RE: THE ARBITRATION OF:

THE ESTATE OF ESTELA PEREZ DE GUZMAN, by and through ALEXIS DE GUZMAN, Personal Representative,

Plaintiff,

vs.

PORT ST. LUCIE MGT, LLC, a/k/a PORT ST. LUCIE MGT, LLC, d/b/a EMERALD HEALTH CARE CENTER; THE PALMS MGT, LLC; W. STEWART SWAIN; L.P. HERZOG, a/k/a LAVERNE P. HERZOG; ANDREW J. BARTH; and JASMINE MELODY CARR (as to EMERALD HEALTH CARE CENTER),

Defendants.
/

DEPOSITION OF PERRY J. STARER, M.D.
Taken by Counsel for Defendants
(Pages 1 - 131)

Thursday, April 14, 2016
10:30 a.m. - 2:00 p.m.

Esquire Deposition Solutions
200 East Robinson Street, Suite 725
Orlando, Florida 32801

REPORTED BEFORE:
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Florida Professional Reporter
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Deposition taken before Heidi Kay-Harmer, Florida Professional Reporter and Notary Public in and for the State of Florida at Large, in the above cause.

* * * * *

THE COURT REPORTER: Do you swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: Yes, I do.

THEREUPON,

PERRY J. STARER, M.D.,

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

DIRECT EXAMINATION

BY MR. SESSIONS:

Q. Good morning, sir.

A. Good morning.

Q. Would you state your name for the record.

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

Q. Dr. Starer, and you are a medical doctor?

A. That is correct, sir.

Q. All right.

Dr. Starer, I know that you've been

deposed on several occasions, is that correct?

A. That is true.

Q. About how many times have you had your deposition taken?

A. I would estimate between 75 and 100 times.

Q. How many times have you been deposed in the last 12 months?

A. I'm not sure. Maybe about 12 or 15 times.

Q. And how about in the preceding 12-month period?

A. That I don't know, but it might be on the list that I brought for you.

Q. And the reason I ask is that I had an opportunity to review a few of your transcripts and I think you gave a similar estimate of your deposition testimony back in 2014. So I realize you're just giving me a general estimate, but it may be more than 100 depositions by now?

A. It could be, and I really do estimate. I don't think it's 200. I don't even think it's 150.

Q. How many times have you testified at trial?

A. I think about 15 to 20 times.
Q. Fifteen to 20 times?
A. Yes.
Q. And how many times have you testified at arbitrations?
A. Never.
Q. This case is scheduled for arbitration at the end of this month. Do you plan on testifying live if you're asked to do so?
A. If invited, I will attend.
Q. It sounds like a party.

Well, I'm not going to go through all the preliminaries because you're very familiar with this process.

I will ask that -- that you -- if you don't understand my question, or if I ask a question that is confusing or inartful, please let me know so I can rephrase it so we can make sure that you understand the question and, therefore, that your answers under oath are given in response to a question that you understand, okay?
A. Fair enough.
Q. And, also, you and I need to work together to make sure that this transcript that is being generated by this lady to my left here is

clear, so I'm going to do my best to not talk or start a question while you are still giving an answer. And if you would, sir, please wait until I'm done asking my question before you begin your answer so we're not talking at the same time.

A. I agree.

Q. And, lastly, a promise I made to the court reporter, I'm going to try to speak slowly because sometimes I speak fast.

Doctor, what is your professional address?

A. 87-08 Justice Avenue, Office No. C5, and that's in New York City.

Q. And we are down here in Orlando, and I told you I'd do this on the record, thank you for arranging this deposition on short notice.

A. It is my pleasure. I happened to be in Florida, so I tried to accommodate you.

Q. Sir, when did you obtain your medical license?

A. Oh, I think around 1981. I had graduated medical school in 1980 and then took about a year to get the license. I think it was about 1981.

