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IN THE CIRCUIT COURT OF

PULASKI COUNTY, ARKANSAS

FIFTH DIVISION

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JAMES D. LAWSON and DONNA LAWSON, Individually, and as Co-Administrators of the Estate of BARBARA ELAINE LAWSON and on behalf of the wrongful death beneficiaries of the Estate of BARBARA ELAINE LAWSON,

Plaintiffs,

vs. No. CV03-2249

HEALTH MANAGEMENT ASSOCIATES, INC. and LITTLE ROCK HMA, INC. D/b/a SOUTHWEST REGIONAL MEDICAL CENTER, BENNY J. GREEN, M.D., and LYNN C. THOMAS, M.D.,

Defendants.

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DEPOSITION OF DR. PERRY J. STARER

New York, New York

Monday, April 4, 2005

Reported by:
ELIZABETH F. TOBIN, RPR
JOB NO. 170678

April 4, 2005

10:15 a.m.

Deposition of DR. PERRY J. STARER, an expert witness, taken by defendants, held at the offices of Esquire Deposition Services, 216 East 45th Street, New York, New York, pursuant to notice, before ELIZABETH F. TOBIN, a Notary Public of the State of New York.

APPEARANCES:

WILKES & McHUGH, P.A.
Attorneys for Plaintiffs
425 West Capitol Avenue, Suite 3500
Little Rock, Arkansas 72201
BY: THOMAS G. BUCHANAN, ESQ.

MITCHELL, WILLIAMS, SELIG, GATES & WOODYARD, P.L.L.C.
Attorneys for Defendants Health Management Associates, Inc. and Little Rock HMA, Inc. d/b/a Southwest Regional Medical Center
425 West Capitol Avenue, Suite 1800
Little Rock, Arkansas 72201
BY: MICHELLE H. CAULEY, ESQ.

BARBER, McCASKILL, JONES & HALE, P.A.
Attorneys for Defendant Benny J. Green, M.D.
400 West Capitol Avenue
2700 Regions Center
Little Rock, Arkansas 72201
BY: WILLIAM H. EDWARDS, JR., ESQ.

A P P E A R A N C E S: (Continued)

ANDERSON, MURPHY & HOPKINS, L.L.P.
Attorneys for Defendant Lynn C. Thomas, M.D.
400 West Capitol Avenue
Suite 2470
Little Rock, Arkansas 72201
BY: OVERTON S. ANDERSON, ESQ.

PERRY J. STARER, called as a witness, having been duly sworn by a Notary Public, was examined and testified as follows:

EXAMINATION BY
MR. EDWARDS:

Q. Dr. Starer. My name is Bill Edwards and we're here to take your deposition today in the case of Lawson versus Health Management Associates and others.

I realize you've given depositions before; is that correct?

A. Yes.

Q. On how many different occasions?

A. I don't remember exactly. Maybe ten or 12.

Q. You're familiar with the ground rules, but I'm going to go ahead and restate them in any event. If I ask you a question you don't understand, ask me to repeat or rephrase the question. If you don't ask me to repeat or rephrase the question, I'm going to assume that you understood my question and have given me an answer to the best of your ability.

Starer

Fair enough?

A. Yes.

Q. And if you will, for our court reporter's benefit, continue to answer out loud with yes or no or whatever answer is appropriate rather than shaking or nodding your head.

All right?

A. Yes.

Q. And if we could avoid uh-huhs or unh-unh, use a yes or no response, that would be good as well.

A. Yes.

Q. This is not a marathon. If you need to take a break for any reason, just holler and we'll take a break at that time.

A. Yes.

Q. We're here today pursuant to notice of deposition, which I'll go ahead and mark as Exhibit 1 to your deposition. And we've also been provided with a copy of your CV which lists your education, training and experience.

(Starer Exhibit 1, notice, marked for identification, as of this date.)

Starer

Q. Am I correct that your education has all taken place here in New York?

A. That is correct.

Q. And your experience, likewise, is all here in New York?

A. My practice?

Q. Yes, sir.

A. Yes, sir.

Q. I've reviewed your resume.

It appears that you are currently teaching at Mount Sinai; is that correct?

A. Yes, I have an appointment at the School of Medicine.

Q. What do you teach?

A. I teach geriatrics and internal medicine.

Q. And is that to med students?

A. Medical students and the house staff, interns and residents. And I teach my colleagues as well.

Q. When you say you teach geriatrics, is that the title of a course or is that a particular branch of medicine that you teach multiple courses in?

Starer

A. Let me see if I can explain this. I have a geriatric unit of which I am the director at the hospital. So we have different people rotating through, some for a month and some for longer. This could be house staff. It can be medical students, pharmacy students, nurse practitioner students. So that's an ongoing teaching by working together in the care of patients.

And then also within the area of geriatrics I will give formalized lectures, classroom. But I don't know if we actually would call it a course. Maybe call it more you rotate through the geriatric division as part of your workload.

Q. In working with your geriatric unit, is that part of your teaching duties?

A. There's no clear distinction. It's also part of my professional obligation and my employment responsibility, yes.

Q. When you say you give formal lectures, do you give that to a classroom setting, give tests, assign grades?

A. I speak in an auditorium. I stand

Starer

up in front of the room. I don't give the final grade. I will do evaluations. I fill out evaluation forms on the student and the house staff.

Q. In this position are you employed by the City of New York?

A. I actually have two employers. I am employed by the New York City Health and Hospitals Corporation and I'm also employed by the Mount Sinai School of Medicine.

Q. Is your employment with the city by virtue of the geriatric clinic that you operate?

A. It's one entity. It may -- if I can explain -- I know, it's not always clear to us either. In New York all the major medical schools have partnered with the City of New York in order to provide care to underserved areas.

So, you may have heard of Bellevue Hospital and that's partnered with NYU Medical School. And Mount Sinai is partnered with Elmhurst and it just goes on and on. And they both operate the entity. There's a little bit

Starer

of a division of labor that the City of New York wants to make sure that the underserved community is served and Mount Sinai wants to make sure you have a high level of academics and it's combined. But it's the same thing.

MR. EDWARDS: If you need to take a break.

(A brief recess was taken.)

Q. Have you ever engaged in private practice?

A. No.

Q. Have you ever practiced in any state other than New York?

A. No.

Q. Are you a member of the A.M.A.?

A. No.

Q. Are you a member of any other physicians' associations?

A. Yes.

Q. Which?

A. I'm a member of the -- we have our own Attending Physicians' Association and I'm a member of the Doctors' Council, which is a New York City organization.

Starer

Q. Those are both doctors' unions, aren't they?

A. Yes.

Q. Are you an officer in any of those organizations?

A. Yes.

Q. What position do you hold?

A. I am the secretary-treasurer of the Attending Physicians' Association and I am a delegate to the Doctors' Council.

Q. And is that a union that -- you tell me.

What group does that encompass, physicians in the State of New York?

A. New York City area.

Q. You mentioned that you're the director of the geriatric clinic?

A. Yes.

Q. Does that operate at Elmhurst or is that Mount Sinai Hospital?

A. It's Elmhurst Hospital.

Q. What do you do as the director of the geriatric clinic? What are your duties?

A. Duties. Well, I'm responsible for

Starer

the patients on the geriatrics unit. It's a very broad way of saying that I oversee the care and treatment of the patients while I'm there, and I work in concert with the physicians, nurses, pharmacy -- individuals from the pharmacy department, physical therapy, social work and then the various rotating students and other learners who come through to make sure there's a comprehensive approach to the treatment of the elderly patient.

Q. Are you the attending physician for any of the patients or residents at the geriatric clinic?

A. You're mixing the term clinic with unit. I'm talking about an inpatient unit. Clinic would be an outpatient area which I'm not involved in. For the inpatient area, I will rotate through on a monthly basis. The structure is a little more complex than just saying we have this one unit. Because I also do internal medicine.

For six months out of the year I admit patients into the internal medicine

Starer

service at Elmhurst Hospital as well. This is not all geriatrics. So, there are certain times where I am not the attending physician for the patients on the geriatric unit where I'm the director and there are other times that they're actually my patients and my primary care responsibility. Because it's a public hospital, we get assigned patients as they arrive.

Q. For those patients in which you are the attending physician, is that by virtue of the fact that they were admitted as part of your rotation as an internist?

A. Internist, yes, internal medicine.

Q. As part of operating or overseeing the geriatric unit then, you do not -- you are not the attending physician for those patients except those that may be admitted by virtue of you being an internist?

A. That's correct.

Q. You mentioned earlier that patients will rotate through in one month intervals? Did I --

A. No. I rotate through on a one month

Starer

interval.

Q. What's the average stay of a patient in the geriatric unit?

A. It is very variable. It can be one day. It can be a month.

Q. Would you characterize this as acute care or more chronic care?

A. This is acute care for the geriatric patient.

Q. In your geriatric clinic, do you use physical therapists?

A. Yes. You said clinic again, so you threw me off.

Q. I'm sorry. Unit.

A. Unit, yes, sir.

Q. I'll try to get together with the terminology.

In your geriatric unit do you use physical therapists?

A. Yes.

Q. Do you use physical therapists to assess patients?

A. Yes.

Q. Do you use physical therapists to

Starer

assess patient in terms of their need for rehabilitation and mobility and strength training?

A. Yes.

Q. How many physical therapists are on staff at the geriatric unit?

A. How many do we have?

Q. Yes, sir.

A. There's always one and then sometimes there may be a second one coming to assist. There's always one.

Q. Is it the physical therapists who do the assessment of the patients in terms of their physical capabilities on admission?

A. They participate. It's not solely them.

Q. Who else assesses the patients in terms of their physical capabilities?

A. Physical capability, you're using it broadly. What are you asking?

Q. Who assesses patients for their ability to ambulate, stand, walk, what need they have in terms of rehabilitation?

A. Oh. Well, the first part, the

Starer

ability to stand, walk, the physician will do it, the nurse and the physical therapist. The latter part, the need for rehabilitation medicine, then we'll have the physical therapist get involved.

And then it will go one step. If the physical therapist feels that the patient may benefit from more gymnasium-based rehabilitation medicine, then we'll have a physiatrist come and do a formal evaluation from the rehabilitation medicine department.

Q. Do you write admission orders as part of your job duties at the geriatric clinic?

A. Geriatric unit, no.

Q. Thank you.

Is the geriatric unit operated as part of Mount Sinai?

A. Well, we're -- it's all under the Mount Sinai -- New York contracts with Mount Sinai to staff the institution, so it's all under the Mount Sinai umbrella, yes.

Q. Is Mount Sinai a hospital that emphasizes geriatrics?

Starer

A. I'm not sure how to answer that question. There is a geriatric department there. But I don't think they emphasize it more than they emphasize pediatrics or any of the other divisions. It's not a geriatric hospital. It's just one component.

Q. I think I read somewhere that Mount Sinai claimed to be the only hospital with a geriatric department.

Do you believe that to be correct?

A. I believe you read it. I don't know what actually that means. It may be a distinction that it's a free-standing department as opposed to a subdivision of medicine. I'm not sure what the meaning of that is.

Q. Your CV has a list of publications attached to it.

Do any of your publications focus on fall prevention?

A. I didn't bring all my publications there are, but -- I'm sorry I didn't bring it. I believe I had one in here, nursing home care and in there there was a section.

Starer

Q. Why don't you take a minute and review the articles and --

A. I'm just -- "Medical Care of the Elderly in the Nursing Home," number nine, I address falls. I didn't know we needed it. But there's a section on falls in there. I recall writing that.

Q. Have you ever written any articles dealing with fall preventions in a hospital?

A. No, not that I recall.

Q. Do any of the articles listed here deal with hospital care as opposed to nursing home care?

A. Let me just quickly -- I just want to take a quick look and try to remember where each study was done. Some of the articles were based in a hospital population.

Number 12, number 14, number 15, number 17 and 18 and 19. My recollection. And the others were conducted in a nursing home population. These are the articles. I'm not talking about the other -- the letters to the editor and the textbook chapters.

Q. Do any of the textbook chapters deal

Starer

with hospital care as opposed to nursing home care?

A. I'll take a look at that. I guess the first textbook chapter, "Urinary Incontinence," that would have encompassed hospital-based patients as well. Second one, "History and Physical Examination" would have also addressed hospitalized patients. And the other publications were just book reviews. They could apply, some of them -- number three and number four, the abstracts, one would apply to hospitals and number three, "Nonchild Resistant Container" abstract was done in a hospital.

Q. Doctor, do you maintain a list of cases in which you've testified?

A. No.

Q. When we started, you estimated that you'd given approximately ten to 12 depositions?

A. Yes, I was estimating.

Q. How many times have you testified at trial?

A. Let me think. I think about four.

Starer

Q. This case is currently set for May 16th.

Are you currently available to testify in Little Rock somewhere in that week?

A. I have to check my schedule and I guess we can arrange something, yes.

Q. Currently, it's your intent to testify if called as a witness?

A. I hadn't been invited, but it's my intent, yes.

Q. In the depositions you've given and the trial testimony you've given, have you ever testified on behalf of the defendant?

A. No.

Q. Then I'm correct in saying that all your testimony has been on behalf of the plaintiff?

A. Yes; all depositions and trials, plaintiff, yes.

Q. How did you first become involved in litigation?

A. This is called litigation?

Q. Testifying.

A. Okay, testifying. I can't remember

Starer

the year now. It may be seven years ago. I received a phone call and it was a lawyer saying, "Do you do expert witness work"? I said "No."

He said, "Would you be interested"? And I said, "What is it"? And he began to explain this case and would I look at it. And I said, "All right, if you like." I said, "This is not really what I do." And that's how it started.

Q. Was this a lawyer that you knew?

A. I didn't know the guy, no.

Q. Just a cold call?

A. It really was. I actually said, "How did you find me"?

Q. What was his response?

A. "I saw one of your articles."

Q. Do you do any advertising?

A. No.

Q. Do you maintain business cards which list you as a consultant?

A. No.

Q. In this case the plaintiffs' counsel is the firm of Wilkes & McHugh.

Starer

Have you ever worked with them on any prior cases?

A. I think this is the first time they've contacted me, but then subsequently they called me for other cases. But this is the first time.

Q. How many current files do you have with the firm of Wilkes & McHugh?

A. It might be four. I think they're based around the country. I don't think they've all come out of Arkansas. I think there be might be four other contacts.

Q. How many current cases are you consulting on?

A. It's the same number. Is there a difference in having the files or --

Q. Are all the cases that you currently consult on Wilkes & McHugh files?

A. I'm sorry. I see what you're saying. I thought it was still the Wilkes & McHugh. Sometimes I receive something and they say, "Can you take a look at it and just let us know," and then that's the end of it.

Are you asking something which is

Starer

active?

Q. How many open files are you currently consulting on without regard to who the counsel is?

A. I'm not sure when it's closed or not. They say, "Can you look at this," and then I don't hear anything again. There might be another four, I think.

Q. That would be a total of nine?

A. It's my estimate.

Q. What are your charges per hour?

A. $200 an hour.

Q. I take it that's what you're charging us for today?

A. Yes, yes.

Q. I take it you're not licensed in Arkansas?

A. That's correct.

Q. Never practiced there?

A. That's correct.

Q. Have you treated any patients from Arkansas?

A. No, I have not.

Q. Have you been to Arkansas before?

Starer

A. No, I have not.

Q. Are you familiar with the standard of care in Arkansas?

A. I'm familiar with the standard of care in a community similar to that in Little Rock.

Q. What community would that be?

A. New York City.

Q. Do you have any experience or training outside of New York City?

A. What do you mean by -- I mean, you say training, educational experiences. In the past I've attended conferences and lectures outside of New York, yes.

Q. Where have you attended conferences and lectures?

A. I don't remember them all now. New Jersey, California. But this goes -- this is years. I don't remember every one.

Q. When did you first meet with any of the attorneys from Wilkes & McHugh?

A. I met only one attorney, Mr. Buchanan, that was yesterday at 5:30.

Q. Do you keep an itemized bill of the

Starer

time you spend reviewing cases?

A. You mean ongoing?

Q. Yes, sir.

A. No.

Q. Do you have an estimate of the hours you put into the Lawson case?

A. Yes.

Q. What would that be?

A. Fifteen hours.

Q. You understand this case involves a hospital and two doctors?

A. Yes.

Q. Have any of the other cases in which you've testified also involved a hospital or doctors?

A. My recollection, yes.

Q. How many?

A. Well, I don't remember how many. I mean, certainly maybe more than three. But I don't remember all the cases.

Q. Have you testified in a malpractice case involving physicians before?

A. Yes.

Q. Do you recall the names of those

Starer

cases?

A. No, I don't. I'm sorry.

Q. In what state did those cases occur?

A. I believe there was one in New Jersey and probably Texas. I remember Texas. Now I don't remember if I testified -- I can't recall, sorry.

Q. Is it fair to say that the majority of cases in which you've testified have been against nursing homes?

A. That is a fair statement, yes.

Q. Have you ever been sued?

A. No.

Q. Ever had a claim made against you?

A. Not that I'm aware of.

Q. Pursuant to our notice you brought with you today a couple of notebooks which I presume contain medical records?

A. Yes, sir.

Q. You've brought some articles with you?

A. Yes.

Q. And a couple of pages of notes?

A. Notes, letters I received.

Starer

Q. And you've also reviewed some depositions?

A. Yes.

Q. Which depositions have you reviewed?

A. I have a deposition of Mr. Larry Kerr and Dr. Benny Green and Dr. Lynn Thomas.

Q. Are you aware that there are other depositions that have been taken?

A. I'm aware there are other depositions.

Q. Why did you not review those?

A. I had just received those, so I focused on what I felt I needed to see and the others -- I discussed it with Mr. Buchanan again yesterday when I first met him, is it all right if I concentrate on these.

Q. Do you intend to review any additional depositions taken in this case?

A. If there was something relevant that someone needed me to review -- if asked to, I will.

Q. I ask if you review any additional materials that result in a change in any of the opinions that you express here today if

Starer

you would please let Mr. Buchanan know so he can alert counsel.

A. Absolutely.

Q. By my count, there are 16 articles you brought, the majority of which appear to deal with falls.

A. Falls and head trauma, yes, yes.

Q. Have you made any notes or highlights on any of the depositions?

A. What I've done is, I folded corners and made lines on those pages, just pertaining to certain paragraphs. But that's all I've done to the depositions. Corner folding and line making.

Q. I take it the folded dog-eared pages that you have are of marked sections that were of interest to you?

A. Yes.

Q. Why don't we take a minute and if you would go ahead and read through the depositions and give us the pages that you've dog-eared.

A. This is Larry Kerr, K-e-r-r, and I marked Pages 18, 19, 20 and Page 23, Page 36,

Starer

pages 43 through 45 and there's one I did on the bottom, I think. Yes, 55. That's Larry Kerr.

Dr. Benny Green; page 84, 91, 92, 94, 95, 96, 108, 99, 100, 84. I went backwards. That's Benny Green.

And Dr. Lynn Thomas; 25, 49, 50. Going backwards a little bit, 51, 26. Okay.

Q. Is there any particular methodology at play in whether you dog-eared the bottom or the top of the pages?

A. I was trying to figure out what I was doing there. It just might have been the interesting paragraph or statement was either near the top or the bottom and that's just where I was looking at the time.

Q. If you would go ahead and look at Dr. Green's deposition. I'd just like you to start with the first dog-eared page and tell me what it was that was of significance to you that led you to dog-ear the page.

A. It may take me a moment just to reread it.

Q. Sure.

Starer

A. On Page 84 at the bottom the question is: "We're going to talk about the falls at Traditions. Do you recall that"?

Dr. Green says, "Yes, sir. It seems like all three falls now are related to going to the bathroom, too."

That was -- I was looking for the circumstances of the fall and the response of the staff to the fall. So here they had this discussion that all falls were related to episodes of toileting.

And then a follow-up question is, "Is it your belief it should have been picked up by the nursing staff"?

And Dr. Green says, "No. All of it had to do with the bathroom; one of them trying to make it to the bedside commode, one the medical unit. She's trying to get to the bedside commode. I don't know about the third one. I think she was in the bathroom there, too."

So, it just was interesting to me that although all episodes related to toileting, when asked whether it should have

Starer

been picked up by the nursing staff, the response was no, the pattern could not be detected somehow. So I just marked that.

Then at the bottom of that same Page 85, there was a section, when it says, "Doctor notified times two, does that mean they notified two doctors or notified you twice"?

And I had seen that marking also in the records and I was unclear. Notify doctors and they had the X sign for times and then the number two. I wasn't sure whether or not that meant -- I assumed they had called the doctor twice but here they're asking for clarification, does it mean they called one doctor twice or two doctors one time. So, when they asked Dr. Green what it means, he said he doesn't know what that notation means.

Should I go on?

Q. Please.

A. Here I have Page 89, I marked something. So, here the question is asked to Dr. Green, "Would you have expected someone on the nursing staff to assist her off the

Starer

toilet"?

And Dr. Green responds, "I think I would have expected probably for someone to be there, not exactly lift her off, you know, but be there." And I agree. I agree with that statement.

Page 91, let me just read this. All right. So there is this -- Page 91, the whole page is discussing neurologic checks. The question is asking for a clarification what neuro checks are and the response is, "Looking at the pupils to see that they're reactive and equal to light. Making sure the patient is mentally awake." This is what Dr. Green is saying. "No signs of vomiting or decreased mental status, no headaches, no vomiting. Making sure you can move all extremities."

He explains neurologic checks, defines that. Then the question is "Who performs the checks"? He responds, "It's the nurses." He says he thinks it would be a nurse, not the CNA.

"Would do you expect the nurses to do when you order them to perform the

Starer

neurologic checks"? And he responds that he expects them to examine the patient every two hours, make sure she's talking, she's not complaining of anything new, headaches, make sure the eyes are equal. And he goes on to reiterate the same thing.

