the labs, has no idea that the labs exist, is not taking care of Dr. Malone, has no knowledge that Dr. Malone was discharged from the hospital, then it would be difficult to criticize Dr. Turlo.

Q Now we know in this case that Dr. Turlo has testified that he knew that John Malone was in the hospital between December 21st and January 9th?

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A Yes.

Q And we know that he testified that he went and made some social stops in Dr. Malone's hospital room?

A Yes.

Q Let's assume, hypothetically, Doctor, that Dr. Turlo knew that the patient was being discharged on the 9th, but he was not the ordering physician for these labs, nor did he know that the labs were being drawn on the 14th, or any other day for that matter, would you agree that he would not be the one that would have breached the standard of care with respect to follow-up of these lab results?

MR. MEYERS: Form.

A If he knew that Dr. Malone was being discharged on the 9th and Dr. Turlo knew that he would be the primary-care doctor, then he would also know that Dr. Malone was to have laboratory studies done once a week.

Q I understand that, but would that mean he would have breached the standard of care if he did not know what that one day a week was, nor did he have lab results available in his hand?

Starer

MR. MEYERS: Form.

A If he's the -- if he knows that the patient to whom he is going to be providing care for is being discharged, then he knows that week something needs to be done, either he is going to order it or someone else ordered it for him, but he would have to at least make that inquiry: "Did somebody else order the tests? Or should I order?" At worst, he may have ended up duplicating the lab test.

Q Now we know there was a communication between Dr. Malone and Dr. Turlo after Dr. Malone went home?

A Yes.

Q There was at least one phone call between the two?

A Yes.

Q What was the reason for that phone call as far as you understand it?

A According to the deposition of Dr. Turlo, a letter needed to be written for Dr. Malone to excuse him from an appointment of some kind.

Q It wasn't just an appointment, was it,

Starer

Doctor? It was an actual court appearance; isn't that true?

A I don't remember the exact nature of it, but he may have had an appointment or scheduled appearance somewhere.

Q What is your understanding as to the reason for that appointment?

A I don't have enough detail to give you an answer.

Q You recall reading the letter that Dr. Turlo prepared on Dr. Malone's behalf that was dated January 10th of 2009?

A Actually, I don't recall the details of it.

Q Have you reviewed at some point a letter that Dr. Turlo prepared on Dr. Malone's behalf?

A I might have, but I didn't take notes on it.

Q I will show you this. It's a three-page document and it specifically indicates within that letter that Dr. Malone will not be able to make any court appointments until his recovery is complete.

Starer

Do you recall reading that?

A I recall something about an appointment.

(Perusing.) Yes, this looks familiar.

Q That refreshes your recollection as to Dr. Turlo preparing that letter on Dr. Malone's behalf?

A Yes, it does.

Q Any idea what court appointment that Dr. Malone was missing because of his condition?

A I can't say with certainty, no.

Q Do you have any information at all available to you that would allow you to make an educated assumption as to what that was for?

A Not based upon this letter.

Q How about based on any information you reviewed in this case?

A I think there might have been a discussion of it in the deposition, but I didn't take notes on the actual specifics. I would have to review the deposition again.

Q Is it your understanding that he may have had a DUI somewhere in the state and needed to appear in court on behalf of that specific issue and

Starer

this letter was being written for him to excuse him from that appointment?

A It doesn't say that specifically in the letter, but that might have been the case.

Q That's the only other evidence that you have seen in the case that would suggest what I indicated to you just now, right?

A Yeah, I really don't know much about that aspect.

Q Hypothetically, if Dr. Malone had received a DUI within a recent period of time leading up to this letter, you would agree that he obviously must have been continuing to drink up to that point in time?

A I don't really know what happened.

Q That's a terrible question.

MR. MEYERS: It sounds like Judge Judy.

Q Based upon your experience, Doctor, an individual doesn't receive a DUI unless they have been drinking alcohol; is that fair?

A I don't have experience with that, so I don't know what happens.

Q But this letter does refresh your

Starer

recollection as to the fact that this letter was written by Dr. Turlo dated January 10, 2009, sent to Robert Whims indicating that Dr. Malone would not be able to make any court appointments?

A That sounds right.

Q Other than that, you have no additional information with respect to this specific issue?

A I don't really know what happened there.

Q Tell me, Doctor, what your understanding is of the conversation between Dr. Malone and Dr. Turlo on January -- or around January 10, when Dr. Malone called Dr. Turlo and asked that he author this letter for him?