Q. And how many states are you currently licensed to practice medicine in?

A. One, and that's New York State.
Q. Have you ever been licensed to practice medicine in any other state?
A. No, I've not.
Q. Do you have a specialty, sir?
A. I have a specialty in internal medicine with a sub-specialty in geriatrics.
Q. Are you board certified in internal medicine?
A. I am.
Q. And have you obtained any additional certifications as a geriatric physician?
A. Yes, I have.
Q. When did you first obtain the special certification in geriatric medicine?
A. It was in 1988.
Q. And when was the last time that you renewed that?
A. 2008.
Q. And is that certification current?
A. Yes, it's current, I believe, until 2018.
And just to offer an additional explanation, this process changes over time, so now they are calling it maintenance of certification, and that means that it's an ongoing

process as opposed to waiting every ten years, so I am maintaining my certification at this time by complying with certain requirements.

Q. Okay.

Sir, you were asked to bring some documents to your deposition and you have several documents in front of you, so let me just take these one by one.

Do you have a copy of your current curriculum vitae?

A. I do.

MR. SESSIONS: I'd like to attach that as the first exhibit to this deposition.

(Defendants' Exhibit No. 1 was marked for identification.)

BY MR. SESSIONS:

Q. Sir, you told me that you had a list of trials and I think deposition testimonies, is that correct?

A. Yes. I asked -- I was asked to bring my most current list. This is the most current list. It's put together. It may not -- well, it does not include 2016, but it goes back three years from 2015.

Q. Was this generated because you were

involved in a federal suit as a witness?

A. No. This is something which I am maintaining now because in the past I had been involved with a federal case, and I was told that you have to have a three-year list, so I keep one going.

Q. Okay, sir. And that includes deposition and trial testimony?

A. That is true.

MR. SESSIONS: I would like to attach a list of testimony as the second exhibit to the deposition.

(Defendants' Exhibit No. 2 was marked for identification.)

BY MR. SESSIONS:

Q. You have some more paper in front of you that looks like it's correspondence. Would you describe what those documents are for the record.

A. These are the cover letters I had received from the law office of Wilkes & McHugh, and each letter lists some materials which were contained on an accompanying compact disk or what I call a compact disk.

Q. I was going to say it is called compact disks?

A. You know, they called them CDs, but they probably are not called CDs anymore.

Q. Let me take one more look at the papers. You let me take a look at these before the deposition.

A. (Hands counsel.)

Q. Thanks.

I realize you don't have your records in front of you or your computer where you might be reviewing the records. Do you have a hard copy of the records, or do you use digital records?

A. For this case everything is on these disks.

Q. Okay.

And a question I have for you, and I don't know if you can answer this now since you don't have the records in front of you, you have Lawnwood Regional Medical Center from September 24th, 2008, to October 8th, 2008. There was a couple of different sets of the records going around. One's, for lack of a better word, I'll call it abstract, but it's -- it doesn't contain that much material, and there's another set that's pretty voluminous.

As we sit here today, do you know which

one that you saw? Was it only a few pages or was it hundreds of papers?

A. No. The ones that -- I didn't count the papers, but what I saw -- I don't know if it also was contained in the third transmission.

Q. Yes, sir. There are. You're right. There's two different [inaudible], you are right (indicating).

A. So I was looking at the most recent set of records and, to me, it looked fairly complete.

Q. Okay. You would know what I'm talking about. I mean, it's a two-week hospitalization. I saw one set of records that was roughly 12 pages and, obviously, that clearly wasn't the -- all the records. Then there was another one that was far more complete.

A. Right, and that's the one -- well, I may have looked at both of them, but the one I was using was the more complete one.

MR. SESSIONS: I would like to attach as the third exhibit to the deposition three letters that Dr. Starer referenced, total of four pages.

(Defendants' Exhibit No. 3 was marked for identification.)

BY MR. SESSIONS:

Q. Doctor, do the documents in Exhibit 3 represent all of the correspondence that you've received in this case?

A. I believe it has. If there's another letter, then I never saw it or I lost -- this is everything that I had kept together in my file, so that's everything that I have received and looked at. And I don't know of any other letters that were sent, however, there's also electronic mail.

Q. That was going to be my next question.

A. Yes, and the electronic mail only consisted of messages concerning an arrangement for a deposition and today's deposition.

Q. Okay.

Is there any correspondence which you generated that you would have sent to Plaintiff's counsel regarding this case?