And then the last question there is -- now it gets into a question of the value of the neurologic checks. And he's asked, "Can neuro checks detect intercranial hemorrhages"? And the response is, "Yes." And, "What is more reliable in detecting an intercranial hemorrhage, a CT scan or neuro checks"?

And he says a CT scan, and then they go on to discuss the ordering of the CT scan. He didn't order one at 1:30. It just flowed into that section. This is the whole section on neurologic checks, how it's done, what the value of it is and whether it can detect changes before a CT scan can.

I also had a question here, I don't know if they meant to say intracranial hemorrhage and it got translated as

Starer

intercranial hemorrhage. I would have read it more as intracranial hemorrhage. I'm just marking things.

Q. Okay.

A. So the next one I have here is Page 94. No, I'm sorry. I missed the bottom markers. Did I? I just want to be accurate. We did 84 and 85. Right. So 94.

So, this was a -- they're discussing the value of the CT scan and the time of it. At the bottom of Page 94 they're discussing why a CT scan had been ordered previously but was not ordered on this particular occasion. There was a falling episode and a CT scan was done on June 24th and then now with the event on June 28th they didn't order.

And the response is about her having a big knot on her head at this time. Last time it was -- she didn't have a big knot on her head. He was going by the external physical finding. That before she was more confused than she is now. And he comes back and says she had a hematoma on her head. And then he is asked, "Doctor, early in your

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testimony I asked you why you order a CT scan. You said because she is on Lovenox."

"Yes."

"She was on Lovenox when she fell a second time. You chose not to do that"?

"Yeah," he says. It's just more of that discussion of why if she's on an anticoagulant did she hit her head one time, you got the CT scan and one time you didn't. So I marked that.

Then on Page 96 -- okay, here, it goes back to that same area of questioning about the value of the neurologic checks. Dr. Green is asked, "Is there a significant amount of intercranial hemorrhage that cannot be detected by neurologic checks"?

And he said that -- "I would say that there is" -- changes a sentence, "It would be less than 25 percent, probably that would not be detected. The majority, 70 to 80 percent would be detected by neurologic checks." So I marked that, his understanding of the CT scan.

And on Page 99 he's asked -- this is

Starer

the question about the -- they're talking about dizziness as an indicator that one would need investigation and the question is, "Later on in the afternoon the nursing staff calls you and said, 'doctor, Ms. Lawson is experiencing dizziness.' Would you have ordered a CT scan"?

And he said, "Probably would have."

He goes on to discuss how dizziness is one of the indicators as part of his neuro check.

At the bottom of 100 he says -- let me see what the question was. They're talking about if at 1:30 the nursing staff informed you Ms. Lawson is dizzy, would you order a CT scan taking into consideration Lovenox.

He says, "I already knew Lovenox was on board. The dizziness is the key thing. It's new. She wasn't dizzy when I talked to her."

That's Page 108. "At 1445 we have a patient who is complaining of throbbing head pain." The response is "Yes, sir."

"And the CT scan is not ordered

Starer

until 1645"? And he says "Yeah."

So, that's some information on the time course between the onset of the head pain symptom and the CT scan being ordered, two hours passed.

And then I have Page 110, this is just a reiteration of a question. He says -- the question is, "now, as I recall, the testimony earlier though, however, you -- now, as I recall your testimony earlier though, however, you said that you would have expected somebody to have accompanied Mrs. Lawson to the bathroom, correct"?

"Yeah, yeah. That would be the right thing to do."

Those are the sections I marked.

Q. Okay. And for Dr. Thomas.

A. Okay, so the first thing I marked on Page 23, they're talking about the fall risk assessment and I think they're asking Dr. Thomas why she was not considered to be a high fall risk and she goes over the criteria, saying that Ms. Lawson wasn't combative, not older than 70, didn't have a visual

Starer

impairment. She scored 29 out of a 30 on a mini mental status exam. Then she said, "That's better than I do on some days."

She was not complaining of syncope or vertigo at that time or, to our knowledge, at any time right around that time. So that was an explanation of the fall risk score or assessment. So I marked that.

And on Page 25, they're just talking about the point system and how you are stratifying somebody's fall risk and the question is "Upon either your recollection or your review of the record did it appear that anything occurred with her that increased her fall risk during her stay in Traditions."

Her response is, "No, I don't, I would not have, I can't think of anything that would have made her go to a Level II." And they start to talk about whether confusion is part of the assessment and there was a little back and forth on that. I marked that.

Then on Page 26 -- I think the questioning now is along the lines of fall protocol aside, that's -- that's what the

Starer

question says, "Fall protocol aside, what about the use of anticoagulant medicines? Was the fact that she's on anticoagulant medications combined with the fact that she had already fallen once in the hospital something that caused concern to you with respect to the level of fall precautions that might need to be taken"?

And she now, Dr. Lawson is talking about how each patient is an individual and sort of deviates from the form a little bit. She says, "I look at an individual. I look at what medications they're on. I look at why they're here, what the purpose is. And in my judgment nothing else need to be done even given the knowledge I had that she was on anticoagulants. Because the whole purpose was to move her toward independence. And restraining her or having somebody stare at her for 24 hours, seven days a week was not going to serve that purpose."

So, she's saying that this would not have changed her treatment plan. I noted that.

Starer

Now I'm on to Page 49. The question is, "Are you telling me it was your intention at that point to order a head CT"? So, I think this -- "Are you telling me it was your intention at that point to order a head CT"?

"That's exactly right."

"What actually got done" is the question.

"A skull film and an x-ray."

"Was the skull film just an x-ray of the head"?

"Yeah." So it's -- a little confusion as to -- a CT scan is not a skull film.

"Why did you want a CT as opposed to an x-ray of the head"?

"Because a patient with a fall, witnessed or unwitnessed, if you had suspected they hit their head even if you're not sure, if they have a change in status, one of that being a headache, then the next to thing to do is a head CT to assess for any trauma, including a bleed."

So, she's explaining why she wanted

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a CT scan at that time.

Then Page 50, this is a discussion now, I guess of what the event -- this event was. I'll read it as it's here.

"Reggie came to me and said the patient now is confused, she's worsening. And I said, 'well, we haven't heard from the head CT. What did it say'? Because the way it works is you send them down for the head CT. If the radiologist sees anything, the onus is on him or her to immediately call. You know certainly later if I hadn't heard, I would follow up. But I was assuming she had had the head CT. It was either had not been read yet or had been read and it was okay. They would call with the results. I said 'what.'"

That's what it says here, "what."

"Has the head CT come back yesterday yet or I think I said, 'oh, is she back from having the CT.' Reggie said, 'What CT'? I immediately realized that, you know, there was a problem."

Page 51, "Why the exclamation point"?

Starer

Answer: "Because I was frustrated it had not been done earlier." So, they were still talking about the same thing, including CT or something in the note.

And that's all I can see that I marked. That's Lynn Thomas.

Q. You also took some notes based on your review of the depositions and the medical records?

A. Yes, I did.

Q. Do you have those notes with you here?

A. Yes. This is blank.

MS. CAULEY: Off the record.

(Discussion held off the record.)

Q. Have you reviewed the outline of your opinions that's contained in the interrogatories in this case?

A. Not very recently. I don't know if I even have it with me. I had looked at it, yes. I reviewed them, but I don't have them with me right now.

I have them now. I actually do have a copy.

Starer

Q. Following your review of the depositions do you have any changes that you wish to make in the opinions you intend to express in this case?

A. Okay. Let me just review this. That would be the section over here. This is where I would make the following criticisms. All right, so, based on what I've been presented since this, you're asking me would I make any changes?

Q. Yes, sir.

A. The answer is yes.

Q. My next question would be: What changes would you make?

A. Until I saw the deposition, looking at the records I had, it did not appear that the physicians had examined the patient. I think number two says neither treating physician performed an in-person individual exam of Ms. Lawson and chose not to perform a CT scan.

So the deposition offers different information. The physicians do say that they examined the patient, although the

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documentation of that was not in the chart. So, that throws into question whether they examined them or whether they just did not document it or do it properly. But I did not see documentation, so I'm going to have to question that a little bit.

They're claiming that they did examine the patient. I just don't see -- I didn't see the evidence of it in the chart. The second part about choosing not to perform a CT scan, I have to alter that a little bit. It seems that Dr. Thomas did choose to perform a CT scan at a certain point but did not get it obtained in a timely manner.

Q. You said it throws into question whether the exam was done by the two physicians.

Do you have reason to believe they are being untruthful in their depositions that they performed the exam?

A. Oh, I'm sure they're telling the truth. Let me see if I can find -- if you could just bear with me for a moment. My notes tell me exactly where the sections are.

Starer

I don't have the section in the deposition, but I believe he's talking about -- how Dr. Green and Dr. Thomas were both at the nursing station and they took turns going in and examining the patient. This is very, very important as he indicates with his neurologic checks. And then he's going to have the nurses see the patient every two hours.

So I would be interested when I look at the note at the time of the event, what did the doctor find and -- because that has great value. The doctor will be able to examine all the things he spoke about, the eyes, the movement, the reflexes, the muscle strength, the mental status and then people can use that as a baseline going forward.

The only note, and it's untimed, from June 28th, 2002, from a physician -- unless Dr. Thomas is recording elsewhere, I'm going to presume because of the B that this is Dr. Benny Green, so the only physician's note that I see in the chart somewhere around the event starts off with the expression, "Barium swallow okay. Got dizzy. She stood up and

Starer

fell back and hit head. Check neuro. Increase methadone to twice a day. Check EKG."

And then there's no other discussion. So, I'm not sure whether this means -- this makes it questionable in my mind. Does it mean he's already done the neurologic check and it's all right at whatever time this is or that he's going to go forward and do the neurologic check. I'm not saying he's being untruthful. I'm saying I don't have the results of his neurologic exam, nor does anyone else who's caring for the patient at the time.

Q. Would you agree with me it appears the neuro check was done by both Dr. Green and Dr. Thomas?

A. Not from review of the chart, no.

Q. Based upon all the evidence you have before you?

A. They state they checked them. I just don't know at what point and what the results were. Maybe it's in the part of the deposition I didn't see, but it's not in the

Starer

medical record.

Q. What is your recollection of the testimony of these physicians about when they performed the neuro checks?

A. I'm not recalling exactly a time course. I just remember these statements about they're were standing at the nursing station and they knew there was some sort of commotion and chose they would go in one after the other. Something about, I have, they don't want to crowd the patient.

My recollection would be they examine the patient closer to the episode of hitting the head as opposed to later on. That's my --

Q. And the results of their exam was that the patient exhibited no signs or symptoms of any injury?

A. Well, once again, I don't know how extensive the exam is. They did not leave a record of it. They sort of say, it was okay. She was talking and she was smiling. I don't have my notes here now, but my sense was they felt everything was okay.

Starer

Q. Any other changes in your opinions beyond what you've just expressed?

A. No. That was basically it. The other thing about choosing or -- it was just the timing of the CT scan. That may have to be altered in this opinion.

Q. Can we agree that based upon the testimony of the physicians that they did examine the patient?

A. They are testifying that they examined the patient.

Q. Do you have any reason to disagree with them?

A. No. I'm disagreeing with -- I'm saying they just didn't leave a record of it. They didn't share that information.

Q. Your interrogatories also indicate you have reviewed Office of Long Term Care Regulations and certain portions of Code of Federal Regulations.

Have you reviewed any of those documents?

A. These were provided to me and I looked at them. Yes.

Starer

Q. Did they have any relevance to your opinions?

A. I don't always know what to make of these things, but I'm not relying on them extensively.

Q. Are you relying on them at all?

A. I can't recall any specific areas of the regulations at this time.

Q. You reviewed Dr. Green's deposition with regard to the status of his license?

A. That he has a license? I mean, I just start reading, they usually ask those questions about are you a medical doctor, is your practice, professional address. So I just don't remember seeing that he didn't -- he was not licensed. I assumed he was.

Q. He was in fact licensed.

Do you recall he was asked concerning the conditions under which he practices medicine about his license?

A. There was some stuff at the very end of the deposition. I don't remember if it pertained to the license exactly.

Q. Does the status of Dr. Green's

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license in your opinion contribute in any way to the allegations in the plaintiffs' complaint?

A. I would have to review that. I don't actually remember if the license was under jeopardy or some sort of special conditions. I don't recall that. I would have to know a little bit more. I went through that quickly at the end.

Q. If you assume that Dr. Green's license that he was serving under some kind of probation where he was supervised and takes periodic blood and alcohol tests regarding an incident that occurred three years ago, would that have any bearing on the opinions you expressed in the care and treatment rendered in this lawsuit?

A. I have to think about that. I didn't know he was being monitored or supervised. I guess I'd have to know the conditions of which, the level of supervision, if he's supposed to have all of his orders and care, you know, supervised. Or he's just supposed to -- see, I don't know what level of

Starer

supervision that is.

It might impact if he's supposed to have a very close supervision of delivery of care. If it's a substance abuse problem and he's clean, then he is, he's successful. But I don't know the parameters.

Q. Assume for me it's a substance abuse issue and he has been clean.

Would that have any relevance?

A. If the man's judgment is not impaired at the time he's delivering care, then it would not have -- if he's not impaired by abuse of substance at the time that he's making these decisions, then it has no impact, as far as I'm concerned.

Q. Doctor, what is the distinction between attending and consulting physician?

A. There are different people -- it really has -- I guess the reason I'm sort of fumbling for a moment is it's really what the doctor's understanding is. The term attending can be used very broadly. I would want to more closely define it to those entities of primary attending physician, the primary care

deliverer, the patient's doctor who makes the final decision along with the patient what to do and the consulting physician, who the attending physician will speak to for advice and guidance, but the attending physician would make the ultimate decisions.

Q. What is your understanding of the distinction between the Southwest Hospital and the unit called Traditions?

A. I had to have that explained to me.

Q. By whom?

A. I asked Mr. Buchanan. I was looking through the depositions and the charts. It made sense, but I just had that clarified for me yesterday. My notes never came back. For this, I don't need them. I don't want to mix up the timing. It seemed that this is one physical entity with different divisions within it. And you have the acute care medical component, I guess that's Southwest Regional and then you have Traditions which appears to be an geriopsychiatric unit and they're both operating I guess under the same roof, but I guess it's different sections.

Starer

Q. And how would Traditions compare with the acute care geriatric unit that you serve as manager of? Do you see similarities or are they two distinct creatures?

A. I don't know. There's probably some overlap. They're calling it geriopsychiatry. We don't call ourselves that. We're more of elderly patients in an acute care setting, but we're not segregating based on psychiatric or nonpsychiatric need. It's slightly different.

The common thing is they are old people in a hospital. Maybe there are certain shared needs between our two units. But theirs seems to be more focused on the behavioral problems or emotional problems, from my understanding.

Q. I'm going to ask you about your review of medical records and I assume you do want your notes for these questions. Your notes contain some observations that you made regarding your review of the medical records of Ms. Lawson; is that correct?

A. That is correct, yes.

Q. You recorded in your notes the

Starer

various physical conditions that she had on admission as part of her medical history. If you would just read for me what you've written down?

A. You're talking about at the top, the right upper corner.

Q. Beginning with "Stage III vaginal cancer."

A. I wrote, "Stage III vaginal cancer for which Ms. Lawson received chemotherapy from January 2002 to May 2002 and radiation therapy June 2001." I also have written down, Hypertension. Myocardial infarction which occurred in May of 2002. Orthostatic hypotension, depression. A hysterectomy which was done for endometriosis in 1975. And then hydronephrosis with a nephrectomy, which was treated with a nephrectomy tube and it was removed on June 5th, 2002.

Q. Was it your understanding that her cancer had reappeared at the time of her admission to Southwest Hospital?

A. My understanding was that she had the cancer. I don't know -- it wasn't my

Starer

understanding it had gone into remission and recurred. I thought it was just ongoing.

Q. You used the term mild myocardial infarction?

A. I must have stammered. I meant myocardial infarction.

Q. Do you know why the nephrectomy tube was installed?

A. Hydronephrosis. I would have to presume whether it was obstruction from the cancer or unrelated. I just had written down from hydronephrosis which is a backing up of the fluid. It would have to be drained with a tube.

Q. You understood that they installed stents to replace those tubes?

A. Right. So there's a blockage. There was some mechanical problem.

Q. What is your understanding of the status of her cancer?

A. Well, it -- my understanding was that at the time where she's entering Southwest, which was in June of 2002, that the -- I guess the decision had been made that

Starer

this was no longer curable and that it would be more of a comfort care approach. I think they were starting to discuss, explore, hospice for her.

Q. Have you ever followed a patient with end stage vaginal cancer?

A. I don't recall being involved with someone at that stage of -- no. Not vaginal cancer at this stage.

Q. What is Stage III vaginal cancer?

A. I actually am not familiar with the staging system exactly for vaginal cancer. But it is more advanced than a Stage I or II. I can't tell you -- my presumption is it's not metastatic throughout the entire body but it has gone from the reproductive tract to involve other areas. I think Stage IV would be the most severe level.

Q. You mentioned supportive care and a hospice having been mentioned.

Do you know what supportive care would be for a Stage III vaginal cancer for a patient?

A. I just want to go back to the

Starer

oncologist's notes.

Q. Doctor, are you referring to the last report?

A. Yes. I didn't want to rely solely on my memory.

Q. Is that the document you're looking for?

A. Yes. Now I'm frustrated I can't find it. Okay. Yes, that's the one. We're thinking of the same thing. Let me just review this thing. This is the one, thank you.

They feel at this point they were not going to try other curative treatments and that the oncologist is advising the family the best thing to do would just be to treat it conservatively/supportively with pain management and not try therapeutic measures at this point. Considering her well condition, the prognosis is poor. And then they're talking about the possibility of hospice. Supportive treatment is the last phrase. Thank you for refreshing my memory.

Q. Certainly. And we're referring to a

Starer

clinic note from Dr. Juan Roman dated June 7th, 2002?

A. Yes. That's the one I was looking for.

Q. Do you know what supportive treatment would be?

A. I'm not sure what they had decided on, but usually what people are looking for is something which will preserve comfort and dignity, pain relief. And then, as we're all too aware of, decisions are made about what's going to happen in the future as far as feedings and ventilators and things like that.

I don't recall actually seeing an itemization of advanced directives, but the theme is to keep the person comfortable, to allow them to optimize their function and to take advantage of what time they have left.

Q. Is cancer in its end stages a painful condition?

A. It can be. It depends.

Q. You read earlier from some of the deposition testimony of Dr. Thomas which noted that Ms. Lawson scored 29 out of 30 on a mini

Starer

mental exam?

A. That's right.

Q. Did you consider Ms. Lawson to be mentally competent in reaching your opinions?

A. Well, competency, I probably would have to have that better defined. What do you mean by that?

Q. Do you consider her in need of a guardian? Is she mentally competent?

A. Let me see if I am answering it. Because, you know, sometimes you'll be competent to do certain things but not be competent to do other things. I think you know this as well as I do. Obviously she's not going to be competent to start putting up wallpaper if she's not done that before.

I think you're asking what does the mental status exam test. That's going to be alertness, memory, things like that. The problem in this particular instance is, although the mental status exam has a very good score it obviously occurs at one period of time. And they are noting in addition to depression there is also a delirium which

Starer

occurs in her at certain times. And also that she is -- and it's their expression not mine -- not in touch with her present limitations.

So, if she does have moments of cloudiness and confusion and is not able to be aware of her limitations, then I can't give her a blanket competency label. Clearly, we have to go over this bit by bit. I think Dr. Thomas actually agrees with that. Saying everybody's an individual. I don't want to say she's mentally competent and turn her loose to do everything. We probably would have to explore that a little bit more.

Q. In reaching your opinions in this case, have you formed an opinion as to her mental competence?

A. Well, I think they're saying that she does well on the standardized exam but she also is troubled with episodes of delirium and has some judgment problems.

Q. And do you have any opinions about how her judgment is affected?

A. She -- my opinion is based upon what

Starer

I saw in the chart. So, yes, I do have an opinion.

Q. What would that be?

A. That she does not know what her boundaries should be in her activities.

Q. What boundaries in her activities are important to you?

A. Well, to attempt certain tasks without assistance.

Q. What are those tasks?

A. Well, here the one which kept getting tested is toileting.

Q. If I understand your testimony, you don't believe she understands the boundaries affecting her with regards to the toileting function?

A. She attempts to toilet herself without assistance, yes. So, she doesn't understand it's not the best thing for her.

Q. During the course of Ms. Lawson's admission to Southwest Hospital, did her physical condition continue to improve?

A. She was there for a short period. You're talking about the medical side. She

Starer

was there for four days. These were short stays. So, I'm not -- are we talking about the whole stretch, medical --

Q. From Southwest Hospital, the medical unit.

Did you find from your review of the records that from the time of her admission until the time of her discharge and transfer to Traditions that her physical and condition improved?

A. Well, there's different parameters. She came in and was treated for urinary tract infection. That improved. On the other hand, she did slip and bump her head. That was a bit of a setback. I'm not sure which way the balance would go. I'm not sure what you're saying by physical condition, eradication of infection or ability to ambulate independently.

Q. Did her ability to conduct her life improve as a result of that five-day admission at Southwest?

A. As a result of it, I don't think that was the result of it. Apparently not,

Starer

because she then went -- I'm synthesizing all this. She was then transferred to the Traditions side as opposed to being transferred home. She did not attain that ability to live independently.

Q. At the time she was admitted to Southwest Hospital she came in with a urinary tract infection?

A. Correct.

Q. She had some delirium on admission?

A. She came in and she was screaming, yes.

Q. She had fever?

A. I believe that's why she was brought over. I can't remember exactly what the temperature was, but it was an infectious problem.

Q. And the infectious problem was largely resolved during the time of her admission to Southwest Hospital?

A. It appears to be.

Q. When she came into Southwest Hospital, was she largely confined to bed?

A. When she came in, the activity

Starer

levels, this is being ambulating independently, that's the report that they have there on June 21st, 2002. Was she confined to bed, are you asking what was her status prior or --

Q. At the time of her admission.

A. At the time of admission, they have it listed as ambulating independently.

Q. Does that accord with the other observations in the medical record?

A. Well, before her time there was done she was actually restrained, so that's not ambulating independently any more. That does change on the 23rd where they put a restraint on.