A All I really know is that a request was made for a letter and the letter was written. I don't know much more about the conversation.

Q During Dr. Turlo's deposition he did talk about additional things that were discussed with Dr. Malone at that time; isn't that true?

A There might have been some things which were discussed. I just don't recall.

Q Including when Dr. Malone was going to

Starer

follow up with him?

A I don't remember the details as to when it was, but I think there might have been a discussion about having a follow-up appointment on the 21st of January.

Q All things being equal, we can agree that that would have been a reasonable follow-up time for a patient being discharged from the hospital.

MR. MEYERS: Form and foundation.

A Well, in general, it is reasonable.

Q Now, you indicated the alternatives on January 15th -- assuming Dr. Turlo was contacted by the lab with respect to the creatinine level, the options available to Dr. Turlo at that time had he received that information on that date were to either have the patient re-present to the hospital or be followed up by a physician?

A That is true.

Q Follow up with a physician would have been at what point following January 15th?

A Well, it would have been the same day.

Q And what exactly would the standard of care have required of that physician at that

Starer

appointment?

A At that appointment, if it took place, the physician would examine Dr. Malone, would ask questions, and possibly order additional tests.

Q Assuming, for the sake of argument, January 15th was a Friday. Would it have been reasonable for a call to have been made to Dr. Malone asking him to follow up on with a physician on Monday morning?

A No.

Q The standard of care would have required, based upon your position, that Dr. Turlo tell the patient to either go to the hospital that day or come to his office that day or go see another physician that day?

A Right.

Q We can agree that it is not within Dr. Turlo's control as to whether or not Dr. Malone would have actually taken that advice, fair?

A We can agree to that.

Q If Dr. Malone was provided with that information and he chose not to follow up at a physician's office or re-present back to the hospital that no longer would then fall on Dr. Turlo

Starer

as being an alleged breach of the standard of care; we can agree with that?

A If the information was communicated properly to Dr. Malone in a way that Dr. Malone was able to understand it and then he still refused to, I guess, comply with the recommendation and understood the consequences, then we cannot blame Dr. Turlo.

Q Any other breaches of the standard of care that you believe Dr. Turlo was responsible for with respect to his involvement in Dr. Malone's care?

A No. Just in general what we spoke about.

Q Do you have an opinion, Doctor, as to whether antibiotic therapy was going to be successful in eradicating the bacteria from Dr. Malone; thereby, avoiding the necessity for an amputation?

A Yes, if implemented early enough, an amputation, more likely than not, could have been avoided.

Q Now, when you say "early enough," do you mean earlier than December 21 or 22?

Starer

A Earlier than -- oh, December. I thought you were talking about the January.

Q I'm talking in general. My question is really a general question.

It is your opinion that amputation could have been avoided with respect to Dr. Malone?

A If we are going back to December, he was on antibiotics and didn't have an amputation, so it was avoided then, and then later on I believe that it could have been avoided.

Q Would the antibiotic regimen have changed in your opinion, or do you believe just continual antibiotic therapy would have ultimately conquered, for lack of a better word, this bacteria, therefore, avoiding the necessity of amputating that toe?

A It may have been a combination of things. Since it wasn't done, we have to say more likely than not antibiotics plus a drainage procedure would have avoided an amputation.

Q That is exactly what he received during his time at Harper Hospital was antibiotic therapy and drainage procedures by Dr. Till; isn't that true?

Starer

A During the December admission.

Q December through January 9th?

A Yes.

Q We can agree that did not successfully completely eradicate the bacteria?

A Well, whether it eradicated and it recurred or it persisted, we can agree that Dr. Malone still had problems.

Q Dr. Malone still had an ongoing infection when he went home on January 9th; didn't he?

A That is true.

Q You are not a podiatrist nor are you an orthopedic surgeon? That's fair?

A That is a fair statement.

Q I would assume that you did not consider yourself an expert with respect to whether amputation is a necessary option for someone like Dr. Malone?

A I would say that I have certainly participated in these decisions. However, I do not perform amputations.

Q With respect to the type of bacteria that was growing in Dr. Malone's toe, was that

Starer

bacteria that, in your opinion, could have eradicated with appropriate antibiotic therapy?

A It may have required some assistance of a surgical procedure of some kind.