A. No written correspondence, and the email was just messages. Simple word like yes or okay.

Q. Okay.

You also have in front of you these three disks that you referenced, and, for the record, will you describe what's on them just in general?

A. Each one contains what is listed on the

cover letters, so it will be records pertaining to Mr. [sic] Guzman's hospitalization at Lakewood [sic] Regional Medical Center, and her residency at Emerald Health Care, and her residency at Sunny Days Assisted Living Facility, and also the care being rendered by Treasure Coast Hospice. There's also some records from the doctor's office; there's the death certificate; there are deposition transcripts; and medical bills; and surveys of the Emerald Health Care facility.

Q. So the bottom line is what's on those disks will correspond with the letters that we have marked as Exhibit 3, correct?

A. Yes.

Q. Okay.

And there's no additional information on those disks other than what's outlined in Exhibit 3?

A. None that I saw.

Q. Okay.

MR. SESSIONS: I would like to attach copies of the disks to this transcript in whichever fashion would be the most efficient for Esquire, and there's three disks, three separate disks.

MS. COOLEY: Are we attaching the disks separately as exhibits or Composite No. 4?

MR. SESSIONS: Composite No. 4.

(Defendants' Exhibit No. 4 was marked for identification.)

BY MR. SESSIONS:

Q. Doctor, are there any other documents that you brought with you today?

A. The only other material which I brought today are my handwritten notes.

Q. And would you describe for the record what those notes are.

A. These are notes which I created while reviewing the material. I have it organized in a fashion which I think is usable, at least for me, that each facility that I was reading about has its own page, and within the facility I may have taken notes pertaining to a particular topic.

And then, also, I have notes that I had taken concerning the surveys and just a minimal number of notes that I took while reading the deposition transcripts.

Q. Okay.

You said one thing that I would like you to clarify for me. You said it sounds like you

have a page for each facility, and then you said something about then I may have taken notes within that about a certain facility. Explain that to me.

A. Okay.

So the notes themselves, when you'll see them, you'll see the notes do not contain any opinions, editorial comments. They are direct transcriptions.

When I was looking at Emerald Health Care and organizing my notes and analyzing the case, I created separate pages pertaining to topics, and the topics were skin, nutrition and mental status. So it's organized that way, but it still contains no opinions.

And, also, when I started taking notes on the hospice care, I wrote a little bit at the bottom to show me a timeline. The topic here would be end of life, or possible end of life.

So I -- to me, it makes sense. You know, to someone else looking at it, it may not make sense, but I can explain why the pages are created the way they are.

Q. Very good.

Were your notes generated at about the

same point in time?

A. No -- well, I mean, if you look at it you'll see that the pages may have different tints to them. The ink may be a little different. So it was an ongoing process.

I began generating the notes when I was first contacted and received first records and I've been adding on to them, and I was adding on to them as recently as this morning.

Q. Okay.

Let me take a look at your notes, Doctor.

A. Sure (hands counsel.)

Q. Thank you.

MR. SESSIONS: Off the record.

(A discussion was held off the record.)

MR. SESSIONS: Doctor, thank you for providing us with a set of your notes which I will mark as the fifth exhibit to this deposition.

(Defendants' Exhibit No. 5 was marked for identification.)

BY MR. SESSIONS:

Q. Are there any other documents which would make up your file in this case?

A. No.

Q. Have you generated any billing statements?
A. No, I have not.
Q. Okay.
Did you receive a retainer?
A. I did not.
Q. What are your fees for services, sir, for reviewing records?
A. $200 for an hour of time.
Q. Okay.
What is your fee for testifying at deposition?
A. It's the same, $200 for an hour.
Q. What is your fee for testifying at arbitration or trial?
A. It will be $200 an hour.
Q. When did you first begin consulting in medical/legal matters?
A. I think around 2000 roughly.
Q. How did you get involved in the consulting business?
A. I didn't even know there was a consulting business. I was sitting in my office in New York City and the phone rang, and I answered my phone and the gentleman said he was a lawyer from Texas

and asked me if I would do a -- consulting work.