Q. Other than her restraint, did her physical ailment cause her to largely be confined to bed?

A. That's hard to say. Now she's tied up in a bed, so I don't know -- you're saying -- I'm not understanding the question.

Q. Was her urinary tract infection disabling to her in some measure?

A. Well, it was. I mean, it was

causing her nausea and vomiting and I guess the fever. So, it is disabling.

Q. And the urinary tract infection was largely cured during the time of her admission at Southwest and removed that disabling factor from her?

A. The nausea and vomiting seemed to have revolved, yes.

Q. And the fever as well?

A. Yes. My recollection. I can't tell you exact temperatures.

Q. Do you believe the delirium was also reduced?

A. Well, being that it was not -- you know, it's -- I can't say that with certainty because when she moves over to the other side, they're still listing her as being delirious. They're saying due to multiple medical issues is what they said. Maybe the urinary tract infection was removed from that group of multiple medical issues but they still feel there's other components, and that's their assessment.

Q. Do you feel her delirium was reduced

Starer

by curing the urinary tract infection?

A. Based on my review of the records, I don't know. It might have been replaced by something else.

Q. Do you know what it was replaced by or just speculation?

A. My speculation is not that she is still delirious, because they are actually recording that. But if asked why do I think she would still be delirious after curing the urinary tract infection, then I could begin to throw out some possibilities.

Q. Do you have any basis for any of those possibilities?

A. Well, the quickest one I could come up with, when you tie somebody down who doesn't want to be tied down, they might increase their level of agitation leading to delirium, confusion.

Q. Any other possibilities?

A. Medications, perhaps. I think they were also looking at that as well.

Q. Anything else?

A. Well, then we'd have to take a look

Starer

at all the other variables, which I don't have here now, but there is this entity of, you know, there was some anemia and some electrolyte imbalances. Those would be areas to investigate. If you wanted an answer, I could take a look at that.

Also, the ongoing depression is a possible, you know, affecting her mind. I'm not sure. They may not have done such a detailed assessment as far as mood. It's still something I would want to explore if I was asked to evaluate.

Q. Doctor, have you come here prepared to give us your final opinions in this case?

A. I give you my opinions based on what I reviewed to date, yes.

Q. Do you consider them to be your final opinions?

A. Unless some additional information is presented to me, this would be it.

Q. Do you anticipate that additional information will be presented to you?

A. I don't know. I didn't expect that this was going to come. I don't know if

Starer

there's anything else out there.

Q. Is it your understanding that there are some additional depositions taken that you have not reviewed yet?

A. I don't know. I don't know what else there is.

Q. Is it your understanding that there have been some additional depositions taken that you have not reviewed yet?

A. I would have to say yes, because I don't know that they're there, then I haven't reviewed them.

Q. Do you have any criticisms of Dr. Green's care of Ms. Lawson while she was a patient at Southwest Hospital?

A. You're talking -- and this is medical or Traditions or both?

Q. Southwest Hospital.

A. Okay. Southwest is what we're going to call the medical side. Well, I guess I would have some criticisms, yes.

Q. What would those criticisms be?

A. It's all in the area of the falling. I don't think that the response was as

Starer

comprehensive as one would like.

Q. That's a fairly general statement.

A. Sorry.

Q. How --

MR. BUCHANAN: Object to the form.

A. Sorry. We do have an accident there. We know that. She slips and bumps her head. And he does respond, you know, with a CT scan at that time. He discusses an evaluation and that is appropriate. But I don't think I find evidence that he really develops a plan for going forward to prevent future falls. I do know in two days she moves over to the other side. Even for the couple of days she's there at the Southwest Hospital side, I don't see where he's really implementing a care plan or supervising a care plan or even reassessing a care plan to prevent future falls.

Q. Is your criticism of Dr. Green's care at Southwest then confined to his failure, in your opinion, to implement an appropriate care plan for falls after the fall incident on the 24th of June?

Starer

A. You used the word confined?

Q. Yes, I did.

A. I just want to refresh my memory on that. I think I'm going to agree. I just want to take a look. I just want to be as accurate as possible. I'm looking at the doctors' order sheet. What I'm looking at are the orders, how he makes his plans known to the rest of the staff. To answer your question, I might have to extend my criticism just a little bit further.

The criticism that I had made was that he does not respond to altering a care plan or putting one in place after the slipping. But as I look at my notes, I realize he may not have implemented a care plan on admission either. I don't see it in his admission orders that he puts into effect any sort of fall precautions.

Q. Have we covered your criticisms of Dr. Green's care at Southwest Hospital?

A. As best I can recall, yes.

Q. You understand that's why I'm here, in part?

Starer

A. Oh, absolutely, absolutely.

Q. So, to capsulize, your criticisms of Dr. Green's care at Southwest would be not implementing a care plan or revising a care plan after the fall and not implementing a care plan on admission?

A. That is correct.

Q. And no others?

A. Not that I can think of now.

Q. And if you think of any others, you'll let Mr. Buchanan know?

A. Oh, absolutely.

Q. I take it you then have no criticisms of any medications administered to Ms. Lawson while at Southwest Hospital?

A. So, let me explain. I understand that there are medicines being used for pain, for sleep and this might impact upon the patient's fall risk. I do not at this time have any criticisms of his choice of medications. My criticism would go back into the fall risk care plan as far as assessing medications as possibly a contributing factor. But I'm not specifically criticizing his

choice of medications.

Q. That would include the use of blood thinners?

A. He has chosen to use Lovenox based upon his suspicion of pulmonary embolism or blood clots and I'm not going to criticize his decision to use them. That's not -- not what I feel at this time, no.

Q. Were you aware there was a care plan in place at Southwest Hospital?

A. Maybe, if you could show it to me, maybe I don't understand -- we may be using different terminology. I was looking at the order sheet and what he is directing the staff to do. If there's something you'd like me to look at.

Q. Do you know if the hospital had a care plan in place?

A. You're talking about something outside of the medical record?

Q. The nurses.

A. I looked through this. This is not a care plan, so I'm going to have to say right now I'm not recalling a separate care plan for

Starer

falls.

Q. Doctor, who prepares a care plan on admission to the hospital?

A. If we're talking about a care plan, once again, it may be a general thing. If we're talking about specifics about toileting and feeding and things like that, I believe that there is input from both nursing and the physician staff and then any other individuals who may have some other input. The dietary care plan would have some input from the nutritionist. The pharmacist may have some input as to medication interaction.

So, you have a multiple disciplinary approach. I don't recall seeing a sheet that was specifically marked care plan.

Q. I guess I'll start with the fundamentals.

What is a care plan?

A. A care plan is going to be an approach to the basics of what the patient needs. And then we go on from there, if they're considered to be at risk for certain entities. Start with food, picking a diet,

Starer

making sure the food is taken, monitoring for certain things. If there's going to be vital signs need to be checked in a certain way, that would be done. Toileting, check for incontinence. You have an approach and then you go from there. For pressure ulcer prevention, you may have turning and repositioning.

Go forward from that if the patient is not doing well. The area for fall risks, assess for that. And also orientation, make sure the patient doesn't become confused by their settings. Reinforcing uses of the call bells. I see there might be little pieces of it here and there, but I didn't actually see a form that would suggest --

Q. Did you see these issues you just went over, diet, medication, vital signs, toileting, pressure ulcers, orientation, were dealt with in the chart?

A. Well, I'm not recalling seeing it on one sheet. I know there's a section on Is and Os. I mean there's a section here, it says food intake, 15 percent, 90 percent. But I

Starer

don't -- I guess what I'm saying is, you have this where it says food intake. I want to make sure I'm in the right section. We're talking medical. And the patient has only 15 percent, which is what she had.

The care plan would be, if it drops below 50 percent, reevaluate for -- that part I didn't see. I see a recording of values. I didn't see a comprehensive approach of what happens if the patient begins to deviate from the norm. I don't see a central part where one is monitoring and then reacting to some of these variables.

Q. How often should a care plan be revised in a hospital?

A. Well, you put one into place and then as needed. So if somebody stops eating food, then you revise it. If somebody falls down, then you would revise it.

Q. Who would revise it?

A. Well, it depends on what the entity is. See, I don't think this counts as a care plan. You'd have to choose the entity.

Q. In the dietary example you gave me,

Starer

who would make the revision?

A. Good example. If a patient stops eating, the nurse notifies the doctor. The doctor says to the nurse, they've stopped eating. From there you do an evaluation, is the patient not eating because it's the wrong food or they're oversedated and can't eat or the mouth is so dry or an obstruction swallowing. Something like that, they can't sit up to eat and they're choking on it.

And based on that, the physician can obtain a consultation from the dietician, can we change the diet or call a gastroenterologist because of swelling. You take that approach first if there's a problem and activate the team.

Q. In the example you just give me of a nurse talking about an eating problem and the doctor orders a consult, all that takes place without a revision to the care plan?

A. No, not necessarily. I mean, part of the care plan is if there's a change in the patient's condition, evaluate. And then if they decide nothing needs to be done, then

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there's no change. They might decide this patient needs soft foods. That's a change. This patient should only eat while sitting up. Should not eat while lying in bed. Medication might be drying out the mouth, so change the liquids.

Q. The consult and trying to identify the problem would all take place without a revision to the care plan?

A. Well, identifying -- it's while you're trying to identify which way to go next, there's no change in the care plan.

Q. Who would make that change?

A. Well, the team, the doctor and the nurse. The doctor could write an order and then the nurse would implement it and make suggestions.

Q. Who actually writes up the care plan based on your experience?

A. I haven't seen the care plan.

Q. At your geriatric unit?

A. We all sign it. So, you have -- it's a team effort. There's little boxes. The physician, nurse, we do include the social

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worker for the sort of spiritual social approach and we then, depending who else -- very often the physical therapist is involved because of, you know, the special needs of the elderly activity. And then we can always -- additional consultants can be invited in on an as need basis. The core of the team is physician, doctor, social worker, physical therapist and dietician.

Q. I understand you may all sign off on it, but who actually prepares the care plan?

A. We all sign off on it. It's -- we all talk about it. If you're talking about who fills out the boxes, sometimes that falls to the nurse, but we're all participating.

Q. You say sometimes the nurse is the one filling out the boxes.

Is that generally the case at that your hospital?

A. Yes. Sometimes they say you do it and I'm the one writing -- it's a matter of who's sitting there with the form and the pen. But the nurses do it more often than not.

Q. When Ms. Lawson fell on the 24th of

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June at Southwest, did you note any consequences in the fall, from the fall?

A. Well, the consequences of the fall, I think he was actually saying there was a bump on the head, called a knot. There was a hematoma.

Q. Beyond the knot on the head, were there any other consequences?

A. The consequence is she then ended up getting tied into bed. I'm sure she would have considered that to be a consequence. I would as well.

Q. Any other direct consequences from the fall other than the knot in the head?

A. None that were evident in the records. The knot in the head and the restraining. Don't leave that out.

Q. If I use the term direct physical consequence, I'm talking about an actual physical injury caused directly by the fall.

With that definition, did you find that she had any consequences from the fall other than the knot on her head?

A. Okay. That leaves out the

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restraints, that sense of being tied down. There's no evidence on review of the chart that she had any broken bones. And the CT scan did not show any bleeding at the time. So there was a bump on the head and that's all the physical evidence.

Q. At the time of the fall on the 24th do you know how long Ms. Lawson had been on blood thinners?

A. The Lovenox, I think, had just started. She fell early morning the 24th. I'm not sure. I think the doses might have just started the night before.

Q. Do you know if they had reached therapeutic levels?

A. I did not see a partial thromboplastin time listed in there, so I don't know if it had or not. I'm not sure exactly when she got the first dose. But I think you get a quick onset with this medication.

Q. Do you have an opinion if she had reached a therapeutic level of Lovenox by the time of the fall on the 24th or you just don't

have an opinion?

A. If I could have a chance to look through this, I might have an answer for you. It would just take a moment or so. I might look at the medication records again. I'm just having trouble finding where it was actually first administered. If it's important, I will look for it a little bit longer. I see where she got it on the 24th, but I can't find -- it looks like it's actually 9:00 a.m. which would be after the event.

I'm having difficulty finding evidence that she had actually received the medicine prior to the fall based on the medicine administration records. It might have been given at -- she might have gotten her first dose at -- I wonder if that's 12:00 noon. It's possible. I'm going to say I'm not certain.

Q. Do you have an opinion that Ms. Lawson sustained any injuries from the restraint?

A. Physical injuries, no. I have no

Starer

evidence that she sustained any physical injuries.

Q. Do you know why the restraint was placed?

A. I believe that based on what I saw in the records she was placed on restraints due to a risk of falling and this was used for fall prevention.

Q. Did you also note that she was pulling at her IVs and catheter?

A. That I saw in the restraint -- the physical restraint form that Dr. Green had filled out, that he had checked that off also. So, there was some interfering with the appliances in addition to the fall prevention.

Q. And did Ms. Lawson need the catheter and IV lines?

A. Well, these were being utilized to maintain her, so I would imagine based on what I saw that the doctor felt this was needed, so he was protecting them.

Q. Is a restraint an appropriate way to maintain the integrity of the IV and catheter?

A. There probably are other ways to do

it. This is what was chosen. I don't know. It is a way.

Q. Is it a medically accepted way to maintain the IV and catheter?

A. It -- see, I don't -- I prefer not to. If one has to, if one has exhausted other alternatives, then it has been an accepted use. But it has to be revisited. The vest -- here they used the vest. It has to be released periodically and you have to reevaluate for the continued use of it, which they did. I mean, they did not continue restraining her indefinitely.

Q. Have you ever used a restraint with a patient who pulls at her IV and catheter?

A. Really, if I've done it, it was in the past. Now I try other methods before I use something as confining as the vest restraint. Because I find it can cause more problems than you solve, so I try not to. I have.

Q. Is there a developing trend in the medical literature that urges physicians to not use restraints?

Starer

A. There has certainly been publications trying to move the community away from the use of restraints, yes.

Q. Is that something you're in favor of?

A. I do endorse that, yes.

Q. Have you had falls at your geriatric clinic?

A. Unit.

Q. Unit, thank you.

A. Falls do occur.

Q. Have you had falls at the geriatric unit involving toileting by various patients?

A. There have been episodes in the unit where people have fallen in proximity to the toilet, yes.

Q. If you were going to prepare a care plan on a patient like Ms. Lawson, what would you include?

A. At which point? There's two components here.

Q. How about on her admission to Traditions?

A. Okay, good. That's a good question.

Starer

So, we would -- I have to say we, because I would have the team. That would be part of it. Everybody comes. We must discuss this. And the plan would consist of determining first is she at risk. And the answer is going to be yes, we have somebody at risk. No argument here. We have somebody at risk.

And I would ask the team members -- it's interactive but I guess you just have me here now. I would say why is she at risk and what can we do to reduce these factors, get it down to zero, if we can. People start chiming in, what were the circumstances of the previous fall. She's at risk because she's done it before. The Lovenox thing is there. We know it may not contribute to her risk of falling, but it may contribute to her injuries. Now we're careful, we don't want her to fall. Everybody agrees she's at risk.

Well, what were the risks of the previous fall. She's getting up in the middle of the night and on her way, whatever, changing position, toileting herself, moving around in the dark, she slips. Focus.

Starer

Footwear. You know -- and I tell you, it would be that. We're not going to know for sure exactly what happened the first time. Sort of discovered was the witness. But we put as much into place as we can to prevent the fall. If we're hearing she slipped, I want to know why she slipped.

Physical therapist, get me a balance assessment. Nursing, take a look at the shoes. Is she walking around in bare feet or wearing slippers. Turned around to the person who cleans the floor in that room, are we waxing it too much, is it too dark. We do a quick walk in and do the environment. The care plan then would be to eliminate obstacles externally. No obstacles in the room. To optimize the patient would be balance, you know, whether it's the medication or telling her to get up slowly. It would be anticipating her needs.

And here, if we're hearing that this woman is going to be going to the toilet and not calling us, we have certain options. One is tie her down and then she never goes to the

toilet. But short of that, we would make sure she doesn't go to the toilet when we're not expecting it, which would mean keeping a record of her toileting activity. If we can track that, knowing she's going to go after meals or in the middle of the night or toilet her preemptively so she doesn't have the sensation. Or going in before bedtime and she won't get up or meal related. Tracking the activity and working around it.

If we do find -- if we had the information that they had, this is a woman that has episodes of delirium and doesn't know her limits, then just saying to her call us when you need us may not be enough and we'd have to be a little more proactive. Either moving her somewhere where we can watch her or anticipating her needs, as I suggested, or having somebody just with her to make sure she doesn't make a move.

But we would examine closely why does this woman suddenly feel she can do it on her own. Why does she not know her limitations. That would be part of the care

Starer

plan.

Q. That deals with falls?

A. Yes, addressing falls.

Q. You're aware of the facts surrounding Ms. Lawson's fall in this case from your review of the depositions and the medical record?

A. Well, the facts that I saw -- I only know the information that they extracted and then reported and we all know that certain things don't make it into the chart. Based on what was shared with me, I know those facts.

Q. How would your care plan have prevented Ms. Lawson's fall?

A. If we're talking about the fall on the 28th, if I knew nothing -- obviously certain facts can only be generated if I'm there to ask for those facts to be generated. If I don't have the toileting record -- let's say I go in and don't have the information on toileting, I don't have a discussion on delirium and medications. I see this is somebody that's going to get up, I would put somebody in the room with her until we can

Starer

settle this. Or put an alarm and have somebody come. If suddenly she starts getting up when she's not supervised and this thing on the bed rings or the chair rings, without restraining her, and have someone come in and ask can I assist you, Ms. Lawson, do you need to go to the toilet, is there something I can get for you. And then we can prevent a fall.

Q. You understand that there was somebody with her?

A. Yes, I do understand that.

Q. So, that would be in compliance with your care plan?

A. No, that would not be --

Q. How so?

A. Because the individual was not responding properly. He was observing her and reporting the fall afterwards. He did not assist her.

Q. He offered to assist her?

A. That's not a question.

Q. Didn't he?

A. Yes.

Q. Was Ms. Lawson within her rights as

Starer

a patient to refuse that offer of assistance?

A. So, if this is a discussion of autonomy, she's within her rights if she has the state of mind to refuse assistance which I think has already been determined by the care team here that she did not. They actually say she does not know her present limitations. Although you might say she's within her rights if she's in a protective setting and can possibly endanger herself, it really is within her right to be kept safe.

So I would say she's not within her rights to refuse assistance to doing something which has already been determined to be dangerous for her.

Q. Did you find that Ms. Lawson's condition was improving during the time that she was a resident at Traditions?

A. The condition did not appear to be -- I mean, she's coming in in a state of depression and delirium and I don't see any evidence that that improved in the few days she was there, three days.

Q. Did you find that she became more

Starer

socially active?

A. I know that there was a -- going to the dining room and things like that. I mean, I don't know how to measure that. If we're going to go back to when she was vomiting, that is an improvement. I'll say she's socially active. I don't have any standardization of how much more social she was. I can't say yes or no. I'm going to say I don't know. She's socially active. I don't know how it is on the scale, up or down.

Q. When you say she has episodes of delirium where she doesn't know her limitations, is it your opinion that those episodes are constant or intermittent?

A. I'm relying on the records and according to the records they describe delirium. They don't say whether it is constant or intermittent and delirium is something which sort of has a temporary component to it. So, I'm speculating that may be what they meant. But she might have been delirious throughout. So I'm going to have to say I don't know if it was constant. I know

Starer

it was there.

Q. Do you know if Ms. Lawson had successful toileting episodes?

A. I'm going to say maybe. I have to take a look at the record to see a documentation of a successful toileting episode.

Q. At the time following the 28th the testimony of Mr. Kerr is that he walked in and she had gotten up, dressed herself, was standing in front of the mirror, brushing her hair.

Are those all signs of independent functioning?

A. Let me just take a look at the deposition. I may not be able to find it. But you're saying -- okay, rather than taking up time looking or for it, she stands up, she goes to the mirror, she combs her hair and dresses herself, then she is able to carry out those activities at that time, with him watching her.

Q. She carried those out before he got there, he walked in and she was brushing her

hair.

A. I don't know. What is brushing hair testing? It's the ability to move the arm above the head. I didn't actually watch what she was doing. I'm assuming she was doing it the right way and not doing it for three hours. It's a sign of manual dexterity. If she's using a mirror as opposed to not using a mirror.

Q. It's also a sign that somebody cares for their appearance, improved mental outlook?

A. I'm hoping so. I don't know. I've seen people brush their hair and they're not doing such a good job. I'm assuming she's brushing it the right way and not doing something which might be less productive, ripping the hair out or something. What you're telling me, he saw efficient hair brushing.

Q. He sees a woman operating in a normal fashion?

A. Sounds good, yes.

Q. Is it your testimony that Mr. Kerr failed to exercise good judgment under those

circumstances?

A. You're talking about the hair brushing incident?

Q. In allowing her to go to the rest room unaccompanied.

A. I think he did not have -- probably -- because he -- the thing is, he says he did what he thought he was supposed to do based on the information he had. I don't know if I want to use the word judgment. I'm going to say he was uninformed what he was to do.

Q. You saw the physical therapist had assessed her?

A. Correct.

Q. He was relying on the physical therapy assessment that had been done on Ms. Lawson?

A. Correct.

Q. In your clinic you use physical therapy assessments?

A. In our unit, we do.

Q. And do your therapists rely upon those assessments?

Starer

A. Oh, yes.

Q. And do you rely upon the assessments of your physical therapists?

A. As one component, yes, absolutely.

Q. Was he justified in relying on the assessment of the physical therapist at the hospital?

A. As one component, yes, yes.

Q. Is there something else he should have done?

A. Yes.

Q. What?

A. I want to go to the physical therapy thing for a second, if I may. Sorry. I want to be as accurate as possible.

Q. We've been going a while.

Do you want to take a break and we'll let you look at the records.