Q Can we agree that based upon the evidence that you have reviewed to date Dr. Malone did not want an amputation?

MR. MEYERS: Form and foundation.

A I don't know with certainty whether he wanted one or not.

Q I'm asking you based on the evidence that you have reviewed in the case to this point, do you have an opinion one way or the other.

A I can't say at which point he would have agreed or disagreed. I can't say with certainty.

Q Can we agree that if he would have had an amputation, that would have impacted his ability to be a surgeon?

A It may or may not have depending on the rehabilitation process.

Q How long would that have taken for a man of Dr. Malone's age and body habitus?

A It could take a few months, but it can

Starer

be done.

Q Are you going to be rendering opinions in this case, Doctor, as to whether or not John Malone was going to require an amputation with a reasonable degree of certainty?

A I'm not expecting to offer such an opinion. I can't really say.

Q You would defer to the other specialists with respect to that specific issue?

A At this particular point, I'm not expecting to render such an opinion.

Q We can agree that an amputation would have likely affected his ability to be a surgeon in some way?

A It probably would have changed how he practiced surgery, but it probably would not have ended his practice as a surgeon.

Q We can agree that during your professional career as an attending physician, you have not practiced as a surgeon?

A We can agree to that.

Q Would you defer to surgeons, individuals who have actually done surgeries, with respect to whether or not an amputated toe would

Starer

have impacted an ability to do surgery, particularly gynecologic surgery?

A I would say the best person to make that -- to render that opinion would be the surgeon who has the amputation themselves. I don't know how somebody else can speak on behalf of somebody as far as the way they choose to practice being a surgeon.

Q Do you have any other opinions or criticisms with respect to the care and treatment provided to John Malone that we have not yet talked about?

A I think we have covered it in general.

Q You are not going to be commenting upon the discharge of this patient with respect to the hospitalist or the infectious disease physician? You are leaving that to other specialists?

A Yes, I'm not expected to give any opinions on that.

MR. MEYERS: Form of the last question.

MR. McKINNEY: It's too late.

MR. MEYERS: Hospitalist.

MR. McKINNEY: Just kidding.

Q It's my understanding that you have

Starer

opinions with respect to the cause of John Malone's death?

A Yes.

Q What is your opinion as to the cause of his death?

A The cause of his death was septic shock and secondary to renal failure, secondary to injury to the kidney from medication.

MR. MEYERS: Cullen, I did indicate that I was going to provide him with a copy of the most recent factual deposition taken, so ...

MR. McKINNEY: Off the record for a minute.

(Discussion off the record.)

MR. McKINNEY: Back on the record.

BY MR. McKINNEY:

Q Doctor, we can agree that pneumonia could cause renal failure which then could have been a contributing factor and/or a direct cause of the patient developing septic shock and death?

A Pneumonia can lead to sepsis and septic shock and death, yes.

Q You have heard of something called

Starer

aspiration pneumonia?

A I have.

Q Hypothetically, Doctor, for the sake of argument, if Dr. Malone had aspirated something, that could have contributed or caused pneumonia, renal failure, septic shock, and death?

A Hypothetically, it could occur.

Q Based upon the fact scenario that you have seen here, if there was evidence that there was something like that that occurred at home with respect to Dr. Malone, he would have presented with the same presenting signs and symptoms on January 19th as he did in this case?

MR. MEYERS: Form.

A Well, some of the signs and symptoms.

Q What would not have been present had that occurred?

A He presented with lower extremity edema.

Q What is that related to?

A That may be more related to the kidneys.

Q But we agreed that pneumonia could cause renal failure which would then result in lower

Starer

extremity edema; isn't that true?

A Well, it's a different sequence of events. That's hypothetical.

Q Based upon your review of this case, Dr. Starer, what were John Malone's comorbidities as of January 2009?

A He had high blood pressure. He had hepatitis C. He had gouty arthritis.

Q Cirrhosis?

A I'm sorry. Cirrhosis of the liver.

Q Anything else that you are aware of?

A Those are the ones that I remember.

Q You would agree that each of those contributing to a decrease in the patient's life expectancy would be dependent in part on the length of time that he suffered from each of them?

A They are -- if they are uncontrolled, some of them may contribute. I'm not sure if gouty arthritis is going to have much of an impact on life expectancy.

Q Even if high blood pressure, hep C or cirrhosis are controlled, they still will contribute to a decrease in life expectancy. Do you agree with that?