I said no. And I thought that would be the end of the conversation, but he was persistent and I was persistent, and I said I do not do this. I don't even know what this is and you probably have reached me in error.

And he said, well, we have a problem with a -- you know, a nursing home in Texas, and could you just please look at the records for us and tell us whether what we think happened happened.

I said fine. Short story.

So he sends me the records. I look at it. I go, yeah, there was -- they did something wrong and the person got hurt.

He said, well, would you be willing to write a report?

I said no, but -- you can see where this is going. He -- I said to him, why are you calling me? You know, you have doctors in Texas.

Q. What was the answer to that question because I was thinking the same thing?

A. Okay. And he said the doctors in Texas won't do it for whatever reason.

And I said then I have to do it.

So, you know, I wrote the report. So now

you have your report.

Well, would you be willing to give a deposition?

And at that point I said I -- I don't even know what that means. I [sic] said, oh, you just answer questions. You know, it will be very respectful and courteous.

And it really wasn't. It went on for about eight hours and the attorney was a little bit aggressive, and the next thing I know, well, are you willing to come to Texas for a trial to testify?

And at that point, you know, I was involved, so I went. I testified in Texas, and then I started getting phone calls from other attorneys.

Q. And that was the first case in which you were ever an expert witness?

A. The first time ever I did the full, I guess, expert experience.

Q. Did you have less than the full experience as an expert prior to that?

A. I had never been an expert prior to that.

Q. That's what I was getting --

A. So I -- I thought, and I don't know if

the attorney also had thought, that all I would do was write a report and that would be the end of it, but it went all the way to trial. So it was the first time I ever gave a deposition. The first time I have testified at trial. The first time I think I ever was in the courtroom.

Q. So in all the cases in which you've been retained as an expert and you provided deposition testimony, has it always been in favor of the plaintiff?

A. I've -- for the most part I only get called by plaintiffs' attorneys, so any time I've -- as it worked out, the only time I've ever given testimony at deposition or at trial has been for the plaintiff.

Q. Okay. You've never been an expert witness on behalf of the defendant in a nursing-home case?

A. I've spoken to defense experts [sic] a small -- to defense attorneys a small number of times, but they have never -- it's never gone beyond a phone call or a quick review of the records. The attorneys did not want to pursue it with me.

Q. And, again, I've had a chance to look at

your testimony history. It looks like you testified in a number of different jurisdictions, is that fair to say?

A. I have given depositions for cases in many different states, but often the depositions are conducted in New York.

Q. Yes, sir.

A. Then, as far as trials I've done, I've gone to different states for that.

Q. And that includes the state of Florida such as this case?

A. Once in Florida.

Q. That involved Freedom Square over in Seminole, Florida, Pinellas County. Does that ring a bell?

A. You may know better than I do. I just know one time I was in a courtroom in Florida. It was in Tampa, the courtroom.

Q. Yes, sir.

How many times have you been retained by the firm of Wilkes & McHugh?

A. I don't know the number. I'm going to guess 30 or 40 times over the years. I'm guessing.

Q. Yes, sir.

And of those times, in how many of those cases did you provide deposition testimony?

A. I think most of the time. As I said, maybe 70 -- whatever the number's going to be -- I would say 75 or 80 percent of the time.

Q. The times that you've been hired by Wilkes & McHugh, has that always been out of their Tampa, Florida, office, or have you also been retained out of some of their other offices?

A. Just to be clear, the phone call comes from Tampa and sometimes the attorney is actually based in Tampa, but the case may be in another part of the country.

Q. To the best of your recollection, has the law firm of Wilkes & McHugh been the firm that has retained you most often?

A. I don't think so because there is an attorney in New York who has been retaining me a lot.

Q. Would Wilkes & McHugh be in your top three as far as being retained most frequently?

A. Just to be careful, I'll say maybe the top four.

Q. All right, sir.

Have you ever worked in a long-term care

facility?

A. I have.

Q. All right.

Have you ever worked full-time as a medical director of a long-term care facility?

A. I had.

Q. Pardon me?

A. I have done it in the past, yes.

Q. All right.

When was the last time that you worked as a medical director for a long-term care facility?