A. I'll look at this real fast. I think there was a physical therapy component in here and -- I didn't put these together.

MR. BUCHANAN: Can we take a break?

MR. EDWARDS: Sure.

(A brief recess was taken.)

Starer

Q. Dr. Starer, we've taken a short break.

Were you able to find the other documents you were searching for in there?

A. Yes. I hope I didn't lose it now. The first document that I wanted to address was the actual physical therapy -- actually, I forgot what the question was. I think you were asking about the judgment --

(Record read.)

A. You're talking about whether he should -- right, the different components a physical therapist needs to know in order to implement a plan or even just stand there in a patient's room and help her. And I believe that this -- I don't know if this is filled out by Mr. Kerr or utilized by him, but this is the physical therapy initial evaluation and it is dated the 26th prior to the event. And it's an assessment, as we discussed, of mental status. He actually rates her mental status as being a little lower than the others. He has her as alert -- I'm -- whoever did this, I'm not sure if it's Mr. Kerr, his ongoing or

Starer

her ongoing evaluation, is we have fall precautions and patient is alert and oriented times two. So, it doesn't go on to -- there's a section for comments, but there's no additional comment on the mental status. But as you know, alert and oriented would mean oriented to person, place and time. So one component is missing there.

And then it discusses other things like balance. And the balance is rated on a scale of nine. Now, this is their score. It's all explained here. Nine out of nine is independent and high activity levels. It's a score of zero to nine. And they look at sitting and standing and within sitting and standing is static and dynamic. Static would be sitting, not moving and dynamic is moving. And what you'll see here is that -- you have it, too, if you look at the balance section, there is a five out of nine.

So, he knows or the physical therapy division knows even without talking to anybody else that there's going to be a little bit of a problem with balance when changing position,

Starer

standing. A little bit of standing static, but it's there.

Q. Are you finished with your answer?

A. Yes, I am. Thank you. The other part was -- that was the part of the physical therapy thing. Then the other part in the deposition I recall him saying that he wasn't aware of certain factors in the chart. The sense I got was there are things written in the chart that the physical therapist did not have available to him when he was making his decision whether to help her in the bathroom.

Q. Do you believe those other things to be of significance?

A. Yes.

Q. What were they?

A. We didn't go through his deposition. I marked some sections here. I just have to find them. Okay. Unless you want me to tell you everything I marked, I'll just tell you what I think is relevant to this question now.

On Page 19 you're talking to Mr. Kerr and they're asked, "Did you know that she had a fall while she was at the hospital part

Starer

of Southwest"?

"I was not aware of that." That's that key fall. Remember, we were talking about the whole care plan thing. I said one of the most important things is to know she's a toileting-related faller. So we can go forward from there.

Now, the physical therapist who's only information he has is, is it a standing balanced kind of risk, if he knew that she's already fallen once around the toilet, coming from or going to toilet, he might be more interested in not allowing her to go in that room unassisted. And the discussion goes on. There's just more of that sort of not awareness.

He actually himself says that he would have done something. "Is that something you would have wanted to know when thinking about whether you were accompanying her to the bathroom or not"?

"Yes. If that person was not rational and alert and oriented times three." Which is interesting, because right here

she -- the physical therapy knows that she's alert and oriented times two. He actually is giving himself this information, not utilizing it. But he's also not utilizing the other information from the other caregivers.

That's why it's so important to have a plan. Everybody gets together, talks together, doesn't just focus on their own notes. Know your patient, take care of your patient. He agrees with me. He just didn't have the information. So, that's why I said not that -- it's not that it's poor judgment. It's just uninformed.

Q. So he would want to know the circumstances of the earlier fall at Southwest Hospital?

A. Correct.

Q. Would be the other piece of information you would want him to know other than the evaluation that the physical therapist did?

A. He would probably -- yes, that would be another piece.

Q. Any other pieces?

Starer

A. Well, it would be the whole approach. If you're going to try and prevent falls, he would want to know the circumstances then and he would want to know any other factors now. Now, he might want to know what other medications she is on, anything she's taking might possibly jeopardize her ability to remain upright while moving. So that's a factor as well. It's just a matter of looking at the other notes in the chart.

And also you'd would want to know about the cognitive component. He didn't really have a handle on there. He's talking about -- some people are writing that she's delirium, and some say she doesn't know her limitations. If it's clearly written she's not in touch with her limitations and she says to him, "I don't need your help," if he knew that, maybe this is not someone I'm going to take her at her word. Let me call a nurse, let me talk to her and know more about this and stop the independent toileting which occurred and then she fell.

Q. Page 2 of that form that you have in

Starer

front of you --

A. I don't have this. Am I missing half of the chart, like the back of everything?

Q. Take a minute to review that.

A. Okay. I'm looking at that now. Okay, yes.

Q. Is there an assessment of her mental capabilities on Page 2?

A. Yes.

Q. It shows that she has mild confusion?

A. It says mild confusion.

Q. Is that unusual in geriatrics who are hospitalized?

A. Oh, I can't -- no, you can't make a sweeping statement that every old person who goes into the hospital is confused.

Q. Is it unusual is my question.

A. It occurs. I don't know if it's the norm or the majority. There are some patients who become confused in hospitals.

Q. Have you ever worked in a geriopsyche unit?

Starer

A. No, I mean, I've consulted in it, but I've not actually been physically placed in it, no.

Q. What is the significance to you of the assessment of the physical therapist that Ms. Lawson had a standing dynamic score of five out of nine?

A. Well, I am relying on their evaluation and five out of nine is actually explained right to the side there on the right. You see they have a dynamic balance scale key. So, five out of nine, move 75 percent range -- they spelled range wrong -- with GCA -- CGA. So you look up and that's contact guard assist. Or 50 to 75 percent of stand by assist. So, the percentages are, I guess, to once again stratify her limitations, but they are certainly using those phrases, contact guard assist or stand by assist which means somebody is there with her, that's my understanding, during the dynamic standing component. There's someone very close to her or very, very close to her.

Q. Do you have an opinion about what

Starer

stand by assistance means in terms of distance?

A. I can't give you an actual measurement but I would imagine within arm's length that you're going to be able to get to the patient and prevent the fall.

Q. Doctor, is it your testimony that the circumstances of the earlier fall in Southwest Hospital are similar to the fall at Traditions?

A. There are similarities, yes.

Q. Do you think that the similarities predominate?

A. It depends how many variables you're going to look at. If you say time of day -- I believe it -- I think it's going to predominate if you look at the theme of undertaking an activity unassisted and not calling for or refusing help. I think that -- focus on that, it's more similar than dissimilar.

Q. Other than some involvement with the toileting function and Ms. Lawson herself, are there any similarities between the two events?

Starer

A. The similarity is the injury occurs in the same place, which is very interesting, her head. She lands on her head. Not breaking her hip or anything. Falling in such a way both times that she actually hit the head. That's interesting that she hits the head.

Q. That would be the consequences. I'm talking about the manner in which the original action occurred.

A. I believe this is an important clue. How she lands, I'm trying to think if I can do it with a coke bottle. But, how do you hit your head as opposed to -- some people slide out of their chair and land on their buttocks. Something happened where not only is she moving -- because she's moving, the head is going forward or backwards. She's thrown off balance in such a way that the head takes the brunt of it. Plus, she's unable to protect her head.

The similarities are very interesting, because some people would actually put their hands out first and the

hand would take the trauma. You know, natural reaction -- but she doesn't do that. So, it's certainly something to explore. Why did she hit her head on two separate occasions as opposed to breaking her hip or snapping her wrist?

Q. Do you know where she hit her head on both occasions?

A. One time it's the back of the head and the second time it's the back of the head.

Q. Switching gears just a minute, did you find Mrs. Lawson sustained any harm from Dr. Green's failure to participate in the care plan on her admission to Southwest Hospital that you've previously expressed opinions on?

A. Now, we're not -- I know we said we have two Dr. Greens here, medical Dr. Green and Traditions. The first --

Q. At Southwest.

A. She suffers the pain of bumping the head and the restraining in the bed. The first component, she -- the injury is not as severe as the second time. The first time, she bangs her head nicely.

Starer

Q. Other than the knot on her head, did she sustain any harm from the care plan at Southwest Hospital?

A. Well, the initial care plan to prevent a fall, she does not -- she sustains no harm. Going past that, harm does occur later on. But it's in another division of Southwest.

Q. My question, just so we're clear, is limited to Southwest.

A. You're limiting to Southwest Medical as opposed to Southwest Traditions?

Q. That's correct.

A. Between June 21st and June 25th I don't see any -- or June 24th, I see no evidence in the chart aside from a hematoma on the back of the head and the necessity for restraining, any additional harm accorded.

Q. And the restraining was also occasioned by her straining against the IV and catheter?

A. This is also listed as a reason, yes.

Q. Is it your testimony that Ms. Lawson

Starer

was experiencing an episode of delirium at the time she fell on the 28th?

A. I don't have enough information to say that. One may say she was experiencing poor judgment and based upon previous episodes there's a possibility that she might have been delirious at that time as well or confused.

Q. But you don't have any basis for that?

A. The only basis is somebody offered to help her and she refused it. But I don't have any other information.

Q. Is the act of refusing an offer of assistance an act of delirium?

A. If -- it can be, yes.

Q. Do you think it was in this case?

A. It might have been based upon what she's done previously.

Q. In utilizing restraints with Ms. Lawson at Southwest Hospital, did Dr. Green act below the standard of care?

A. You're focusing just on the restraints alone?

Q. Correct.

Starer

A. If he had -- using the restraints is one component. By not adding to that he acted below -- using restraints solely as his approach to prevent falls, he acted below the standard of care.

Q. Earlier you said it was your preference not to use restraints, but that it was an acceptable medical practice to use restraints in these circumstances?

A. As a temporary measure until you can get everything figured out, that's correct.

Q. What is it, in your opinion then, that makes those actions below the standard of care?

A. That's a very good question. Because it's almost -- I don't know if you want to hear an analogy. I'll just say it. If someone is going to get up and fall and you know that's going to be a problem and you restrain them for a short period of time, but then after you remove their restraints you don't do anything further, then you have not put a plan into effect to deal with the problem.

Starer

The problem has not gone away due to a temporary restraining. It's a holding action, but you have not solved the problem, which is demonstrated in her case. She went on to fall again.

Q. You're focusing on the care plan and what took place after the restraints were taken off. My question is limited to the restraints.

A. If you're limiting it to that, which apparently is what Dr. Green does in his approach, for that moment it solved the problem. But he did not live up to his responsibilities to protect her in the future.

Q. And my question again is: Is it your testimony that his actions in placing those restraints were below the standard of care?

A. For 3:00 a.m. he did the right thing.

Q. The answer to my question is it would not be below the standard of care?

A. It would not be below the standard of care for that moment.

Starer

Q. And that moment extends until the restraints were removed?

A. The way they've done it. I don't want people to go out and restrain people forever. It's a temporary tool to prevent further falls and then you put something else into place, correct.

Q. And his actions in ordering the restraints, in your opinion, were not below the standard of care?

A. In ordering the restraints it is one acceptable measure, but he did not have a component to prevent future falls, therefore, he's below the standard of care. You can't show up for an orchestra with just a horn. You have to have the rest of the players there. He only did one thing.

The question is an odd one. I'm doing this one thing. That's okay. Yes, that's okay. But where's the rest. That's below the standard of care.

Q. Let's just concentrate on one thing.

Can we agree that Dr. Green's actions in ordering the restraints the morning

Starer

of the 24th in response to the factors shown in the chart were not below the standard of care?

A. Let's take a look at the order if that's all right because I want to be as accurate as possible. You just said the morning of and I want to make sure that's when he's ordering it. All right. So, as I thought, he did order these at 3:00 a.m. and these are all the reasons that we had discussed. So that's all there. The patient restraint by protocol. It's 6/24 at 3:00 a.m. So, I'm sure you could read this as well.

However, I do now have a possible criticism here. There's a checklist and there's a lot of interesting things here which he signs. At the very bottom of the checklist there is something called "alternative strategies such as verbal redirection and removing from stimuli have failed to prevent combative behavior."

I'm not sure if that's applicable here. I don't know if it was combative behavior or just refusing to be helped.

Starer

Number five, all reasonable efforts prior to being restrained -- actually the sentence is not written well, but unsuccessful. So, he might have deviated from his own protocol by not considering all reasonable alternatives. And that's why I'm saying, it has to be a comprehensive plan. You don't just do one thing. That's number five at the bottom before you sign it. You have to consider reasonable alternatives.

That's exactly what we were talking about before. This is something which is accepted by the medical community assuming that something else is not utilizable and I believe Southwest Regional Medical Center has a protocol in place which mandates that the physician considers all reasonable alternatives prior to using restraints. So that's good. That's a great protocol.

Q. Back to my question.

A. Okay. Sorry about that. But accuracy.

Q. Is it your opinion that Dr. Green's actions in ordering restraints on the morning

of the 24th were below the standard of care?

A. I'm going to have to say that without evidence that anybody explored the reason why she's getting up that -- I know you want a yes or no. But without knowing why she's doing what she's doing, it might have been premature to have used the restraint. Just based on their very own protocol that they might have just asked why are you getting up, is there something that you need.

I don't see that reflected in the notes that Dr. Green undertook this investigation or asked anybody else to undertake it. They just put the restraints on.

Q. So your answer is?

A. I think he deviated from Southwest Regional's standard of care.

Q. And due to what fact?

A. That there was no investigation as to why she's getting up to go to the bathroom at 3:00 a.m. and what we can do to ameliorate it. They might have just wanted to -- here it becomes all the possibilities that night.

Starer

Maybe she was up. It was time to, you know, she felt she had to get up the a 3 o'clock in the morning. They could have just had her sit in a chair rather than tying her there. Somebody could have talked to her. Maybe she could have watched TV. Maybe withdrawing her from the sedative or something like that. I don't know. But without that investigation and moving directly to the restraint use, he may have actually violated the house -- the local protocol.

Q. Dr. Starer, is it sufficient for you to offer an opinion that a physician is operating below the standard of care if you have a question based on some unknown that he might not have pursued the variables available to him?

A. That's a very good question, very good, indeed. I'll tell you why it's a good question. Because it doesn't look like he examined the patient at the time that this was written. So, I don't have the information because the information is not there to be had.

Starer

Q. And that's sufficient, the lack of information is sufficient for you to opine that he is operating below the standard of care?

A. Now that you phrase it that way, the doctor has ordered restraints which requires a very comprehensive approach, yet there's no evidence in the chart that the doctor examined the patient at 3 o'clock in the morning. In fact, it doesn't even look like he signed it at 3 o'clock in the morning. That the order was put into place at 3 o'clock and he signed it afterwards.

So, I would have to say that I'm offering an opinion based upon there is no information because the doctor himself didn't have the information.

Q. Have you ever taken phone calls at 3 o'clock in the morning?

A. Yes.

Q. And issued telephone orders?

A. Correct, yes.

Q. Based upon information supplied you by nurses or someone you trust at the

Starer

hospital?

A. Well, usually it's provided -- if you're talking -- okay. I will receive phone calls from doctors who I am supervising. If a nurse calls me and asks for something, it really depends what they're asking for. They may ask for a dietary order for the next day. I'll go fine. This, I think, requires more. In fact, if you're going to restrain somebody, you might want to make sure that they're not sick.

Why is she -- if you would -- this is a very good question. I'm glad you asked it. If I may answer. If a patient who we sort of discussed is ill, has an incurable disease, has moments of confusion, has medications, and starts acting aberrantly unusual against protocol, and we don't have any history that Ms. Lawson in the past began to -- at least not there, began to act against the directions of the staff, began to resist, began to get up in the middle of the night, how do we know she's not having a bad event, a stroke? I'm not saying she did. How do you

Starer

know the confusion is not a medication reaction, a heart attack, a stroke, stomachache, pain, and she's having difficulty verbalizing getting confused?

And you asked me before is it unusual for people to be confused, the reason you knew it's not unusual is that older people get confused in the hospital either because the environment is different or because they're sick. Just to react by tying them down is probably not the right thing to do. Evaluate, take a blood pressure, look in the eye -- all the stuff they do at other times. And then say, you know, she's just a little upset right now. Nothing terrible is going on. Put this vest on her and hold her still. But to do it over the phone is probably not appropriate. And you're telling me that's what happened.

Q. Is it, in your opinion, always inappropriate to authorize a restraint over the phone?

A. If you know your patient -- it's inappropriate to authorize a restraint for the

Starer

first time. She's never behaved this way before and never been restrained before, so the first time is probably inappropriate. If you're saying it's been going on for years, we know what this is, we've looked at this, she does this every night at 3:00, then okay.

The first time, new event. It's like the first time you get chest pain. This is her chest pain. This is a call, something is wrong, something is different. Something needs to be evaluated. You don't tie somebody up. And the -- I use analogies. When a baby starts crying, you don't tie them up. You find out what's wrong. I'm not saying she's a baby. But there's something already upsetting her and it's not being communicated clearly, let's evaluate. Then when everything is free and clear if you really want to use a restraint, use it.

Q. If you received a phone call at 3:00 a.m. and the nurse told you the patient was pulling at medically necessary lines such as IVs and catheters, that she had fallen and there was confusion and was thrashing in bed,

Starer

unable to comprehend instructions, you would not have ordered a restraint under those circumstances?

A. No, she's thrashing in bed, do we have a doctor? I'm coming in. Why is she thrashing in bed? Is she in pain? As far as the IVs and stuff, I would take a look and I think we could take a look and say are there any medicines that need to be given between now and the morning. If the catheter -- if she's pulling it out, we can intermittently catheterize. Before we tie her down, let's reevaluate. That's what I'm saying. Do something. Don't just call up, restrain her and I'm going back to bed.

Let's go over this. Does she need any medicines between now and 8:00 a.m. when I'll be in? If she pulls the catheter out, we remove it. Can we intermittently catheterize her as needed? It will be less agitating to her and we'll see her in the morning. She's trying to up. Can you walk her around the nurses' station, put pillows around, until we get a chance to evaluate her. Let's just not

do this thing. Or you can say, call me at 4:00 a.m. if she's still thrashing. Because this doesn't go away.

I don't see any of that in place. It's below a standard of care. It's below their standard of care.

Q. Is it below accepted methodology of medicine?

A. I think so.

Q. Do you think there's an area where there's room for a difference of opinion among physicians?

A. I'm not sure what you mean by that question. Is there someone somewhere who's going to be able to say this was an okay thing to do, I don't think so. I think many people, if not most people -- I don't know. I don't know what all doctors are going to say. I just know that the standard of care, taking care of people, before using restraints is to evaluate. And they're not differing with me. They're -- this is their protocol. All I'm doing is supporting their protocol.

Q. Do you think it's below the standard

Starer

of care if a doctor does not participate in a care plan?

A. Yes.

Q. In each instance any physician that does not participate in a patient's care plan is below the standard of care?

A. The physician writes the orders and direct the staff. Each instance, you're talking -- it's very, very broad, it could be in the past, the future. You're talking about this particular patient or --

Q. I'm talking about just as an abstract principle. The doctor writes orders, directs the care of the patient, but does not participate in the care plan.

Is that doctor operating below the standard of care?

A. If we're going to define care plan, that is the care plan. The well-being of the patient is part of the care plan. The doctor should be aware of the care plan and have input into the care plan and make sure it's implemented. I don't believe the nurses or the physical therapists are acting

autonomously. That goes back to the whole phrase of attending physician.

Q. Your definition of care plan, a doctor is participating in the care plan if he's writing orders and calling on the patient and making notes and changing his orders in response to what he observes?

A. Well, he has to do it effectively, yes. That's part of the care plan. We have to take a look at what he did here and he didn't do everything he could have done.

Q. Is that the standard by which you judge physicians?

A. I judge physicians by how well they take care of their patients.

Q. Is that the standard, that you do everything you could have done?

A. Do everything you can to help somebody, yes, absolutely.

Q. Is that your standard for operating under the standard of care?

A. My standard of care -- you're saying my personal thing. But it meshes. It comes together. The standard of care is what is

Starer

practiced in a community -- we're talking about here, Pulaski County, Little Rock, Arkansas, it's a community which is similar to the community I practice in. I'm applying the same standard of care.

Q. And does your standard of care mean that the doctor has to do everything he possibly can and if he does not he's operating below the standard of care?

A. We're talking abstractly, but I can't imagine a doctor anywhere who would not want to do everything he possibly can to help a patient. But it's so abstract that it may not be answerable.

Q. I'm just asking about the premise upon which you base your opinions, and I'm asking you if that is your premise.

A. Well, my premise is based on what the medical community does. I believe we have an oath to first not harm the patient. That's how it begins, and to me that suggests doing everything you possibly can. But if we do go by the oath, the Hippocratic oath, the first thing you say is first do no harm.

So, I'll use that as a standard which I think everybody agrees with.

Q. Does the Hippocratic oath form the basis for your opinions on the standard of care?

A. That component of it certainly does. I don't recall the entire oath but that stands with me. First do not harm your patient.

Q. Are there any other components to your standard of care?

A. The standard of care is what is practiced, a reasonable and prudent health care provider would give to a patient in the same or similar condition as Ms. Barbara Lawson.

Q. One of the goals for Ms. Lawson that was noted in the chart was her desire to go home?

A. I believe I saw that, yes.

Q. If you were going to craft a care plan for Ms. Lawson whose goal it is to go home, you would want to encourage strengthening her; is that correct?

A. Strengthening her in what manner?

Q. Making her stronger, able to walk, care for herself.

A. Physically strengthening her, yes.

Q. Or enhance her mobility?

A. Improve mobility, yes.

Q. These are things that physical therapy was concentrating at Traditions?

A. They got started with that, but, yes, that was in there, I believe. I don't have it in front of me now. I would say yes.

Q. Would you agree with me that in order to increase strength and mobility you have to get the patient up and keep them active and get them out of bed?