Starer

A Yes, there will be some impact.

Q What is your opinion with respect to John Malone's life expectancy?

A More likely than not, based upon my experience, the patients in a similar condition, he would have lived at least another 20 years.

Q How old was he at the time he died?

A He was around 57.

Q What is normal life expectancy for someone such as John Malone with no comorbidities?

A He might make it into the eighties.

Q So it's your testimony that his comorbidities only decreased his life expectancy by three to five years?

A Approximately five years, yeah.

Q If John Malone continued to drink, thereby, contributing to the cirrhosis, would that have further diminished his life expectancy?

A If he continued to drink alcohol, then it would have had an detrimental impact on his life expectancy.

Q Do you have any evidence, one way or the other, as to whether or not he was continuing to drink alcohol?

Starer

A The only evidence I have is based on the records which said that he had quit drinking alcohol.

Q But we can agree if he had a DUI within a short period of time leading up to January of 2009, that piece of information would at least be evidence of the fact that he had drank on that day?

MR. MEYERS: Form and foundation.

A I don't know. All you are telling me is he received a summons. I don't know what the outcome of the investigation was.

Q Let me ask you this, Dr. Starer: When you serve as an expert witness in a medical malpractice case you take that role seriously?

A Yes.

Q You want to have all the information available to you so that you can give reasonable and prudent answers to questions that are then going to be codified in a transcript?

A Absolutely.

Q Whether or not this man was continuing to drink and whether or not that would have further contributed to his life expectancy is certainly important information to your opinions as to life

Starer

expectancy here?

A That is true.

Q Isn't that information that you would want to have available to you when you are testifying as an expert against other physicians?

A The information I had was in the records of physicians who were taking care of him and they were saying he was not drinking. I have no other evidence that he was drinking.

Q It's not your role here to be an advocate on behalf of one party or the other; is that true?

A No, I'm here just to present the facts.

Q So if there is other evidence available that would contribute to your opinions with respect to decreased life expectancy, you would certainly take those into consideration and adjust your opinion with respect to the decrease of life expectancy here?

A If there was other information, I would gladly review it.

Q Any other opinions, Doctor, that you have -- at least that you have been asked to give

Starer

that we have not talked about?

A I think, in general, we have covered my opinions.

Q Anything else from your perspective that needs to be expounded upon further?

A I can't think of anything right now. All I would do is just present additional information which would bolster my opinions.

Q Based on the notes that you have in front of you?

A Based on some of the notes that I have in front of me.

Q So that information can be gleaned from that exhibit?

A I would hope so.

Q Anything that we haven't talked about and/or isn't codified in the 11 pages of notes that we have marked as an exhibit to this deposition?

A I don't believe.

Q Have you ever been named as a defendant in a medical malpractice claim?

A Not that I'm aware of.

Q Have you ever had your license curtailed, suspended, or revoked in any way?

Starer

A No.

Q Have you ever had your medical license reviewed by a medical licensing review board?

A No, not that I'm aware of.

Q Have you ever had any disciplinary action taken against you by a hospital or healthcare facility?

A No.

Q How many open expert review files do you have currently?

A I'm not sure. Maybe about seven, eight.

Q On average over the last ten years, how many new cases have you taken on per year?

A It's very variable.

Q Your testimony earlier I believe was that you reviewed about 70 cases within the last 14 years?

A That's my estimate, yes.

Q Does that mean, on average, you review about five cases a year?

A Yes. Some years less and some years more, and it gets carried over, so I'm really estimating.

Starer

Q Do you know what percentage of your income from last year was generated from medical-legal reviews?

A I think 20 percent or less.

Q Has that been consistent the last five years or so?

A Again, that's very variable, but it doesn't seem to go above 20 percent.

Q When you say 20 percent or less, does that mean 18 to 20, 18 to 22, somewhere in that range? I guess you said or less. Let me strike that.

When you say 20 percent or less, does that mean anywhere between 18 and 20 percent?

A I would say between 15 and 20 percent.

Q What do you charge to review malpractice claims?

A About $200 an hour.

Q How about for depositions?

A The same.

Q And trial?

A The same.

Q And if you were, for example, in this case to travel to Michigan, how you would you bill

Starer

that?

A If during the time I'm traveling I'm preparing for the case by reading, I would charge $200 an hour. If I am sleeping or watching a movie, I will not charge for that.

Q Are there flat rates for depositions or trial?