A. It would have been in the 1990s. It may have been as recently as 1999.

Q. What was the name of that facility, sir?

A. The facility didn't have a name. And just to explain, when I was part of the medical school and I had retired from that position in 2014, there were many different settings in which I had moved over roughly a 30-year period.

And in one of the hospitals there was a skilled-nursing facility unit which was contained within the building. So the hospital was Elmhurst and still is Elmhurst Hospital Center. There was an approximately, seven -- I think it was 72 bed skilled-nursing facility, certified beds, spread

out over two floors, and I was the medical director for that, those units, but we did not have like a name. We were just called the skilled-nursing facility unit.

Q. Which was a wing of Elmhurst Hospital?

A. Two wings, two floors, one right on top of the other and the staircase would connect them.

Q. Okay.

And, currently, sir, what type of practices do you operate or operate in?

A. I am operating within a private practice, which is, essentially, home care, it's home visits, house calls in New York. We do have a physical office and there is a nurse practitioner and registered nurse who works with me. Patients can come into the office, but my primary focus is going into the homes. The patients who have been coming into the office are being seen by a nurse practitioner who is partnered with me.

Q. How many hours a week do you work in that capacity?

A. Well, it's not an -- an hourly/salaried job, and I know that's obviously -- I don't -- I think of it as every day of the week because I'm responding to the patients' needs, and we'll go

into the homes in the evening and on holidays and weekends. There's no fixed scheduled. It's based on need.

Q. I understand. And I'm trying to get an idea of what percentage of your time is spent actually providing health care in this home-care setting.

A. Yeah, I don't think of it -- I know what you're saying -- I don't think of it that way because I could even -- today, even being in Florida, I can actually be providing care by reviewing something, having a discussion or sending a prescription, so I don't break it down.

Physically I will be in -- when I'm in New York, I will be sitting in the office throughout the day and getting up and going to somebody's house, so I'll be there in the office maybe five or six days a week.

Q. Okay.

And during that five- to six-day period, how many hours are you actually spending going to a patient's house and providing care or otherwise providing care to a patient who comes to you?

A. Right, and I -- I don't tend to think of it that way. I don't break it down as to when I

have physical contact with the patient. Let me see if I can do that.

So putting aside time, I'm going through records and reviewing things and making phone calls to go to a patient's home will take at least an hour, and that may not even include the travel time. You have to go there, you have to park, you have to wait for them to answer the door. And once you're in somebody's house, you tend to stay there longer than if they were in your office.

So it depends. It could be days where it is -- it's going to be hours and hours and there may be other days where nobody actually needs to see you.

Q. And that's what I'm trying to figure, Doctor, is how busy is your practice of actually caring for patients?

For example, if you're a physician at a hospital, might be making rounds and seeing patients during a specific set of time, I want to find out, if you can tell me, if you can break it down, what percentage of your work week typically, and if you want to make it monthly, whatever is easiest for you, is spent providing hands-on-care to patients whether it be at their home or in the

office setting?

A. Yeah. I'm going to say I don't know, but I will try 'cause I am -- obviously, this time I'm working with a team and it's not that I'm trying to evade the question. I'm just telling you how difficult it is to maybe put an answer into that framework because there will be times I'll be sitting in the office and the nurse practitioner goes out to the home, comes back and says a discussion -- then we have to go back to the home, and I have to go because of what needs to be accomplished couldn't be accomplished.

But I don't really think of it by the hour. I think of it more on maybe the way a fireman might think, availability, and I have to make myself available during that time.

So I see it as a full-time job and in ways it's less -- it's -- it's less rigid than when I was in the hospital, but more demanding because I can't just walk away from it.

Q. What's the name of that group you're in?

A. Elmhurst Medical Providers.

Q. How long have you worked for Elmhurst Medical Providers?

A. I started -- well, when we created it --

so I created it with the two nurses -- so I was there since the beginning and it was created around the time in 2014 when I decided to leave the medical school, so there was an overlap. In October of 2014, and I was solely devoted to it.