A. Agreed.

Q. Certainly you can't use any restraints in that kind of a situation?

A. No.

Q. You'd agree with me that the physical therapy that was prescribed for Ms. Lawson was appropriate?

A. Let me just take a look at the prescription. I'm going to say by my recollection that it was appropriate.

Starer

Q. Did you look?

A. Oh, I was going by my memory. Did you want me to look?

Q. I thought you were going --

A. I said by my memory. As I recall, it was appropriate. I had half of it, anyway. You had the other half.

Q. At the time of Ms. Lawson's fall, did you consider her to be under the supervision of the physical therapist?

A. I'm not sure. He was there in the room with her by the deposition. So I guess she was under -- he was there but chose not to supervise -- it was his decision not to supervise her.

Q. Well, it was her decision?

A. It was a joint decision. I mean, if she chose not to be supervised, he can then decide whether I want to supervise you or not.

Q. Is it your opinion that he should have forced himself into the rest room against her wishes?

A. Will, force is a very strong term, but I think he should have strongly impressed

Starer

upon her the need for assistance. He is a physical therapist, so I think he did have that obligation.

Q. In your interrogatory responses you offer the opinion that this fall was not inevitable?

A. We're talking about the fall of the 28th?

Q. Correct.

A. I'm going to say this fall was not inevitable.

Q. Why do you say that?

A. Because the report of the fall is she got up too fast to go to the bathroom and fell backwards. So, if there was someone there who could have -- in fact, the way it's described here, she got up too fast to go to the bathroom. The physical therapist probably would have said, you know, as part of our rehabilitation, as part of getting you back active again, my advice is to not to get up too fast. If you choose to get up too fast, I will be there with you on that -- whatever they were talking about, the assistance, the

Starer

contact assistance. Just in case I will be here to catch you.

So, if these mechanisms were in place, being there, educating her, supervising her, working with her, this fall could have been prevented. Sometimes you can just follow a patient with -- the physical therapists know this stuff, too. You can follow her with a wheelchair and catch her if she falls backwards. But none of this was done. He just didn't do anything.

Q. You listed some potential causes of her fall which include medication.

Are you critical of any of the medication she was on at Traditions?

A. Well, you know, we had spoken about that before.

Q. That question was limited to Southwest.

A. I'm sorry. We moved to the Traditions now. I think here -- and I'd have to go back and take a look, but I remember seeing Zyprexa, Effexor, psychotropic medications. They were adding on -- you had

Starer

all these psychiatric-style medications which might contribute to unsteadiness and stuff. I'm not going to criticize necessarily the use of them. I'm going to criticize not taking them into account.

If you have somebody with multiple medications, you just want to be careful in changes of positions and being upright. But he knew that there was some sort of balance problem there, anyway.

Q. Dr. Starer, let me make sure I understand all the documents you consider to be part of the patient's care plan.

Can you just list them for me?

A. Well, the medical record is part of the care plan. If you want me to go through it and look at what they have here and tell you whether it's part of the care plan.

Q. You're not restricting the care plan to a single document that was entitled care plan?

A. There could be a form which actually says care plan on it which has all the elements. Now, I'm not sure whether this is

Starer

it. It says master -- the phrase master suggests that this could be a comprehensive form and it does exist. So this might be it. The multi-disciplinary master plan.

So, this would suffice. This information might be scattered in other places and each place may have their own mechanism for doing it. Here I see they have a multipage plan, a treatment plan. So, I would accept this. Unfortunately, it's blank.

Q. What set of records are you looking at?

A. This is Traditions. This is the time of the event. This is what I was given. I don't know if there is other stuff -- want to take a look? It's signed, by the way, by one person, the activity specialist. But this is what we were talking about. The team member, psychiatrist, dietician, only one person weighed in and signed the blank form.

Q. Your term care plan extends to more than just a single document?

A. I would hope in this setting we could find -- that's why I'm saying I'm

Starer

struggling a little bit. If this master treatment plan does not pan out -- I have to go searching through the medical chart -- they deviated from their own standard of care.

Q. Go back to my question: Your definition of standard of care is not limited to a single document?

A. I would say it's not limited. If this information is somewhere else, of course, I won't hold them to that. But they're already agreeing with me that this should occur. Whether it's on this form or somewhere else in the chart. That's why I said I had trouble finding the single care plan because this is not filled out.

Q. In your opinion, is the entire medical chart part of the care plan?

A. It can all be condensed and summarized here, but the same information, it's true -- here you have an interdisciplinary record. Other components. This interdisciplinary care plan, by the way, which they shoved in here, maybe that's why I had trouble finding it before. This is dated

Starer

the 21st. This actually belongs to the medical side.

You can see, they themselves are using different formats and forms all over the place. This has different components.

Q. But your definition of care plan includes material found in the chart?

A. It is an entity. It is not a piece of paper. It is an ongoing process. This is documentation that the care plan is taking place, but clearly if you document it and don't do it -- so, I don't know if I'm answering the question or understanding the question. There's got to be a plan of care to take care of a patient. You have to market the plan, all the team players, you have to know if you're making advances, or losing ground. How do you do that? One way is a through a form.

Q. One way is through doctors' orders?

A. Doctors' orders feed into the care plan. They have it all laid out. Here's a medical doctor. There he is. It's nice.

Q. You'd agree with me that doctors'

Starer

orders constitute part of the care plan?

A. It's a component, yes.

Q. Along with the rest of the patient's chart?

A. Absolutely.

Q. I had asked you earlier if you had any patients at the geriatric unit where you are a director fall and the answer was yes?

A. Yes.

Q. Have any of those individuals been your patients?

A. I don't recall but there is a possibility. I don't remember like in the last few years that I had a patient who fell. I don't want to say absolutely not because there may certainly have been one.

Q. There was a phrase that I made note of in your opinion that Ms. Lawson was set up for an accident?

A. When I was speaking now? Okay. I said that today? I don't recall that.

Q. No, in your opinions.

Do you recall making that statement?

A. Verbally today or --

Starer

Q. No. Your written opinions that we've been discussing, in your answers to interrogatories.

A. But that means I said that today?

Q. We discussed earlier whether you reviewed your opinions and had any changes to them.

A. I'm not clear. Is there another document? I'm sorry to be difficult. I'm not sure. In my testimony today?

Q. In your answers to interrogatories or counsel's answers to interrogatories explaining what opinions you would offer. The last line of paragraph two at the bottom of this page.

Do you see the line I'm referring to?

A. Yes. I'm just wondering. Why is mine different? I don't have this. I don't even know who to ask. What I have is not the same as this.

Q. Let me review yours, if I may.

A. I apologize.

MR. EDWARDS: Let me go ahead and

Starer

mark this as an exhibit to your deposition because it is different than the one I have.

(Starer Exhibit 2, copy of expert disclosure, marked for identification, as of this date.)

Q. You don't recall making that statement?

A. I don't actually recall it.

Q. What is a neuro check?

A. Neurologic examination. I guess what we mean is periodically examine the patient for signs of neurologic abnormalities.

Q. How is a neuro check conducted?

A. I think if you're talking about in this case here, it is an examination of the pupils' reactivity to light, possibly to accommodation, extraocular movements. They're going to check cognition and probably the neuro checks -- I think it was described in the deposition of Dr. Green, movement of the extremities, strength of the extremities. You're really looking for anything out of the ordinary.

Q. You're checking for symptoms and signs of the patient?

A. You're checking signs. Symptoms a patient would report to you.

Q. When you conduct a neuro check, do you inquire of the patient how she's feeling, if she has a headache?

A. That would be subjective. I don't think the definition he was using, which I think is similar to mine, how you're feeling, dizziness and vomiting would be part of it. I'm not sure if he's saying the neurologic examination would be testing reflexes, things like that. but it's a component of it. If you're trying to encompass things -- sorry.

Q. Would you agree with me that a neuro check is, while not specific, is sensitive?

A. Good question. It's actually not sensitive. We're going to say sensitive. In answering the question, I think we're talking about the intracerebral hemorrhage we're talking about and it is not sensitive -- as sensitive as -- is it a sensitive test? It's going to miss some things.

Starer

Q. What types of things would it miss?

A. It's going to miss hemorrhage.

Q. What are the signs and symptoms of hemorrhage?

A. It depends. Hemorrhage is the bleeding into the brain, compressing the brain and having neurologic changes based upon what part of the brain is changing, is being compressed. So, you might have a pupil which no longer reacts to light. You might have a change in mental status. You might have an arm which suddenly starts operating inappropriately or not at all.

So, those would be the signs. It's not one sign. It depends what part of the brain we have the blood pushing in on. But, as you know, you can have the bleeding and not have any changes in the examination.

Q. Don't intracranial hemorrhages always produce signs and symptoms of some kind?

A. No. That's why I brought you some of these articles today. But no. It's an unfortunate. It doesn't.

Starer

Q. Is the ordering of a neuro check something that's customary following a fall in some cases?

A. Customary standard of care, yes.

Q. If a doctor has reported to him that a patient has fallen and struck her head, he examines the patient, does not find a knot on the head or hematoma, finds that she's behaving normally, use that term in quotes, but not exhibiting any unusual signs and symptoms, in your opinion, would it be below the standard of care if he did not order neuro checks?

A. It would be below the standard of care after head trauma not to order neurologic checks. Yes, it would be, absolutely.

Q. Even if she exhibited no signs and symptoms whatsoever?

A. Having head trauma, yes, because this may evolve over time. You observe them over time.

Q. Given those same set of facts, is it your opinion it's below the standard of care not to order a CT scan?

Starer

A. Now, it depends on the patient. You're saying it very generally. But I would say in an older patient who has sustained a head injury who also has an anticoagulant it would be below the standard of care. And possibly even not -- here you might talk about where doctors may disagree. But there is much evidence -- because this might be an area, we talk about areas where doctors disagree.

There's much evidence to suggest when you have an elderly patient who hits their head even without the neurologic symptoms at first you should order a CT scan. I think what eases us to this, doing it, is actually what we've seen in previous CT scans. In this patient I think you would be really pressed to explain yourself if you don't do a CT scan of the head.

Q. Why is that?

A. Because -- aside from -- you can read these articles later on, I don't want to take up your time. It's been found that when people hit their heads, even the most minor trauma in the older brain, you can begin to

Starer

have bleeding without neurologic findings. And you'll say, well, how can that happen -- and I brought this along because I think this is of great interest to the group -- that when somebody has cerebral atrophy, which I believe was described in Ms. Lawson's case, a shrinkage of brain, that leaves a lot of space around the brain, between the brain and the skull, so the patient can actually start accumulating blood and there's room for the blood to go to. But the patient will not manifest symptoms or signs of the increased intracranial pressure.

So, you just have to be a little more vigilant. So, I just say that knowing there is a report of brain atrophy here and she bonks her head, you might not want to wait until what happened inevitably anyway, that she shows the signs, you might want to visualize the brain sooner.

Q. You say not wait until signs show up, which inevitably what happened anyway?

A. Inevitably it's what happened. She got sicker and then they began to move into

Starer

action and that's what happened.

Q. She had a prior fall which we talked about at some length earlier today?

A. True.

Q. They performed a CT scan following that fall?

A. True.

Q. Which was documented as producing a greater injury, at least external injury, than the second fall and that CT scan was negative?

A. June 24th, no hemorrhage, no midline shift, no masses, yes.

Q. Given the fact that the prior CT scan was negative and this injury by appearances, anyway, appeared less severe than the prior injury, was not the doctor justified in ordering neuro checks?

A. You're postulating because she hit her head once and no damage was done, the second time -- is that what you're asking me? Because we had an injury, we got through it, the second time it happens we don't have to investigate any more? I guess you want to say is that a true statement or a false statement?

Starer

Q. Is that within the accepted medical standard?

A. I mean, that's just irrational. If you throw a rock at a window once and it doesn't break, it doesn't mean it's not going to break a second time. I think each episode has to be seen in isolation.

I know at one point she said that her head is hard. It doesn't give us a right to stand back every time she hits her head. So, I have to disagree with that approach.

Q. Is neuro checks a means of investigating?

A. Well, it is in certain circumstances a component of it. Here a CT scan probably would have been better.

Q. You said the brain shrinks as a person gets old.

Is that just empty space or is it filled with fluid?

A. It's not air. The brain is cushioned. But it's room. It allows bleeding to occur without pressing on the brain tissue. You have the hard skull and the brain inside.

Starer

This has been clearly documented that the atrophied brain can actually handle bleeding without there being the focal neurologic findings in the hands and the eyes.

Q. I haven't read the article, so I am trying to understand.

A. I can explain it.

Q. What you're saying, you're saying that even with a space filled with fluid that there's room for blood to flow into that space without increasing intracranial pressure?

A. That's exactly what they say. Here's a statement. "These age dependant changes increased -- these age dependant changes" -- what you just said, "It allows for expansion of intracranial contents, mass or blood, without increased intracranial pressure and without the classic symptoms expected with this classic pathophysiology." They actually reference it back to 1961. So it's been known for a while. You just have to be careful.

Q. In your clinic, do you perform CT scan on any patient that falls?

A. In our unit.

Starer

Q. Sorry again.

A. We would perform a CT scan of the head if there's head trauma, yes.

Q. On any? If a patient falls and strikes their head, they automatically get a CT scan?

A. There might be times that I'm not aware of every single patient, but it is our policy, our protocol, our standard, in head trauma we take a look at the head.

Q. Is that written or published protocol?

A. I'm not sure. I know we're all doing it. I don't know if we actually have that locally published. It's just our approach to head trauma and everybody does it where I work. I don't want to say everybody. From the emergency room on up we're always getting CT scans of the head when there's head trauma.

Q. If I were to ask for the protocol of the geriatric unit that you're a director of, would I find this protocol?

A. No. We don't have a written

Starer

protocol on head trauma and CT scans.

Q. Do you have a written protocol on care plans?

A. There will be somewhere -- yes, somewhere there's going to be one. I jut don't know in which book. We have all these volumes of protocols and policies. There are protocols in there.

Q. Are there protocols on fall prevention in there?

A. Yes.

Q. What percentage of your patients are on some kind of blood thinner?

A. An anticoagulant.

Q. Is there a distinction?

A. Well, we wouldn't use the term blood thinner because it probably doesn't actually thin the blood. It keeps it from clotting. If you allow me to talk about this for a second.

Blood thickness, I guess you're really talking about hemoglobin. A thin blood would actually be an anemic blood. The anticoagulant just keeps it from clotting.

Starer

You know, so you cut yourself, if just keeps coming out and out. It's still going to be as thick as it ever was. It's just not going to for clots.

So, blood thinner is almost a slang therm for anticoagulant. I don't want to say there's no difference. We just don't use the term blood thinner. Anticoagulant, it keeps you from clotting.

Q. What percentage of your patients are on anticoagulants?

A. I don't have that information. I know it's more now than in the past as the recommendations have changed. It's not unusual now to see someone on an anticoagulant.

Q. And many people take anticoagulants on a prophylactic basis?

A. Certainly there are many people who take them, sure.

Q. Do doctors in your unit have the ability to exercise their independent judgment about whether or not to send a patient for a CT scan if they fall and hit their head?

Starer

A. There is a -- I mean, there's a chain of command and it's our style, but they always will defer to an attending physician if there is a disagreement. I mean, there's actually a mechanism for disagreements. I mean, you're allowed to have your opinion and if there's a disagreement, then you can go to the director of medicine. It never gets to that point. Usually we work it out. To answer the question, we have independence, certainly. We try to work together.

Q. How many doctors are on staff at the clinic -- at your unit?

A. Once again, I have to define the unit. There are -- as far as geriatric physicians, M.D.s, there are two geriatricians, myself and another physician. But then caring for the patient there are many doctors moving through and they rotate on a monthly basis. So we sort of oversee and coordinate. But there could be from 20 to 30 -- depending on whose patients are put on the unit, we could have 20 to 30 doctors at a time.

Starer

Q. These are residents moving through?

A. Of the residents moving through, there's a great number of them. And then right above them there are six attending physicians overseeing that group. I mean, I don't have all the numbers. There are a lot of different doctors.

Q. Doctor, do you know if a CT had been ordered immediately what changes that would have made in Ms. Lawson's care and treatment?

A. If it had been ordered immediately, I do not know what changes -- in her care for the entity. You're talking about the hemorrhage. The only -- I can't say because I don't know what it would have found.

Q. Do you know if immediate CT would have found any blood leaking?

A. I don't know whether it would have or not, no. It's an unknown.

Q. During the initial assessment of Ms. Lawson, did you find any documented signs or symptoms of head injury?

A. Which initial assessment? Coming in or after the fall?

Starer

Q. The very first assessment that was done, I think that would be by Ms. Poge (phonetic), the nurse?

A. Without looking at the chart, I can't tell you who signed it. But I did write -- I have written down -- let me get the actual note. My first note is written at 11:45 a.m. where they're noting that she fell and hit her head.

Q. While you're looking, let me rephrase my question.

I think the first one that performed the exam is the physical therapist.

A. These are all signed by Ms. Poge. We're looking at 6:28 and I don't see actually the note from the physical therapist. I think that note was written retroactivity. Here at 11:45 is the first note I see and, as I suspected, it was written by the nurse. I think somewhere else there was a note by the physical therapist but it was out of sequence.

Q. In the initial assessment did Ms. Lawson demonstrate any signs or symptoms of head injury?

Starer

A. So, what it actually says, she's describing the fall, she says I'm okay, I have a hard head. That's where that information came. And she's alert and oriented. The pupils were fixed. They actually don't comment on any external injuries. Everything is fine. Patient saying I've got a hard head and the pupils are reactive. They don't actually test the extremities at that point, but they say they notify the doctor. That's the first note at 11:45.

Q. So, there's no signs or symptoms of head injury noted?

A. Nothing recorded.

Q. Do you recall any signs or symptoms of any head injury recorded by the physical therapist?

A. Well, I mean, let me just go back and get clarification of that. The sign of head injury would be seeing that the observer sees either a bruise or an internal neurologic disruption. But the symptom is the patient saying my head has been hit. So there actually is a symptom. I've been hit in the

Starer

back of my head. That's a symptom.

Q. That's a history, isn't it?

A. Well, if you're going to -- so, the patient -- historically she's saying my head is hit, but as of this moment my head is not being hit, if you want to define it that way, then we have the report that she hit her head, but we don't have her saying at this moment my head is touching the floor.

Q. Does she have any signs or symptoms of a head injury?

A. By your definition, in this note there are no recorded signs or symptoms of a head injury.

Q. Were there any signs or symptoms of a head injury noted by Dr. Green in his examination?

A. Let me just refresh my memory by looking at his note. Well, actually in his note there's no -- I think we had spoken about this before, Dr. Green does not describe an examination in his note. It's just a description of what needs to be done later on. The way you asked it, there's no recording of

Starer

signs or symptoms of head injury in this note.

Q. And in your review of his deposition were there any signs or symptoms noted by Dr. Green?

A. Now, I don't recall exactly and I'd have to look through this and it might take some time to find that section. I don't remember if she's actually complaining of something at the time. I would say quickly I don't recall. But if you want, I can look through to see if he discusses that.

Q. Did you find that Dr. Green had any further involvement in Mrs. Lawson's care after he have examined her and ordered neuro checks?

A. Additional involvement in the care. I know in the deposition there's some ongoing dialogue between him and I think Dr. Thomas. But in the chart itself, I know there's no additional note -- I'm going to correct myself. Let me just be sure. This is the late entry. I got confused. I found the note. There's no additional progress notes. This is where the physical therapist's note

Starer

is.

And as far as additional care, I don't see the -- the timing suggests that there's no additional orders being given following that June 27th entry where he asked for neuro checks.

Q. Do you have any criticisms of Dr. Green regarding any of his actions that occur after the time he leaves the facility?

A. I don't know what time he leaves the facility.

Q. After he writes the order for neuro checks.

A. Well, my criticism would be there's no documentation of him checking back in. He is requesting certain things to be done, neuro checks and electrocardiogram and also to change a dose of methadone, but there's no evidence that he then goes on to review any of these things in his implementation of neuro checks, his ordering of an electrocardiogram. So my criticism would be that as the patient is beginning to go down this path, he does not seem to be involved.

Starer

Q. Is it your opinion it's the doctor's obligation to check back to determine whether his orders are being followed?

A. Yes.

Q. Without some prior problem of his orders not being followed?

A. Well, is he getting -- this -- in this situation you have an acute event. She's fallen a second time while his patient and he is asking for something to be done. He did ask for an electrocardiogram. I guess he might have suspected that there might have been a cardiological component to her falling down. He want to know whether she's having a heart attack or it's dysrhythmia. But I don't see where he reviews the electrocardiogram.

So, what's his role? Is he supposed to call up and say, did you get the EKG, oh, it wasn't done, please do it. But to do nothing at all and wonder where the EKG went, is probably not the best way to practice medicine.

Q. Is it your opinion that he had an obligation to call back in and check on the

Starer

EKG that he ordered over the phone?

A. Yes.

Q. Do you think he has the obligation to follow-up with the order for neuro checks and see if they all came back negative?

A. Yes.

Q. Is he entitled to rely upon the absence of phone calls from the nurses that the neuro checks were negative?

A. The presumption is that if I don't hear from you everything is okay?

Q. Yes.

A. Well, it let's see what happened. When the neuro checks were normal, did they call him. It doesn't seem they call him whether it's normal or it's abnormal. So, I think he should in a situation like this in a period of monitoring, he would want to stay involved, they would want to be involved with him and I do believe there is an obligation there.

Q. With what regularity should he have checked?

A. With what regularity?

Starer

Q. Yes.

A. That's a very good question. Maybe every two hours because that's when the checks were being obtained.

Q. It's your opinion that any time a doctor orders a repetitive type check like this with a two hour frequency it's his obligation to call back in to the hospital?

A. Well, he's asking it for a reason. The reason I'm saying that, I guess I'm being rigid on that, there are no parameters that he wrote in his note, his order. Because you're going -- you might say, if we're going to check the blood pressure every eight hours, do you want to be called every eight hours.