A No flat rate.

Q How much time have you spent reviewing this case?

A About seven hours.

Q That is total leading up to the start of the deposition here?

A Probably seven-and-a-half hours.

Q Have you billed Mr. Meyers or his firm for review time to this point?

A I have not.

Q Do you request a retainer when you are sent initial medical records?

A No, not always.

Q Did you in this case?

A No, I have not.

Q Have you been paid anything as of yet?

A I don't think I have.

Starer

MR. McKINNEY: That is all I have, Doctor. Thank you.

MR. MEYERS: I have a few follow-up questions.

EXAMINATION

BY MR. MEYERS:

Q There were a lot of, what I would characterize as, overlapping hypotheticals and I would like to ask a few questions to see if we can clarify that for a moment.

The first hypothetical is this: If, in fact, Dr. Saker is wrong, for lack of a better word -- that is, that he never contacted Turlo and told Turlo that John Malone was being discharged and that it was, in fact, Saker's opinion or, excuse me, position that Turlo would follow him as a primary-care physician; in other words, Turlo has no information that he has a responsibility to follow Malone on an outpatient basis, do you have any criticism of Dr. Turlo?

A If Dr. Turlo is not aware that he is supposed to follow the patient?

Q Right.

A And he doesn't know that the patient

Starer

has been discharged from the hospital, then it would be difficult to criticize Dr. Turlo.

Q Sure. Now, you indicated earlier on that you felt it was the responsibility of the primary-care physician following Dr. Malone to order these labs every other day beginning on the 10th and, I guess more accurately, to assess those labs as they were reported to make a determination as to whether or not they would have been required to be obtained every other day or not. Is that a fair characterization?

A Yes.

Q So if Turlo knew through his discussion with Dr. Saker that Malone was being discharged, Turlo would have had a responsibility to order the labs on the 10th?

A Yes.

Q And he would have had a responsibility to communicate to the laboratory that he wanted the results reported to him as soon as they became available?

A Yes.

Q So knowing what we know about -- or knowing what we believe we know about the

Starer

progression of this kidney failure between the 10th and the 14th, if Turlo had ordered the labs on the 10th, he would have known that the creatinine would have continued to have been elevated; is that correct?

A That is correct.

Q And he certainly would have known on the 14th of the elevation that was ultimately reported out on the 15th, correct?

A That is correct.

Q Now, when you say that Dr. Malone would have been directed to go to an emergency room, if that is consistent with what Dr. Crane testified to, the infectious disease expert in this case, would you agree with Dr. Crane as you hypothecated in your affidavit of merit that the most likely scenario is that Dr. Malone would have been directed to go to the emergency room?

A That's what happens in most of these cases.

Q The other alternative would be for Dr. Turlo to say, "Come on into the office. I want to examine you immediately in the office"?

A Yes.

Starer

Q That day?

A Yes, that's another way to do it.

Q And the third option, although it sounds like the least likely option, would be to direct Dr. Malone to see someone other doctor? I assume an internal medicine doctor of some kind?

A Someone equivalent, yes.

Q That doctor that would have seen Malone, let's assume that he wasn't being seen in the emergency room setting, that he is -- excuse me. Let's assume that he is seen in an emergency room setting, that doctor would have been aware of the laboratory results, obviously?

A Yes.

Q Would have been aware that the patient was on Bactrim?

A Yes.

Q Would have been aware that the patient had earlier had a medication-related product with an antibiotic?

A Yes.

Q And, in all probability, would have consulted with an infectious disease doctor at that time?

Starer

A Yes.

MR. McKINNEY: Let me object to form and foundation.

Q Would it be your expectation that the reasonably prudent internist or internal medicine physician with a subspecialty in geriatrics would want to examine the foot to see how the foot was doing?

A Yes.

Q Do you have an opinion as to whether the Bactrim would have been discontinued on or prior to the 15th had this hypothetical series of events occurred? Would the Bactrim have been discontinued?

A With the information that the doctor had available, more likely than not, the Bactrim would have been discontinued.

Q Now, counsel asked you a question about -- in the predicate, and I objected to the form of it, but it was something to the effect, well look, if Dr. Turlo never saw these results, that is the results from the 14th, did he have any obligation to act upon the results. And I think what you have indicated is, well, yes, he would have had an obligation. He would have had an obligation

Starer

to tell the lab he wanted the report, the results faxed over to him or reported to him as soon as they became available. Is that accurate?