Well, the doctor can write please notify me if the blood pressure and put the parameters down. Or the blood sugar. Notify M.D. if. And since he's just writing check neuro and leaving the nurses to do it on their own and not telling them when to call. One presumes he wants to know it all, he's not saying when to call when not to call. He's just saying neuro check.

Starer

I'm looking at it again. There's no parameters on when to call, when not to call. It just says check every two hours for eight hours. It doesn't say notify me or not notify me. Let's protect on the side of the patient.

Q. Doctor, if you have a patient who's diabetic and they have to get periodic testing of their glucose because they're on a sliding scale and someone asks them and the nurse checks and the reading is fine and four hours later checks and the reading is fine, should she be calling the doctor every time to tell him there's no change in insulin?

A. This all goes back to communication. That's absolutely a great question. And the relationship with the patient, with the nurses. Here I see there's an ongoing relationship with Dr. Green. If it's a glucose, this is how we're going to practice medicine on this particular unit. So for me, I know if it it's normal. They know where to find me if it's abnormal.

A very good example, the sliding scale actually gives you the answer. It's

Starer

written down. If sugar greater than 200, whatever, administer this. If sugar greater than 300, administer this. If sugar greater than 400, administer this and contact physician. This is ver nonspecific. It's unclear.

If you're going to order neuro checks, you're looking for something, you put down, if pupil begins to do this, give a call. But he didn't say anything. Just wrote neuro checks. So, figure he's going to stay in touch or be on top of it.

Q. You mentioned earlier a relationship between doctors and nurses and whether they have an understanding between themselves, does that play a role in interpreting doctors' orders?

A. It might if everybody understands each others' orders. If you have a pattern where people aren't reading each others' notes, I don't know. If it's not there -- you can take a look and see how things are usually done. It seems like -- here you go. Here's one which is signed by -- look at what the

Starer

local standard or the local culture is there. He writes an order on Clonidine PO every four hours for blood pressure above or below -- do this, do that. For abdominal pain. I mean, it's more specific than just checking.

So, there is an understanding of certain parameters, we'll restrict certain things.

Q. Doctor, is there a custom and practice with neuro checks that you would report a negative finding?

A. I don't know what the -- I don't know what he was trying to obtain from this, but my criticism was he never -- he did not seem to revisit his patient. I mean, there's other stuff going on here. I don't know who this signature is. But I think the original question was, was I critical of him leaving and it still all comes back to the same thing. I am critical of him not checking the EKG, not coming back and writing everything is okay, not watching the situation.

In the setting, remember, she's on an anticoagulant. I mean, this might be

Starer

different from what they've done before here. If you're saying there's a custom and a culture, the woman is on anticoagulation, bangs her head, stay a little closer with it. Come back, check yourself; phone in; leave a mark. Let us know. Don't leave the building.

Q. Don't leave the building.

You understand Dr. Green has a practice?

A. Then have a mechanism. Call in. I'm using it metaphorically, but don't turn your back on the patient.

Q. Was he justified in leaving her in the care of the nurses to monitor the situation?

A. If he's monitoring the nurses, yes.

Q. It's your position he should have called in every two hours to ask about the latest neuro check?

A. The woman is on an anticoagulant, there should be some measure of communication, whether he calls them or they call him. Some kind of evidence that he's involved. But I don't see that.

Starer

Q. That's your opinion, that he should have called in every two hours?

A. There should be some mechanism. Whether some phone call or e-mail or you guys use some way of communicating.

Q. Would it be acceptable to you if a nurse called if there was a positive finding on the neuro check?

A. All right. So that's the neuro check part. The nurse calls up and says it's positive. Yes, you're supposed to do that, yes.

Q. That would be a mechanism of reporting the results of his orders back to the doctor, that would be acceptable to you?

A. Mm-hmm.

Q. That's yes?

A. Yes, I'm sorry. Yes.

Q. Doctor, I've got a few more questions.

A. Yes.

Q. You mentioned you highlighted some portions of Dr. Green's testimony earlier. You talked about neuro checks only picking up

Starer

an intracranial bleed 75 to 80 percent of the time?

A. I remember saying -- I don't recall what page it was on.

Q. You recall the reference in this testimony?

A. Yes.

Q. You've done some research in the literature.

Did you find any support for that proposition, that estimate?

A. I don't know if I have that actual number in here. Let's see what they have. Okay. Here they say that current -- this is addressed as the elderly, specifically. You know, we're not taking a look at all head trauma. If that's what he's addressing. It says that the present protocols based on clinical findings, which I believe we're going to call neuro checks, will miss 30 percent of elderly intracranial injuries. So that would be -- will catch 70 percent. It's a little off on the 80 percent.

Q. What the title of that one?

Starer

A. "The Use of Head Computed Tomography in Elderly Patients Sustaining Minor Head Trauma."

Q. Have we fairly covered your criticisms of Dr. Green here today?

A. To the best of my recollection, yes.

Q. If you have any additional criticisms of Dr. Green that we've not discussed here today, would you notify Dr. Buchanan or his firm?

A. Absolutely.

MR. EDWARDS: I pass the witness.

EXAMINATION BY

MS. CAULEY:

Q. Good afternoon, doctor. My name is Michelle Cauley. I have a few random questions to start off with. Mr. Edwards has done a pretty good job of being thorough with your deposition. So my questions are going to seem somewhat random do fill in blanks that I have.

To begin, you testified that you've given trial testimony approximately four times.

Starer

Can you tell me, do you know what the outcome of those cases, what the outcome was?

A. You mean by guilty or innocent?

Q. I know that you always testified on behalf of the plaintiff.

In those four cases do you know whether the plaintiff won the lawsuit or whether the defense won the lawsuit?

A. I don't track it that carefully after I leave. But I believe in three cases the plaintiff won. And I think the fourth case the defendant prevailed.

Q. Do you have any idea as to where those cases were?

A. The three that the plaintiff prevailed was in Texas and the one where it was decided on behalf of the defendant was in New Jersey.

Q. You also testified that you have a total number of -- well, I guess when you add them together, it would be approximately eight cases that you are currently working on; is that correct?

Starer

You said about three or four others are for Wilkes & McHugh and then you said there were an additional four, approximately?

A. The file is sitting and the cases are unresolved. I'm not actually doing anything with them.

Q. That was my question, because it was unclear to me whether those were cases where you were asked to review the records or whether they were active cases?

A. It's never clear to me. I look at a case and then a year later I get a phone call.

Q. On the nonWilkes & McHugh cases that you're currently working on, have you had any communication with any of these attorneys that have retained you in those cases say within the last six months?

A. Yes. There's phone calls. Something will come up and they'll ask me a question. So, I'll say yes.

Q. You testified a couple of times that you're not familiar with Arkansas per se but that you believe that the community Little Rock is similar to the community in which you

Starer

practice medicine; is that an accurate assessment?

MR. BUCHANAN: Object to form.

Q. Did I mischaracterize your testimony in any way?

A. I don't know if you're mischaracterizing or misquoting it. I did say that I practice in a community with similar characteristics to Little Rock, Arkansas.

Q. What I was trying to ask, can you list those similarities, how the two are similar?

A. Clearly there might be some differences, the geography. But I looked at the demographics of Pulaski County and I don't see great differences in the population makeup. Nor do I see differences in the medical community. I was looking at a list of the physicians there. So, I don't have any reason to believe that the standard of care in New York is any higher than that of Little Rock nor is the standard of care in Little Rock any higher than New York.

I believe there is an equivalency in

Starer

the two communities.

Q. You're basing your similarities of the two communities on the demographics and also the kinds of practices of medicine? That was poorly phrased, but the different specialties that are available?

A. Yes. I mean, the people there have much in common with the people here. What we're asking to be done for the patients here and there are basic, basic medical practices. The medical community represents the different specialties the way we do here. There are medical schools in Arkansas. There's credentialing.

I mean, such similarities, I do not see that there is any significant difference between where I practice medicine and where Dr. Green practices medicine.

Q. And what you've just told me is your basis for your opinion that the two communities are similar? Is that a complete assessment as to why you believe the two communities are similar?

A. I don't know it's all encompassing,

Starer

but I'm stating similar doctors with similar backgrounds taking care of people with similar needs who require similar response.

Q. There was a mention, too, you had been provided information from the Office of Long Term Care and information contained in CFR sections and I believe you testified that you can't -- you don't recall as we sit here right now relying on the information included in those documents?

A. Right. I just don't recall the specifics of it as we sit here right now.

Q. Do you know, as we sit here right now, whether any of those regulations are applicable to Southwest Regional Medical Center and their Traditions unit?

A. To be honest, I looked at it a while ago.

Q. You're not basing any of your opinions that you're giving here today on information contained in those documents?

A. I might be doing it at a less than conscious level. I might have looked at the documents, these are acceptable ways of

Starer

regulating these entities and I didn't disagree with them at the time. So, maybe at a subconscious level it is coming through. But I can't consciously say I refer to any specific parts of that document.

Q. So, it's fair to say that you are not relying on those documents for your opinions on what is the appropriate standard of care as we sit here today?

A. I'm not recalling relying on them.

Q. If you after this deposition review any of those documents and you decide that you are going to rely on those documents or you find that they are applicable to Southwest Regional Medical Center, will you inform Mr. Buchanan so that we will have the opportunity to explore those opinions?

A. Absolutely, yes.

Q. You testified at one point that you had a conversation with Mr. Buchanan yesterday evening where he clarified for you the distinction between Southwest Regional Medical Center and the Traditions unit.

Can you explain exactly what

Starer

information Mr. Buchanan gave you about the distinction between the two?

A. Okay. So -- and I just met him -- I had never spoken to Mr. Buchanan before. I didn't want to come across as not knowing how to read the records. The way the records were sent to me, it's just put together in one linear fashion. And I had trouble determining why Southwest Regional was different on one date than from another date. Because that's how it was packaged. I said it seems to me you're making a division between the two. And he explained to me there is the medical component -- because the thing just says Southwest Regional. That's why I'm having trouble with the charts.

He said on certain dates Ms. Lawson is in the medical component, which I was made to understand is an active internal medicine part of the hospital. And then there is what is called the Traditions which he described to me to be a geriopsychiatric unit. When he said that, then I said, well, now it makes more sense.

Starer

Q. There was a discussion in your earlier testimony about an understanding based on your review of the medical records that there had been one or more discussions about possibly discharging Ms. Lawson to hospice care.

Do you recall that?

A. I do recall that, yes.

Q. Do you in your practice admit patients into hospice care?

A. Yes.

Q. Is there an admission criteria for a patient as to when they become appropriate for hospice care?

A. This has been a little more complex unfortunately because there are variables of insurance. So, there are certain hospice entities who want us to be able to document that the patient has a defined life expectancy. However, we are able to provide palliative care around that in other settings such as home hospice. I will say I am familiar with certain hospices which are certainly directed more toward a short term

Starer

stay.

Q. Are you familiar with the admissions criteria that Medicare requires for admission into hospice care?

A. My recollection is it's very rigid. It might be three months or something like that.

Q. Do you intend to offer any opinions at trial as to what the anticipated life span of Ms. Lawson would have been if this fall had not occurred?

A. Without -- with the information provided to me, I cannot prognostitize (sic). Unless additional information, which of course you tell him, unless I have that, to date, I cannot prognostitize (sic).

Q. There was discussion various times in your testimony about an overall comprehensive care plan for Ms. Lawson that would encompass all possible care needs such as dietary needs, physical therapy needs, things of that nature. In this particular instance I want to focus on the particular allegations in this lawsuit.

Starer

In this particular instance would you agree that there is no evidence that Ms. Lawson suffered any harm as a result of not having centralized care plan apart from your criticisms on her fall precautions?

A. Let me see if I can rephrase that question.

Q. I want to be certain we're understanding each other.

That's fair enough?

A. My criticism of there not being a care plan might be different from there being a document which has it all on one page. Rather than splitting it out and saying well now there's two things you've done wrong. Basically it's one thing you've done wrong and you're not to be penalized -- if that's what you're asking. I think this is the thing here, that it wasn't filled out in one place. Should this be considered a separate criticism from just having a care plan which is not focused correctly? Is that what you're asking?

Q. Not really. Let me see if I can

Starer

break it down a little bit better.

I understand your opinions in this case to be critical of a lack of fall precautions and it's your opinion that that was what caused her injuries, Ms. Lawson's injuries.

That's kind of a rough summary, but is that basically correct?

A. It sounds right, yes.

Q. But there was also in your testimony a lot of discussion about overall care plans as far as dietary needs and physical therapy and different disciplines and things like that.

A. Right.

Q. And I want to make certain that those are more academic criticisms and not criticisms that you are going to testify at trial actually caused harm to Ms. Lawson in this specific instance.

A. I can't promise that. I don't want to look keep looking at the blank sheet. By not having one central source of information it might have allowed Mr. Kerr to be

Starer

uninformed about some of the risks. If this would have somehow protected her from not being unsupervised, then it certainly would have had an impact. It's not so academic any more. That if everybody puts down their little piece and each specialty signs it and there is a place for -- somewhere in here, I assume there's a place for Mr. Kerr to sign it or read it, then this might have been helpful. When you phrase it that way, I may have to say I will speak about this.

Q. I understand what you're saying and I understand that in medicine there's no -- it's not an exact science, that there's a lot of different variables and possibilities; would you agree with that?

A. No. Science is exact. If you say that there's an art to medicine, then we can have a discussion.

Q. What I'm getting at in my question is the response to my question was it might have changed things. And I understand that's your opinion, that it might have.

But to a reasonable degree of

Starer

medical certainty can you say that these other things, this lack of this centralized care plan proximately caused harm to Ms. Lawson, to a reasonable degree of medical certainty?

A. Yes. And defining that as more likely than not. Since Mr. Kerr himself has said if I knew that these deficits existed I would have acted differently. And since that information was in a separate component -- for me it's all in one place. But Dr. Green is talking about -- clearly -- and I think it was read to me and I'll read it back to you, he documents the patient is unable to comprehend or follow instructions and continues to get up without assistance.

If that was then transmitted and recorded in a place where Mr. Kerr could have seen it, it might have made a difference. More likely than not, it would have made a difference.

Q. You had said something that Mr. Kerr had testified that he would have done things differently had he known about her prior fall.

Do you recall exactly where he said

Starer

that in his deposition? Because to be quite candid with you, I don't recall where he said he would have done things differently.

A. Let me take a look and see if I can find that spot again. I might have paraphrased it and I certainly did not want to twist his words. Just give me a moment. Maybe our interpretations might be different from this, from mine. I guess I'm basing my interpretation on that -- on this line of questioning, on Page 19, Mr. Kerr is asked, "Would that be" -- all right -- he's asked, "Did you know that she fell when in the hospital part of Southwest"?

That's the hospital part, the other chart. And he goes, "I'm not aware of that."

"Would that be something that you would want to know in making your determining as to whether or not you accompanied Mrs. Lawson to the bathroom"?

"Yes. If that person was not rational or alert or oriented times three." So he actually says yes to that, to that question, is that something you would have

Starer

wanted to know in determining whether to accompany her to the bathroom.

And I think it sort of comes up again on Page 28, "If she was considered to be a high risk for falls, would you have accompanied her to the bathroom"?

"I would have either accompanied her or had someone accompany her to the bathroom if she felt uncomfortable with a male."

Q. The testimony that you referenced on Page 19 starts out with in response to the question Mr. Kerr saying again each person is different but if the person was not rational or alert and oriented times three and then he says a person who is alert and oriented and in charge of their own care has a right to refuse help from a therapist.

Do you recall Mr. Kerr's testimony that he found Ms. Lawson to be alert and oriented and mentally competent when he walked into her room and spoke with her?

A. I do recall him saying something along those lines, but I'm not sure if he's actually testing her competency, because the

Starer

choice to go to the bathroom unescorted might have actually been a failure on that test. He might not have recognized that because he didn't know her pattern in the past where she's done things like that.

By knowing this is not something she's supposed to do, he didn't recognize it as being abnormal.

Q. Let me come back to that because I don't want to forget this point. The next testimony that you read, you do acknowledge that he said that if he had determined that she was at a high risk for falls that he would have accompanied her to the bathroom or would have wanted her to accompany him to the bathroom.

It's not your testimony that her one prior fall would have put her at a high risk for falls, is it?

MR. BUCHANAN: Object to the form.

A. I would actually say that it does -- and he's not defining high risk in that little discussion there. If you want to talk about what makes somebody a higher risk than a lower

Starer

risk. I would say if he knew the nature of the fall, he would say she's at high risk of falls. That is to say, if she's fallen up the stairs in the past, and now she's going up the stairs, that's a high risk.

This is a woman who has fallen -- you know, I say, since no one has really investigated, I don't know if it has to do with changing position or pulling up the dress or something like that. Carrying out this activity she's gotten into trouble before. It would really, I think, behoove us to really be on alert, knowing this has gone on before. It all goes back to the question if he had a place to look and looked, he would have known that maybe she is a high risk right now.

Q. Let's visit about the toileting issue, the pattern that you found and the similarities between the fall and the acute care setting and the fall in Traditions.

The fall in the acute care setting was in the middle of the night, correct?

A. Correct.

Q. And it was not during the process of

Starer

toileting but rather was when she was up in the middle of the night disoriented trying to make it to the bathroom.

Would you agree with that?

A. The incident, she slips coming back from the bathroom in the hospital side. And that does occur at 1:00 a.m. in the morning. Here the report is that -- seems to be daylight hours and she falls backwards after getting up, it says. And I think we had gotten into this before, is it more similar or dissimilar. If you're using time as a variable, is a 1 o'clock fall the same as a 4 o'clock fall, certainly you can say it's a different time. I will agree with you it's a different time.

Q. But the first fall was not similar to the second fall in that it was during the process of toileting, it was similar in that the reason she was up was to go to the bathroom, but not the actual process of going to toileting, that something about that process caused her to fall. It was actually the ambulating to go to the bathroom in the

Starer

middle of the night that caused her to fall, correct?

A. And you're going to be a good member of my team. Because that's the kind of rationale I like when we go over a care plan. Exactly. Don't focus on the toilet, I would say to my staff. Focus on the activity. And going to toilets, going from beds to toilets and walking, that is probably what we should look at. That's the commonality. It's not the toilet bowl itself. It's the getting up, going over, sitting down, changes in position.

How often during the day does that actually happen for her. It may be a turn, she's going to and coming back. And that's the commonality we want to look for here. So, it's that activity. She may be going in and brushing her teeth and coming back. It's getting up, going to a little room, getting up, coming back. That's what puts her at risk.

Q. The first fall she fell while ambulating from the rest room, whereas in the second fall she fell when she actually tried

Starer

to get up from the toilet.

Are those two distinct activities?

A. These are activities. That's why this is very, very interesting. It's a balance problem. And it's in -- you can read the fall articles later on. When you're assessing somebody -- I don't know if you want me to show you where it is.

When you're trying to assess somebody for a fall risk, they do what they call the get up and go test where you look at each entity. The patient rises. You can imagine what it is. They get up, they stand, they walk, they turn and they come back. You watch them. If at any point in the process there's instability, you know there's a problem, and they score positive for a risk. It might be artificial, though, to say well, the first time she fell coming back to the bed, the second time she fell getting up from the bed. There's something wrong with her internal equilibrium that's not letting her get through this. I don't know if she's tripping both times. I don't know if she gets

Starer

a little vertigo each time. I know there's something wrong.

And this is someone who probably needs some guarding, which I think they really do agree with that. It's just that Mr. Kerr didn't know it when he was there.

Q. Doctor, I appreciate your explanations, but we are late in the day and if you would just, if at all possible, try to listen to my question and answer just the question that is posed at this late hour.

Is that okay?

A. That's a very reasonable request.

Q. And the question was: The first fall occurred while she was ambulating.

She was walking and fell, correct?

A. That is correct.

Q. The second fall occurred when she stood up from toileting, correct?

A. That is correct. That's what she put.

Q. When Mr. Kerr arrived in Ms. Lawson's room, she was standing, correct?

A. Correct.

Starer

Q. She had dressed herself?

A. This is what -- I heard this, hair brushing, yes.

Q. And she was standing on her own, hands above her head brushing her hair, correct?

A. That's what -- yes.

Q. And she was able at that point to ambulate to the rest room without assistance, correct?

A. Correct.

Q. So, where she had previously fallen was during the ambulation?

A. Right, yes.

Q. And not during the actual toileting?

A. Right.

Q. And in the second fall she was able to get past ambulating on her own to the rest room, correct?

A. Just a moment for a sec. I got confused. I just want to look at his note. I'm sorry.

Q. While you're looking for that --

A. I'm going to have this fast. All

Starer

right. I guess what I'm pausing here is -- the description of the fall, I don't see that Mr. Kerr -- is this Mr. Kerr -- where's Mr. Kerr's note? While I'm looking for that, you can ask me the other question.

Q. Have you ever heard of the retrospectoscope?

A. Is that like a jackalope?

Q. Let me put it this way: Do you agree that it can be easier criticize medical providers' choices of care in hindsight than it is by just looking at the information that's available to them at the time?

A. It's very general. I don't know how to answer that. There's so many different ways of collecting information and things like that. So I'm going to say I don't know. I don't know.

Q. Do you believe that it's fair to criticize medical providers' choices, clinical judgment that's made at the time by looking at it in retrospect and knowing the outcome?

A. I think it's fair. I think it's obligatory. Checks and balances. You don't

Starer

want a long answer. Yes, I think it's fair.

Q. Why?

A. Because this is how we improve our practice. It's quality assurance. Each place usually has on board something like that, where an incident occurs and they review it to see what can be done differently.

Q. In terms of medical malpractice, do you think it's fair to judge a medical provider's decision and clinical judgment that they're making at the time by only looking in hindsight knowing about the end result, do you think that it's fair to criticize whether or not they breached the standard of care by looking at the whole picture in retrospect knowing the outcome?

A. Yes. I have to think for a minute. I don't see how else it can be done.

Q. In this particular case you're aware that Ms. Lawson's granddaughters had or one of her granddaughters testified that she had shortly before her fall had been walking short distances on her own?

A. I'm not familiar with that

Starer

testimony.

Q. I'll represent to you that that is what one of Ms. Lawson's granddaughters testified to.

Would that change your opinions in this case?

A. No. It wouldn't change my opinions.

Q. Have you reviewed any of the family members' testimony?

A. No, I didn't look at that.

Q. Do you feel that that's important to know what was going on with Ms. Lawson from a physical and mental standpoint prior to her fall?

A. I'm relying on the reports of the health care professionals. If there's something you'd like me to review, though, I'll certainly look at that.

Q. You don't think that information was important that she was walking short distances shortly before her fall? It would not change your opinions in this case?

A. The same information was provided in these charts.

Starer

Q. We know based on the information that's -- based on Mr. Kerr's deposition testimony and his notes that said that he came to Ms. Lawson's room that she was standing on her own and brushing her hair as we discussed, correct?

A. Yes.

Q. And we also know that he had an interaction with her, a verbal interaction and that he assessed her to be alert and oriented at that time?

MR. BUCHANAN: Object to the form.

A. I guess the reason I'm flipping through this now is I just -- I'm relying on my memory. But if we can find that part here where I can just see it, it might be helpful. I didn't actually mark that myself.

Q. I thought you did.

A. Not the stuff about the hair brush.

Q. I think you did.

A. Maybe I did.

Q. Hold on.

A. I marked something about oriented times three, if that's what you're talking

Starer

about.

Q. Let's look at pages 18 through 20. I think on Page 19 -- it's a passage that we've already discussed.

A. Okay. I apologize. I'm not certain this specifically says she's alert and oriented. He says if she's alert and oriented.

Q. His testimony was that if a patient is alert and oriented they have the right to refuse assistance and we know he asked if she wanted assistance and she said no and he accepted that answer.

Based on that, even though the specific question may not be asked or we may not be able to point to it right now, but is it a fair assumption that he assessed her as being alert and oriented enough to make the decision to not need assistance?

MR. BUCHANAN: Objection to form.

A. It's a good question. This is making the presumption that this actually was said. Because I can't find it right now myself. But presuming that he said this, that

Starer

she's alert and oriented to person, place and time and she says to me, I do not want assistance, does she have the right to make that statement or does he have the obligation to comply with it. Is that the question? Give me your form of it.

Q. I was simply trying to set a scene what he observed when he had come into her room. She was standing up, she was brushing her hair. There was a verbal communication, exchange between of two of them about her needing to go to the rest room before physical therapy and that he made the decision at that time that she was alert and oriented enough to be able to make that decision and her decision was that no, she did not need assistance.

Is that all a fair characterization as to the circumstances surrounding Mr. Kerr's decision to allow her to go to the rest room on her own?

A. Okay. Good. He walked in and saw her standing by the mirror. Right. Because I can't find that --

Q. By the bed, actually, I believe was

Starer

his testimony.

A. We can't find that right now. Okay, she's standing up, though?

Q. Yes.

A. She says while standing up --

Q. And brushing her hair.

A. Hello, it's June 20 whatever it was. And I do not need assistance, can I go to the bathroom. Here's where I'm getting a little bit foggy. Because according to the nurses' notes it says she got up too fast to go to the bathroom. I can't mesh the two.

His description of the situation is she's brushing her hair and going to the bathroom and then falls. But the nurses report she got up too fast to go to the bathroom, which would actually say she was sitting down and got up to go brush her hair. They're characterizing this entity differently. If he's correct, then it actually is more in line with what previously happened on the hospital side, that she's ambulating not changing position.

Q. It's my understanding the report was

Starer

that she fell after getting up from the bathroom, from toileting, and I believe that's consistent with Mr. Kerr's recollection or documentation as well.

MR. BUCHANAN: Objection to form.

A. I just want complete accuracy.

Q. Absolutely.

A. Absolutely. 11:45 patient says she got up too fast to go to bathroom prephysical therapy. So that's where I'm a little unclear on the circumstances.

Q. If that were the case, then Mr. Kerr would have been right there, based on his testimony?

A. But his testimony -- his recollection may not be accurate of the situation. If he remembers her standing up and going as opposed to having a change in position, getting up and -- if the fall occurred as she's getting up to go to the bathroom, he would have been right there, as opposed to her falling in the bathroom. That's why I would like to see his description now because it actually makes me concerned.

Starer

Q. If you want to take just a minute to find that, I think that's an important --

A. I think we should get that out of the way.

Q. Let me ask you this: If it's your interpretation of the nurse's note that she fell while going to the bathroom, we know that would have been in Mr. Kerr's presence?

A. Correct.

Q. Which would have been her still falling with one on one supervision.

A. Which is why it's troublesome, why he didn't -- let's make certain we know what we're talking about.

Q. Can't a patient still fall with one on one supervision?

A. Certainly it can happen if he is not close enough to her or she's much heavier than he is. But that's not the description I'm getting. It's almost like he had his back turned. Let me see if I can find the part. I don't remember now --

THE WITNESS: Can I take a break to answer the phone?

Starer

(A brief recess was taken.)

Q. I understand you flipped through Mr. Kerr's deposition and you can't find specific reference as to when she fell as far as whether it was prior to making it to the bathroom or after.

A. Right.

Q. We have the nurses' notes.

Have you reviewed his note as well, the 6:28 note?

A. Got it.

Q. Based on what information is available and what information you recall, do you believe that and do you have opinion that it was a breach of the standard of care on the part of the physical therapist to allow Ms. Lawson to go to the bathroom on her own?

A. Standard of care -- now, this is the presumption that -- that that's exactly what happened. Because the other thing about getting up from the bed suggests that she actually fell prior to that. The presumption that she fell in the bathroom, I believe it was a breach in the standard of care for him

Starer

to allow her to go to the bathroom on her own.

Q. Is it that breach of the standard of care on the part of the physical therapist that you maintain proximally caused the injury to Ms. Lawson that directly led to her death?

A. That breach led to the injury, yes.

Q. And it's your opinion to a reasonable degree of medical certainty that it was that breach of the standard of care that proximally caused the injury to Ms. Lawson that led to her death?

A. Yes.

Q. And that's a criticism you have of the physical therapist in this case?

A. Yes.

Q. Do you have any other criticisms of the physical therapist?

A. Well, it's the same criticism, but I guess within that is not being familiar with Ms. Lawson's previous fall history. That's -- it's the same criticism.

Q. Do you maintain that the standard of care required the physical therapist to make himself familiar with Ms. Lawson's medical

Starer

history before allowing her to ambulate on her own to the rest room?

A. With pertinent components, yes.

Q. I'm going to kind of jump around which is what I warned you I was going to do.

I've looked at some of the articles that you have pulled here and I notice one "Guideline for the Prevention of Falls in Older Persons," that's published by the Journal of the American Geriatric Society. The best I can tell.

A. Let me help you. Okay. So this was -- it's this one, Guideline.

Q. Yes, sir.

A. And that is published in the Journal of the American Geriatric Society, that's true.

Q. Are you familiar with the Journal of the American Geriatric Society?

A. Yes, I've read it. I used to have a subscription.

Q. You don't currently have one?

A. That is correct.

Q. Any particular reason as to why you

Starer

don't currently subscribe to that journal?

A. Yes. I don't subscribe to any journals any more because this is the 21st century and you can get everything on-line. I don't have to. You just go on-line and read the articles.

Q. Your not having a subscription doesn't have anything to do with the credibility you place in the journal or the articles they publish?

A. It's a financial decision.

Q. Do you rely on the data that's published in the Journal of the American Geriatric Society in your care and treatment of patients?

A. Not solely, but I do use it.

Q. You consider it to be authoritative?

A. It's reliable and reproducible.

Q. Dr. Starer, do you agree that there is a distinction in the medical literature between fall preventions in nursing homes and fall preventions in hospitals?

A. I don't know if I agree with that. I've been looking at some of the stuff. Many

Starer

of the components translate from nursing home to hospital. So, I don't think there's a clear distinction. I know they might when they write it, they might have different headings and alter thing ever so slightly. But the principles generally translate from one side to another.

Q. In preparing for your deposition, did you review this article that you provided us, the "Guidelines for the Prevention of Falls in Older Persons"?

A. Yes.

Q. Did you rely on the information contained in this article in forming your opinions in this case?

A. I utilized some of it, yes.

Q. Did you read the section on Page 668 that states under the heading "in hospital based study" that states, "Although the strategy is widely implemented, there are no adequate randomized control trials of multifactorial intervention studies to reduce falls among hospital inpatients"?

A. I certainly read that statement.

Starer

Q. Did you follow up on that statement there? I note there's a footnote.

A. Yes, 49.

Q. Did you look at the text referenced in that footnote?

A. I mean, I looked at the article there. I believe that's, you know, an opinion piece. But I know what that statement -- I mean, this is a statement which I'm not going to refute.

Q. Do you agree that falls among older hospital inpatients are common?

A. I know they do occur in the hospital. I don't know what you mean by common.

Q. If the Journal of American Geriatric Society in 2000 had stated in one of their articles that falls among older hospital inpatients were common, would you refute that?

A. Well, I'm not going to refute that the statement was made. But I'd still say I'll go deeper into the article and see a percentage. I'm not going to disagree with it.

Starer

Q. Do you agree that the occurrence of falls after an acute illness may be increased in older hospital patients?

A. Yes. I'm sure in one of these articles it says that, sure. That's why we're writing the articles.

Q. Would you agree that such falls are an inevitable consequence of encouraging patients to regain mobility?

A. Well, it may be a consequence of encouraging a patient to regain -- but inevitable means everybody's going to get it and I'd rather not use that phraseology. I can't agree with the qualifier inevitable.

Q. Would you agree that not every fall in a hospital setting that occurs with a patient who has had an acute illness indicates by its very fact that there is a breach in the standard of care?

A. Yes. If it's an absolute statement like that. I actually forgot whether it's a positive or negative. Not every single case can be a breach of standard of care.

Q. Falls can occur without being a

Starer

breach of the standard of care?

A. I would need the specifics of it. But I'm sure one can describe -- might be able to say it's not a breach.

Q. You'd have to look at the circumstances surrounding that fall, that particular fall at that particular time, in order to determine whether there was a breach of the standard of care?

A. We'd have to look at the factors and see which are preventable and which are not.

Q. Would you agree that hospitals with no falls or a very low fall rate can only achieve this by overcustodial approach or widespread use of restraints?

A. It sounds like somebody made that statement. I would like to see the article where that's been used. There's been other discussions that restraints don't even stop falls in and of themselves. I'm not sure where this hospital is. But I can't imagine that you have to restrain every elderly patient to get your fall numbers down to zero. I would need to see where you extracted that.

Starer

Q. And that's not what I was saying. There may have been some miscommunication.

Would you agree that just overall the only way to achieve an absolute zero fall rate or low fall rate would be to take an overcustodial approach or use of restraints?

A. I guess it's the overcustodial I don't understand. If that's really increased vigilance in supervision, certainly that is a powerful tool. I would agree with it if overcustodial means close monitoring.

Q. Do you agree that there are going to be some falls of patients who have had acute illness if you're going to try to rehabilitate them to regain their mobility, that some falls are going to occur with those patients?

A. It's too general. It depends on the patient population. It may be different sectors. I don't know how to answer the question. It's too general. What are some of the variables we're talking about? Actually I'm not sure what we're talking about. You're saying any time you're try to rehabilitate someone, someone's going to fall. I don't

Starer

know. I'm not certain about that.

Q. Do you intend to offer any criticisms at trial of any of the nursing care that was provided to Ms. Lawson in this case?

A. Well, I imagine I would offer some criticism, yes.

Q. What would those be?

A. It would be in the area of fall precautions and possibly had some additional information on the obtaining of the CT scan prior to the -- following the fall on June 28, 2002.

Q. What are your specific criticisms of the nurses at Southwest Regional Medical Center with respect to fall precautions in this case?

A. Well, they did not -- I do not see a plan being implemented and carried out to prevent her falls. This goes back to what we had spoken about before, monitoring supervision, trying to understand what's going on, you know, with this patient. And that was fall precautions. It's not really dealing with the situation in an effective manner.

Starer

Q. Is there anything specific that you believe the nurses could have done which would have prevented this particular fall under these particular circumstances with the physical therapist making the decision to allow her to go to the rest room on her own?

A. I think it comes back to the whole approach to toileting with this woman and not having the toileting plan in place, not having a way for either the patient to communicate with the nursing staff or with the nursing staff to anticipate her needs and, you know, she just gets up, goes to the bathroom with the physical therapist standing around and she falls.

She could have been on a toileting schedule to make sure the bladder never got or whatever it was, the need to have a bowel movement, never got to the point where she would go off unattended. Just preemptively toileting her, knowing that this is what gets her going, this way she wouldn't have a need to do it off schedule when there's no one around to help her or someone around who

Starer

chooses not to help her.

Q. Doctor, are you going to testify at trial to a reasonable degree of medical certainty that under these particular circumstances, these fact specific circumstances in this case, that preemptive toileting would have prevented the fall, Ms. Lawson's fall, in this case?

A. Yes, I will.

Q. What is that based on?

A. Based on the time that she got up to toilet herself. If we had toileted her -- there's no evidence that I find that she's going to the bathroom just to visit the bathroom. She's going to the bathroom because she has to urinate. She actually says it at one point. If someone had toileted her 15 minutes, half an hour, prior to the episode, she -- come in, here we are, we're going to take you, now you're empty, then she wouldn't have felt a need a half an hour later to get up and go. I think it more than likely that would have worked.

Q. Do you have any information whether

Starer

or not the nurses did ask Ms. Lawson whether she had to go to the rest room prior to the physical therapist?

A. I couldn't find documentation that they were doing the prompted toileting it's called.

Q. Would a nurse be required to document that she asked a patient do you need to go to the rest room? I mean, that's not something a nurse would ordinary document, is it?

A. You know what's important is documentation when people are going to be looking for it. That's the whole retrospectoscope. If it's important now, it might have been important then. If we know that this is going to be her problem, that she gets up and goes to the bathroom and we're going to try to put a plan into place, and you're not going to use your care plan, you're going to leave it blank, then there's got to be somewhere else where you can look at it and go, okay, she's been toileted, I don't have to do it.

Starer

This is a communication tool. It's not supposed to be used the way we're using it. People are putting in information so they can check to see what the last practitioner did. If you're not going to document your interventions, either you didn't do or you're doing it and you're keeping it a secret. If you're keeping it a secret, we have nothing to build on. Who knows whether she went to the toilet before. Maybe it's here. But I couldn't find it.

Q. Doctor, you're saying theoretically if she had this preemptive toileting she might not have needed to go with the physical therapist and the fall wouldn't have occurred.

But isn't it also just as likely they could have had this preemptive toiling in place, they could have asked her whether she needs to use the rest room; she could have said no because she didn't at the time, and then 15 minutes later the physical therapist walks in and lo and behold she needs to use the rest room and then we're exactly back to the same situation that we're in? Is that not

Starer

just as likely?

A. You see, it's just as likely because they at the time did not approach this as a problem. It's one basic criticism. She's falling and she's getting up to go to the bathroom. If someone sat down and said well, let's address this. Let's say that it's toilet related and let's put this plan into place and see if it works and document it. Then there would have been no question at that time whether it was working and no question retrospectively whether it was working.

It wasn't there. However, I will say that their documentation when they find something is pretty extensive. You can almost say that it didn't occur because there's this whole paragraph here about her peeing in the middle of the night and they just go on and on. So, they're not shy about putting down things. Because I think you might suggesting is it important to document these little things.

There's this whole thing about when I need -- she's being quoted. I need to pee.

Starer

I'm going to the bathroom. Should I have pee in the bed? It's all in here. So, they are oriented to part of it. They're just not carrying it out. If you're going to document that the woman is getting up in the middle of the night and she doesn't want to pee in bed, then implement a plan, toilet her and let's see where we go.

This is just -- it's voyeurism. They're collecting the information but they're not synthesizing it into a plan.

Q. You've used the term, it's just speculation.

Is it fair to say whether or not it would have changed the outcome in this particular case would also just be speculating as to whether it would have changed the outcome in this particular case?

A. Well, I'm basing it on the records and on my experience and on the standard of care and more likely than not it would have made a difference.

Q. Do you have any medical treatises or authoritative texts that support that opinion?

Starer

A. I don't have it with me now. If you're talking about the opinion of the effectiveness of prompted toileting, that does exist, sure.

Q. Can you provide that?

A. To Mr. Buchanan?

THE WITNESS: Are we going to do that?

A. Yes.

Q. Also, doctor, do you have any authoritative studies, texts, treatises that support the proposition that in hospital fall prevention programs reduce falls in hospitals?

A. This I would actually have to look before I can say yes or no. I can search for that and see if I have it in my file. I don't know if I have it right now.

Q. Do you know if such studies exist that support the proposition that these fall prevention programs that you have testified should have been in place with respect to Ms. Lawson actually reduce falls in hospital settings?

A. Are you asking for a placebo

Starer

controlled trial or --

Q. What I'm asking for is anything of --

A. I could search for you.

Q. But as we sit here today, do you know of any authoritative medical text, research treatises that support that proposition?

A. As I sit here today, I cannot name one for you.

Q. The other criticisms that you had of the nurses you said have to do with respect to the CT scan.

What is your specific criticisms of the nurses with respect to that issue?

A. I said I might have a criticism there because this -- and this comes back from the deposition of Dr. Thomas. There seems to be some confusion as to whether the CT scan was obtained and I don't know -- I don't know how that was -- the chain of command there. I would need some additional information which might be provided later on where the nurse is the one who, you know, arranges for the CT

Starer

scan after picking up the order or the nurse is responsible for communicating to the doctor that the CT scan wasn't done or the nurse is not even involved.

Without additional information, I may or may not have criticism. It just seemed that the doctor got very annoyed, Dr. Thomas got annoyed that there was a two hour lag, which to me, I would then want to know who did not carry out their part of the -- what was the system for obtaining the CT scan.

Q. Have you reviewed Nurse Poge's deposition testimony in this case?

A. I looked at it. I didn't read it in as great detail as I did these.

Q. As we sit here today, based on the information that you have available to you, do you have any criticisms of the nurses with respect to the ordering or the carrying out of the order of the CT scan?

A. With the information I have in my recollection right now, I do not have a firm criticism.

Q. You said a firm criticism and you

Starer

understand we're here today for us to learn all the criticisms that you intend to express at trial and I don't want to be surprised at trial if there's a criticism you intend to express against the nurses.

A. If I develop a criticism, I will then inform Mr. Buchanan.

Q. Thank you.

Have we thoroughly explored your criticisms in this case against the nurses at Southwest?

A. I believe we have. As best as I can recall right now I am going to say yes. This is Southwest Traditions?

Q. Absolutely.

A. Okay.

Q. On the fall precautions you said that your criticism of them was there should have been this preemptive toileting and we discussed that in detail.

Is it your opinion that the nurses were solely responsible for implementing that plan of care or is this a -- something that is a multi-disciplinary team approach that should

Starer

have been carried out and wasn't or you hold the nurses solely responsibility for?

A. It seems like nobody was carrying it out. I'm holding the nurses and the physician responsible.

MS. CAULEY: I'll pass the witness at this point.

EXAMINATION BY

MR. ANDERSON:

Q. I am Overton Anderson. I represent Dr. Lynn Thomas in this case. I'll be asking you some questions about opinions that relate to her.

Do you have any opinions that relate to Dr. Lynn Thomas?

A. Yes.

Q. What are those, sir?

A. My -- Dr. Lynn Thomas, as I understand, was involved at the Traditions side. I just want to be clear on that. And my criticism is with the reaction after the fall and the obtaining of the CT scan.

Q. What is the criticism? I don't mean to rush you.

Starer

A. I understand you have a time constraint.

After the head trauma there is the neuro checks which we've spoken about and there are changes in her status somewhere along the line, I believe around 1400 hours, 1400 hours and 45 minutes where she begins to complain of pain. That is the symptom that we spoke about. And the doctor is notified.

Now, at this point it seems like Dr. Thomas is in charge and during this time the patient goes and has a skull x-ray, comes back, gets more confused and vomits. The CT scan is delayed. There is a delay in care and probably a lack of supervision in the implementation of the diagnostic plan at this time.

Q. So, is that your sole criticism of Dr. Thomas?

A. Well, Dr. Thomas seemed to be involved -- here I would have to -- the relationship between Dr. Thomas and Dr. Green is not that clear to me. I might be provided with additional information later on or maybe

Starer

right now. But Dr. Thomas writes the admitting orders as well as Dr. Green. It seems that Dr. Thomas, the way this is written, is the primary physician with Dr. Green acting as a consultant for medical issues.

I'm not sure how they're operating, but it does say to me that they are operating almost in tandem. And I think it comes up in deposition. Therefore, I would criticize Dr. Thomas as well for the lack of implementation of a fall prevention plan.

Q. Is that an opinion that you developed after you and I started talking?

A. No. I was giving you the thought process of how I arrived at it. This is an opinion I based upon looking at the chart.

Q. What is your understanding of Dr. Thomas' role in the care of this patient?

A. My understanding is with the information provided to me that Dr. Thomas is the treating physician for this patient.

Q. You understand Dr. Thomas is a psychiatrist?

Starer

A. This is an understanding I have now, yes.

Q. So the answer is yes?

A. Yes.

Q. And if you would give yes answers and no answers and I don't know answers when you're able to do so, would you do that for me, please?

A. I'll do the best I can.

Q. Is it your understanding that Dr. Thomas was to provide psychiatric care for this patient and that Dr. Green was to follow the patient with respect to medical issues?

A. That was not my complete understanding based upon my review of the records. If you're telling me that, then it's my understanding now.

Q. Is there anything in the record that is inconsistent with the proposition that Dr. Thomas was providing psychiatric care and Dr. Green was following this patient for medical issues?