A Yes.

Q By the way, if the lab sent the results to Dr. Turlo and someone in his staff failed to provide them to Dr. Turlo, that wouldn't absolve Dr. Turlo of any responsibility in this case, would it?

MR. McKINNEY: Object to form and foundation.

A If we are talking about his staff, no, it wouldn't absolve him.

Q This business about the curve that you have drawn here, counsel has suggested that the kidney failure may have been related to the underlying infectious process that was occurring and perhaps even pneumonia. Do you recall those questions being asked?

A Yes.

Q When pneumonia causes renal failure, is it in a setting of patients who experience a condition known as septic shock resulting in a perfusion abnormality to the other organs?

Starer

A There is a cascade. The pneumonia is infection which leads to sepsis which leads to septic shock which leads to hypertension which leads to organ failure, and the kidney would be one of the organs failing.

Q And sometimes that cascade of events is referred to as an inflammatory response syndrome?

A There is a term called systemic inflammatory response syndrome, yes.

Q And that is SIRS?

A Yes, S-I-R-S.

Q In connecting the dots between pneumonia and kidney failure, you have to get to a point where you have systemic hypotension where the mean arterial pressure drops below a level where adequate perfusion to the kidneys has occurred; isn't that true?

A Well, that is the connecting dot, yes.

Q Is there any evidence, even upon admission to the hospital on the 19th that, definitionally, Dr. Malone was in septic shock on that date where his mean arterial pressure would not have allowed for adequate perfusion for the kidneys?

A No, he was still maintaining a blood

Starer

pressure. He was not in shock at that point.

Q If the physicians who were actually taking care of Dr. Malone in the hospital when he was admitted on the 19th concluded that in all probability it was the Bactrim that was causing him to become immunosuppressed would that be consistent with the opinions that you have articulated?

MR. McKINNEY: Object to form and foundation.

A That is consistent with my opinions.

Q Bactrim has the potential to interfere with the production of -- is it folic acid?

A Yes.

Q And folic acid is necessary for the creation of white blood cells?

A It has -- you know, with numerous different types of blood cells, yes.

Q By the way, if in fact a physician would have discontinued the Bactrim because of its nephrotoxic effects, again assuming someone had evaluated Dr. Malone on the 14th or 15th -- let me start over.

Assume Malone is evaluated by a doctor on the 14th or 15th because a doctor has

Starer

reviewed the laboratory studies that were performed on the 14th -- are you with me?

A Yes.

Q That doctor, exercising reasonable care, discontinues the Bactrim, Dr. Malone is going to be put on another antibiotic at that time, correct?

A Oh, yes, that is the expectation --

MR. McKINNEY: Objection to form.

Q Would he have been put on another antibiotic if Bactrim was discontinued?

A If he was showing signs of infection, which he was, then more likely than not the physician would have put him on.

Q In a case like this where the patient has an underlying osteomyelitis or at least a significant probability for osteomyelitis where the Bactrim is being withdrawn, would it be your expectation -- perhaps you already answered -- that an infectious disease consult would have been obtained?

MR. McKINNEY: Objection form and foundation.

A More likely than not, it would have

Starer

been obtained.

Q There were questions asked about Dr. Malone and his ability to make judgments different than a layman by counsel.

My recollection is at that around January the 6th, it might have been the 5th that there was some degree of psychosis that was related to a medication that he was taking. Do you have a recollection of that or not?

MR. McKINNEY: Object. Form and foundation. Asked and answered.

A I don't remember specifically.

Q The final dot on your graph -- and I just drew it in a little darker, this final dot -- is that to represent on January 19th, Doctor, when first measured in the hospital the creatinine was 4.1?

A Yes.

Q The slope of the curve or this line reflecting this change between the 14th and the 16th is unknown because the labs were not being obtained, correct?

A That's correct.

MR. McKINNEY: Objection. Asked and

Starer

answered.

Q And the reason, at least from your standpoint -- I guess I don't need to argue the case, but that evidence was not obtained due to what you are characterizing as a breach of the standard of care on the part of the defendant, yes?

A Yes.

MR. McKINNEY: Objection. Form and foundation and argumentative.

Q And, therefore, the absence of evidence is the defendant -- was caused as a result of the defendants' fault, if you will?

MR. McKINNEY: Objection. Asked and answered. Argumentative.

Q We don't have that evidence because the defendants did not obtain it, correct?

A Yes.

Q You don't view it as your role, I would assume, to figure out who is telling the truth or whose testimony is more accurate, that of Dr. Saker or that of Dr. Turlo, I would assume?

A That's not my role.

Q On January 15th, Shirley Evans, the visiting nurse, took Dr. Malone's blood pressure and

Starer

it was 112 over 60, correct?

A Yes.

Q Did that blood pressure suggest that he was in septic shock?

A No.

MR. MEYERS: That's all I have.

MR. McKINNEY: Just a couple of quick followups, Doctor.

EXAMINATION

BY MR. McKINNEY:

Q It's your testimony that Dr. Malone should have been told to stop the Bactrim as of January 15th?

MR. MEYERS: Form.

A Well, no, by January 15th, yes.

Q I mean, based on the lab results that was available at least in written form according to the document itself, it's your testimony that a primary-care physician such as Dr. Turlo would have instructed the patient to stop Bactrim, is that what you testified to?

A Yes.

Q Would he then go with no antibiotic coverage until he's seen by an infectious disease

Starer

physician or would standard of care require Dr. Turlo to instruct Dr. Malone to take some other antibiotic therapy?

A The standard of care would require an evaluation and then that would, more likely than not, lead to another antibiotic therapy.

Q And you would not expect Dr. Turlo to tell the patient which antibiotic to take but, rather, defer to an infectious disease specialist on that issue?

A I think there would be some collaboration between Dr. Turlo and an infectious disease consultant. It might be Dr. Turlo who ultimately tells Dr. Malone what antibiotic to take.

Q But the standard of care would not permit him to do so without at least initially interacting with an infectious disease specialist?

A No, he could, if he feels that he has the information and is comfortable enough to do so.

Q I'm asking what the standard of care would have required in your opinion.

A The standard of care doesn't require that he makes the consultation. The standard of care is that he provides the care. How he decides

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to do that is up to him based upon what his comfort level is and the resources he has available to him.

Q More often than not that would result in a collaboration with an infectious disease specialist?

A I don't say more often than not. I would say it does occur.

Q Which occurs more often?

A I don't have the statistics on how often a general physician speaks with an infectious disease consultant.

Q In fact, you are not, yourself, in this type of a scenario as an outpatient treating physician nor have you been in over ten years because you are treating patients on an inpatient basis; isn't that true?

A Well, I have been in scenarios like this. I don't expect it changed significantly since I have been.

Q But you have not found yourself in a position such as Dr. Turlo in at least ten years?

A That is true.

Q Can we agree, Doctor, that during the December 21 to January 9 admission there is no

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evidence that Dr. Malone was suffering from SIRS during that admission?

A Yes.

Q Can we also agree during that admission there is no evidence that he was suffering from sepsis?

A I don't believe that he was suffering from sepsis. I don't believe there is any evidence that he was.

MR. McKINNEY: That's all. Thank you, Doctor.

MR. MEYERS: I have a follow up.

EXAMINATION

BY MR. MEYERS:

Q In this hypothetical that Malone is seen on the 14th or 15th and he is now suffering this renal failure and he has a previous history of renal failure during the last hospitalization and he had this open wound on his foot with a wound vac, he is going to -- that is a patient who is going to be needed to be seen by a nephrologist, yes?

MR. McKINNEY: Objection. Leading.

MR. MEYERS: Let me ask a different question.

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Q Isn't this a patient who in all probability is going to be readmitted into the hospital? With everything we know about John Malone as of the 14th and 15th, isn't he going back into the hospital?

A Yes.

MR. MEYERS: That's all I have.

MR. McKINNEY: No further questions. Thank you, Doctor.

(Whereupon, at 1:55 o'clock p.m., the deposition was concluded.)

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CERTIFICATE

STATE OF NEW YORK)
) ss.
COUNTY OF NEW YORK)

I, Jean Wilm, a Shorthand (Stenotype) Reporter and Notary Public of the State of New York, do hereby certify that the foregoing Deposition, of the witness, PERRY STARER, MD, taken at the time and place aforesaid, is a true and correct transcription of said deposition.

I further certify that I am neither counsel for nor related to any party to said action, nor in any wise interested in the result or outcome thereof.

IN WITNESS WHEREOF, I have hereunto set my hand this 1st day of October, 2012.

JEAN WILM, RPR, CMRS, CLR