A. Yes.

Q. What?

Starer

A. Looking at the order sheets and they're both writing admitting orders and it seems to be a bit of a crossover here where Dr. Green is prescribing the -- some of the psychiatric medicines. He writes the admitting orders for Effexor where Dr. Thomas takes on the responsibility of ordering diet, vital signs, weights, activity orders, medicines for constipation. That's why my answer was longer, that they seemed to be sharing responsibility.

Q. To the extent that they shared responsibility are you able to determine?

A. I can't determine where one led off and the other began. I see Dr. Green writes orders in the chart. Dr. Thomas writes orders. Dr. Thomas felt very involved in the obtaining of the CT scan. That's a medical component in which she was involved in. That's why I'm having difficulty dividing their responsibilities.

Q. You understand that Dr. Thomas' specialty is psychiatry?

A. You have told me that and I

Starer

understand it.

Q. Is it your intention to express opinions regarding the duty of Dr. Thomas in this case?

A. I need clarification. The duty in what way?

Q. Is it your expectation to testify that Dr. Thomas had a duty to do something she didn't do?

A. Yes.

Q. What is it you intend to testify about with respect to?

A. That's a good question. I would testify that she was involved with the care of this patient as far as preventing falls and also with the obtaining of a CT scan.

Q. What is it that you claim that Dr. Thomas could or should have done that might have prevented the fall of June 28th, 2002?

A. If Dr. Thomas had also contributed to a care plan, which did not seem to exist, there might have been a care plan and then the fall would not have occurred.

Q. How do you know that?

Starer

A. How do I know that?

Q. Yes, sir.

A. Well, in the absence of a plan, the falls continue to occur. In the absence of Dr. Thomas recognizing that the patient is at risk of falls, there was no opportunity to intervene. And certainly this is her purview.

Q. Are you assuming that Dr. Thomas did not recognize that this patient had a risk of falls?

A. I am basing it on my review of the records where I don't see Dr. Thomas discussing the risk of falls. It might be in a document which I don't have. But I don't see that this is addressed.

Q. So you assume that Dr. Thomas did not consider this patient's risk of falls?

A. I don't see any evidence of that.

Q. So, do you assume that she did not address or consider risk of falls in this patient?

A. I can assume based on the documentation that her consideration was not communicated with the staff and the result was

Starer

the patient fell.

Q. You have told some of these lawyers that you don't know whether or not this patient would have died even if she had an immediate CT scan; is that correct?

A. That's correct.

Q. And you don't know if a CT scan conducted, for example, immediately after 11:45 would have shown an intracranial bleed?

A. That is correct.

Q. And you don't know if earlier surgery would have changed the outcome in this case; do you agree?

A. I do not know based on the information I had.

Q. You don't know if any intervention taken by any physicians taken after the fall would have changed the outcome in this case?

A. That's correct.

Q. You used the term standard of care in your testimony.

A. Mm-hmm.

Q. What do you mean by that term?

A. The standard of care is what a

Starer

practitioner who is reasonable, responsible and prudent would provide to a patient in order to deliver care.

Q. What you have given us is your opinion as to the standard of care of what was required of Dr. Thomas and Dr. Green; is that right?

A. That's right.

Q. In other words, the standard of care is not something that is written down, is it, sir?

A. Oh, it can be found, certainly.

Q. Do you believe that there is something written in any of these articles that you have accumulated here to support your opinions that even discusses standard of care?

A. Without going through the articles in detail, I'm not sure if the phrase standard of care is there. But there are guidelines how to take care of patients.

Q. There are recommendations?

A. Recommendations and rules and regulations. Yes, it's all included.

Q. Are there any -- you told us there

Starer

are no written protocols or policies at your hospital with respect to when a CT scan is to be ordered?

A. Not that I'm aware of.

Q. Do you know of any hospital anywhere that has a policy or a protocol that requires a CT scan?

A. Well, certainly I have not been to every hospital. But I, of course, would say I cannot tell you about every hospital, so I don't know.

Q. You don't know if the standard of care in Little Rock, Arkansas, has anything written that says in circumstances such as this a CT scan would be required, do you, sir?

A. You said the standard of care in Little Rock has written.

Q. Maybe I misspoke.

Do you know about any written standard of care that exists at any hospital in Little Rock, Arkansas?

A. No, as I sit here today --

Q. Let me finish my question.

A. Oh, sorry.

Starer

Q. Do you know anything written in any hospital in Little Rock, Arkansas that requires a CT scan be ordered for a patient under circumstances such as this?

A. I don't know of any written documents in Little Rock, Arkansas that addresses this.

Q. Do you know of anything in Arkansas, any written documents, that require CT scan under circumstances such as this?

A. I am not aware of any documents at this time in Arkansas about CT scans about situations --

Q. You have articles that have recommendations, but those aren't rules, are they?

A. Without going into each of the articles. There may be a rule in here. I'll just say in general these are recommendations and guidelines, direct guidelines.

Q. And recommendations and guidelines are not rules and regulations that doctors must always follow?

A. These are not laws. These are

Starer

guidelines.

Q. Do you agree with the statement never say always and never say never?

A. No. But I don't know what it actually means.

Q. Does that apply in medicine?

A. I don't use that phraseology, so --

Q. To what extent is clinical judgment a factor in the standard of care?

A. Clinical judgment is a factor in the standard of care.

Q. How? How is it a factor?

A. Clinical judgment allows you to apply the guidelines in a rational way to the patient you have with you.

Q. You say your practice at your hospital is to order a CT scan under circumstances such as Ms. Lawson's case; is that right?

A. That's correct.

Q. When did you learn what the standard of care in Little Rock, Arkansas was?

MR. BUCHANAN: Object to the form.

A. When did I learn? I guess I learned

Starer

what the standard of care in Little Rock, Arkansas is when I learned what the standard of care is in New York.

Q. Your assumption is the standard of care in New York City is the same as in Little Rock?

A. Yes, applicable, yes.

Q. Is there any locale in the United States that you believe to have a different standard of care than New York City?

A. I would have to go area by area. As of now I cannot think of -- I'm not really addressing other locales, so I can't think of an answer for you.

Q. Do you assume that there is a national standard of care?

A. I believe that there is a standard of care where I practice and when there is an area that is similar as far as population and medical community, then the standard of care where I am applies there.

Q. You mentioned that you looked at the demographics of Little Rock?

A. That is correct.

Starer

Q. Is that information Mr. Buchanan's law firm sent to you?

A. Yes. I received it from them.

Q. What do you mean by demographics?

A. I actually looked at a bunch of things. Should I itemize them?

Q. Just tell me what you mean by demographics.

A. Age and gender distribution, race distribution, household income, infant mortality, infant statistics and I also looked at the physician specialty list, state nurse's aide training programs and some information on nursing home facilities.

Q. So you looked at the demographics of the general population with items such as age, sex, income, what else?

A. Race.

Q. Race.

A. Infant mortality, if that counts.

Q. Let's just talk about demographics. Those items that you talked about, how does that tell you what the standard of care of doctors practicing in Little Rock, Arkansas

Starer

is?

A. It tells me that we're treating a similar population of people.

Q. It tells you that people in Little Rock are similar to people in New York still?

A. More similar than different, yes.

Q. And then you also look at physicians' specialties?

A. That's right.

Q. What physicians' specialties exist in Little Rock, Arkansas and what physicians' specialties exist in New York, correct?

A. Exactly.

Q. How does that help you determine what the standard of care is in Little Rock, Arkansas?

A. It helps me see that the same depth of medical information is available in both places. There are specialists there and there are specialists here and the different disciplines are represented in both geographic locations.

Q. You are not a psychiatrist?

A. No.

Starer

Q. No residency in psychiatry?

A. That is true.

Q. Never held any privileges at any hospital to practice psychiatry?

A. True.

Q. Never taken boards in psychiatry?

A. Yes, that's true.

Q. Never admitted a patient to a psychiatric ward?

A. No, I haven't.

Q. Do you claim any expertise in the field of psychiatry which is Dr. Thomas' specialty?

A. I have no expertise beyond what I would need to know as an internist.

Q. If you encountered a patient who needed psychiatric care, would you consult a psychiatrist?

A. I will say yes. I mean, if it's my patient, yes.

Q. What are hospital privileges? What are privileges?

A. The privilege is exactly that, the right to practice in a hospital. You are

Starer

granted that privilege to take care of patients in that particular facility.

Q. You have privileges at your hospital, I take it, to practice as an internal medicine specialist and a geriatric specialist?

A. Yes.

Q. Is that the extent of your privileges?

A. Yes.

Q. And to gain those privileges you or any other physician have to convince the medical staff that you are educated and trained and experienced enough to practice in that specialty, correct?

A. And ongoing education, yes.

Q. Do you know anything about Dr. Thomas?

A. Aside from what I have in the deposition and the note she's written, that's all I know.

Q. Do you have any reason to believe that she lacks any training or experience to practice as a psychiatrist?

Starer

A. Without having her CV in front of me now, I have no reason to suspect that she lacks the experience and training to practice as a psychiatrist.

Q. As far as you know, is she well trained and experienced as a psychiatrist?

A. I don't know anything about her training, actually.

Q. Have you encountered in your career physicians who are caring physicians?

A. Yes, I have encountered caring physicians.

Q. Do you know whether or not Dr. Thomas was a caring physician?

A. I do believe she's a caring physician.

Q. Do you believe she has the best interest of her patients at heart?

A. I believe everyone has the best interests of their patients at heart.

Q. Dr. Thomas and the other caregivers providing care to Ms. Lawson had to make clinical decisions regarding her care; is that correct?

Starer

A. Could I just hear that one again, I'm sorry?

Q. The caregivers, including Dr. Thomas, had to make clinical decisions regarding Ms. Lawson's care; is that correct?

A. Right. They were responsible for her care, yes.

Q. In doing that, they had to make judgments as to what care would have been appropriate for her; is that right?

A. That is true.

Q. And your opinions that you've expressed indicate to us that you believe you would have made those judgments differently than Dr. Thomas and Dr. Green; is that right?

A. Yes.

Q. I may have asked this. I want to make sure that we have it.

Do you know of any law, regulation, rule or policy which would require Dr. Thomas to do anything differently than what she did with respect to this patient?

A. Law, rule, policy and what was the last thing --

Starer

Q. Just take those. Any law, regulation, rule or policy.

A. I am not aware of any law to check your CT scan. I would have to say with the information I have now, I don't know of any law or rule that requires her to provide the care in the manner that I have suggested.

Q. Or policy?

A. Policy, the policy might differ where I am and I don't know, there might be policies elsewhere. I don't know, I can't say right here as I sit here today that I know of a policy.

Q. Do you know of any writing anywhere that says Dr. Thomas should have done something differently than she did?

A. Any writing that says you should check a CT scan, that it's obtained. I don't know of such an exact written comment as I sit here today.

Q. So, what we're left with is, if there is no writing or rule or policy, what we're left with is clinical judgment?

A. The doctor just does what they want.

Starer

Q. Within the confines of the standard of care where they practice, correct?

A. No. There's no rule. Then, in the absence of rules, laws, policies, one should do according to the standard of care. So, I believe there was a deviation -- I'm not saying that she didn't comply with the standard of care. I'm saying she deviated from it.

Q. You're saying she deviated from what your opinion is as to the standard of care, correct?

A. As my understanding of the standard of care as it applies to Little Rock, Arkansas, she deviated. That is my opinion.

Q. Do you agree that Dr. Thomas had some advantages over you, sir?

A. In what way?

Q. Was she able to see and evaluate this patient?

A. She had the opportunity to see and evaluate the patient and I did not.

Q. Did she do that?

A. I don't see any evidence of it in

Starer

the chart.

Q. You see no evidence that Dr. Thomas saw this patient and evaluated her?

A. At the time of my -- the part of the time that I'm criticizing. There are other times where she has documentation, but I do not see during that critical time documentation that she saw the patient.

Q. What is that critical time as you're using that term?

A. If you give me a moment. I believe the critical time would have been when she realized the CT scan had not been obtained, two hours.

Q. Are you saying Dr. Thomas should have done something differently after she realized a CT scan had not been obtained?

A. Yes.

Q. What is it you claim she should have done differently?

A. Obtain the CT scan.

Q. Isn't that what she did?

A. Well, you have to understand that two hours had passed. So if she waited four

Starer

hours and then obtained it, that doesn't make it any righter (sic) either -- any more right. She did not know that the CT scan had been obtained. And then on discovering it had not been obtained, she ordered it. I don't think that corrects the absence of oversight --

Q. I think we're not communicating.

A. Perhaps not.

Q. I thought you just told me that the critical time as you viewed it was when Dr. Thomas realized that the CT scan had not been performed, which you said was 1445.

A. From 1445 is when the doctor was notified. There's an order in here actually from Dr. Thomas to order -- and I hope I'm reading it correctly, a skull x-ray today as soon as possible at 1500 hours. By this documentation she herself did not order the CT scan and might have made an error ordering a skull x-ray either by mistake or thinking that is the test to be obtained.

Then by her deposition, she comes back several hours later and says why didn't we get a CT scan. From 1445 the patient

Starer

deteriorates. 1445 Dr. Thomas orders a skull x-ray. At 1510 the patient goes for skull x-ray. And then when the patient is vomiting at 1600 hours Dr. Thomas is surprised a CT scan was not obtained.

Q. What did you assume Dr. Thomas ordered at or about 1500 on June 28th, 2002?

A. Well, my presumption is based upon the physician's order which I have here where it says skull x-ray today ASAP.

Q. Is it your assumption that Dr. Thomas ordered a skull x-ray at 1500 on June 28, 2002?

A. That is my assumption.

Q. And then later on in the afternoon you know that Dr. Thomas became aware that a CT scan was not actually accomplished?

A. Based on her deposition, yes, that's what I'm basing it on.

Q. You indicated to us, doctor, that you have never been sued yourself for malpractice?

A. That is right.

Q. Do you realize what you are doing is

Starer

offering the opinion that Dr. Thomas was guilty of malpractice?

A. I would need to have that -- if you're telling me and --

Q. I'm asking if you realize that what you are doing is offering your opinion that Dr. Thomas was guilty of malpractice?

A. I didn't realize that.

Q. What did you think you were doing?

A. I was critiquing her care of the patient.

Q. In critiquing Dr. Thomas' care of the patient, was it important for you to be fair?

A. Absolutely.

Q. Would you want an expert testifying against you in a malpractice case to be fair with you?

A. I hope so.

Q. Would you want such an expert testifying in a malpractice case that you were guilty of malpractice to be knowledgeable in your field?

A. In the areas that I'm being

Starer

critiqued for I would like them to be knowledgeable.

Q. Would you want such an expert to have a basis for his or her opinions?

A. Yes, sir.

Q. Would you want such an expert to guess about things?

A. I would like them to form their opinions on the basis of a reasonable medical certainty.

Q. You wouldn't want them to guess or speculate, would you?

A. No. But if asked to speculate, they may speculate.

Q. You wouldn't think it would be fair for an expert testifying against you and saying you were guilty of malpractice to guess or speculate, would you?

A. They may be asked to speculate. But in the end I think the decision will be made on reasonable medical probability.

Q. You wouldn't think it would be fair for an expert testifying against you to base opinions on assumption?

Starer

A. It should be based on the chart, the depositions, facts.

Q. But not on assumptions?

A. On reasonable medical probability, as I said before.

Q. Why wouldn't you want an expert testifying against you to base opinions on guessing, speculations and assumptions?

A. Because it should be based upon what has happened, what should be done and a reasonable medical probability.

Q. Tell us something about your relationship with this law firm that Mr. Buchanan is with. The Lawson case is the first case you received from this law firm?

A. That's what I recall, yes.

Q. And you said earlier in this deposition, according to my notes, that you had received three or other -- three or four other cases from this firm since the Lawson case; is that correct?

A. Yes. I think it may be three or four. I didn't count them.

Q. So you've received a total including

Starer

this case of four or five cases now from the Wilkes & McHugh law firm?

A. It may be four or five.

Q. And you told somebody here that the cases you now have under review for all law firms are around nine; is that correct?

A. Yes, roughly.

Q. Is the time that you spent on the Lawson case about typical for the amount of time you spent before the deposition today?

A. This is atypical.

Q. What do you mean by atypical?

A. I spent more time on this than I usually do.

Q. You said you spent 15 hours on this case before today.

What would be a typical amount of time for you to spend on the other nine cases?

A. The way those are usually done, more often than not it doesn't go to the point of deposition.

Q. That's why I restricted it to before the deposition.

A. But in preparation for the

Starer

deposition, I start doing more work. You're saying before the deposition is announced?

Q. Before you met with Mr. Buchanan yesterday.

A. Once they started notifying me there was going to be a deposition, I started working again. In any case, prior to a deposition, then it would be the same if a deposition was to occur.

Q. How much time have you spent on this case this month before today?

A. This is a very short month. That would have been since Saturday.

Q. Say the last 30 days.

A. I did some work on Thursday -- Thursday might have been an hour. Friday I did like a couple of hours. Saturday maybe two more hours. And then yesterday I devoted a lot of time, maybe six hours or so.

Q. And all of that totaled up to 15 hours total that you expended to this case?

A. I may have lost a number. Prior to the deposition I might -- probably went five hours and then maybe ten over the last two or

Starer

three days. But I don't have exact numbers for this. And I'm estimating 15. But I'm going to say 15.

Q. And you said that this is an atypical case.

Before you started preparing for your deposition was there anything different about the time you spent on this case?

A. No. No. It's the same. This was all the same.

Q. Do you keep any time record of the time you spend?

A. No. It's very informal. I have so few cases I just --

Q. Nine doesn't sound like a few.

Is this more cases than you've ever had in your career at one time?

A. No. It's a rough number of hours. And I just have a certain memory that I've done this. And I move it to piles so I sort of know at what point I'm looking at how many hours. Really I'm estimating hours. It's not very rigid.

Q. Have you billed any time on the

Starer

Lawson case so far?

A. No.

Q. Did you require a retainer before you started looking at records?

A. I asked for one. I didn't get one this time.

Q. Have you received more than four or five cases from any law firm other than the Wilkes & McHugh law firm?

A. Yes.

Q. What other firm would that be?

A. Four or five. Let me think now. I know the Filmore law firm in Texas I may have done four. There is another lawyer who's never done a deposition but sends me cases to look at. The name is Doolan, D-o-o-l-a-n, in New York. And there might be another guy, another firm in Pennsylvania. I think we might have hit the four mark. Dorian, D-o-r-i-a-n.

Q. Dorian is the Pennsylvania firm?

A. Pennsylvania. Doolan is New York. Filmore is Texas. I'm trying to think if there's any more where I've done four or more.

Starer

Q. Another question I had was, now you tell me you estimate nine cases that you are currently working on.

Is that more cases than you've ever had in your quote inventory close quote since you've started --

A. There's no regularity to it. We're talking about things that stay open. So there's an overlap. Some of these cases may have been open for -- over time, it's more than seven years ago, but might be the average for around the last couple of years.

Q. So for the last couple of years you estimate you might have had nine open cases?

A. It really varies. Something ends and something comes.

Q. We're all supposed to file income tax in the next couple of days.

A. Absolutely.

Q. For 2004 how much money did you make from your reviews?

A. I'm going to estimate because it's in the hands of my accountant now. I don't know if it's 15,000 or 20,000. It will be

Starer

certain on April 15th.

Q. Yes, sir. Your best estimate now is somewhere in the 15 to $20,000 range?

A. Yes. It's all these little slips of paper and then I hand it over to the accountants.

Q. And 2003, would that be about the same?

A. Yes. I don't even remember now. It might be less.

Q. It would be the same or less in 2003?

A. Maybe the same or less. It varies from year to year.

Q. And 2002, do you have any estimate?

A. I don't know. It's not going to -- it shouldn't go much higher than 15,000.

Q. And you have in earlier depositions estimated that your income from this activity on behalf of lawyers would range in the five to ten percent of your income?

A. Yes. I think that still stands.

Q. Your other income from your practice, and we won't get into whatever else

Starer

you have, is salaried income; is that right?

A. That's right.

Q. The income you make from this kind of activity, do you take leave, do you take vacation? You're full-time employed, so how do you do that?

A. That's a very good question. Vacation.

Q. So you're on vacation today?

A. It just became a vacation. It wasn't in the morning, but it became vacation.

Q. When you're on trial, you would have to use vacation?

A. I have to use vacation, yes.

Q. Doctor, you produced these articles to us today and we have not, of course, had time to review them. When we do review them, we may have additional questions. But I know we all have planes to catch. So I'm going to quit at this point with the proviso that we may on review of the documentation need to supplement by telephone.

Fair enough?

A. Fair to me.

Starer

MR. BUCHANAN: I have one. We'll offer that as Exhibit 3.

(Starer Exhibit 3, curriculum vitae, marked for identification, as of this date.)

BY MS. CAULEY:

Q. Doctor, you don't plan on coming and testifying at trial that anyone acting on behalf of Southwest did anything intentionally or willfully to injure Ms. Lawson, do you?

A. Willfully or intentionally, no, I don't think that anybody intended to hurt her.

MS. CAULEY: That's all I've got.

EXAMINATION BY

MR. BUCHANAN:

Q. Doctor, have your criticisms of these defendants been expressed to a reasonable degree of medical certainty?

Starer

A. Yes.

MR. ANDERSON: Object to the form.

(Time Noted: 4:05 p.m.)

_____

PERRY J. STARER

Subscribed and sworn to before me

this ___ day of _____, 2005.

_____

C E R T I F I C A T E

STATE OF NEW YORK)

: ss.

COUNTY OF NASSAU)

I, ELIZABETH F. TOBIN, a Notary Public within and for the State of New York, do hereby certify:

That PERRY J. STARER, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.

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

IN WITNESS WHEREOF, I have hereunto set my hand this 12th day of April, 2005.

_____

ELIZABETH F. TOBIN

---------- I N D E X ----------

---------- EXHIBITS ----------