Q. What was your reason for choosing to leave the medical school?

A. You -- if you want to hear my -- of my life stories, I'll be very happy to tell you, but stop me if you think it goes too far afield.

So somewhere in the summer of 2013 I became ill on a family trip, so I had the rare experience not only getting sick, but getting sick in front of my family.

At that time there was a lot of discussion about stopping working, you know, as you can imagine. It was probably more frightening to be watching me than to actually have been me in that setting, but I just remember there was a ride in an ambulance and my wife and my daughter were in the ambulance with me.

Survived it, but then they said, well, you have to retire.

And, of course, I said okay, I will. And I did buy a house here in Florida.

Q. Okay. And that's what I was --
A. You see where it's going.
Q. -- I was wondering if you were slowing down. That's what I was wondering.
A. Well, I slowed down and then sped up again.
So the retirement quickly turned into a semi-retirement, and then quickly returned to no retirement whatsoever, but I had already put in notice into the medical school.
Q. In the past 12 months, what percentage of your income would be comprised of the work that you do in consulting and medical/legal matters?
A. I think it's still, I said before, like 15 to 20 percent. I think it's still around that, maybe 20 percent of all income.
Q. Okay. All right, sir.
MR. SESSIONS: Let's take a quick break and I think we're going to get into your opinions.
THE WITNESS: Fair enough.
MR. SESSIONS: Thanks.
(A brief recess was taken.)
BY MR. SESSIONS:
Q. Doctor, we are here today because you've

been identified as an expert witness for the Estate of Estela Perez de Guzman, and it's my understanding that you have some opinions regarding our client Emerald Health Care, is that correct?

A. That is true, sir.

Q. I know in other cases you prepared reports or affidavits. We don't have that in this case.

So what I'd like to do, if you can do it for me, I'd like to outline your opinions, then I'd like to discuss them with you. Can you do that?

A. Fair enough.

The overriding opinion, which is a criticism of Emerald Health Care for the residency of Miss Perez de Guzman October 8th, 2008, to November 7, 2008, is a failure to properly individualize the care provided to her; coordinate the care; properly devise care plans; properly communicate the care plans to the workers; and how these failures then led to a decline in her condition and how that contributes to death.

Now, within that framework I am critical of their approach to her skin care as far as the

assessments of her skin condition and the creation and implementation of the care plan.

Q. All right. Let me stop you there, Doctor, because you're looking at your notes, and if I can, I would like to sort of look at the same page you're referring to.

A. -- so if it's okay, what I'll do is I will tell you what page I'm looking at as I'm speaking --

Q. Yes, sir.

A. -- and I'll try and do it slowly.

So I had just looked at what was page two which would say on the left side in the upper left-hand corner "pressure ulcer."

Q. Okay.

A. And I was just scanning that to see what notes I had made concerning the assessment of her skin and the creation of the care plan.

Now I had just flipped to the next page when you had asked me that question, and you'll see on this page it says in the left upper corner "eating," and this is my opinion concerning the failure of Emerald Health Care to properly respond to Miss Perez de Guzman's nutritional needs and specifically what she needed in order to properly

maintain and improve her nutritional status. And it will have to do with creations of care plans, revisions of care plans, and also coordinating the recommendations of consultants, and then will then flow into how this failure contributed to her death.

And then I would flip to the next page which in the upper left-hand corner says "mental status," and because of the failure to insure that she is eating properly Miss Perez de Guzman suffers a functional decline, which then results in her death. All of this may not be written in the notes itself, but by looking at the notes, I'm reminded of that.

Q. Yes, sir.

A. And there are other -- I had noted also, looking at the depositions of family members, that there were complaints concerning hygiene and clothing and areas of dignity. I do recognize that, too, as a problem at the facility. I'm basing most of that on what I saw in the deposition transcripts, but it was not my main criticism, but I'm not saying it's not something I would -- would not be critical of. I would be critical of that if they were putting her in

somebody else's clothing or allowing her to lay in her excrement.

Q. Yes, sir.

We may have covered this with your earlier testimony, but just for perspective, when was the last time that you worked regularly in a long-term care or skilled-nursing facility?

A. The last time I was there regularly, which would be either everyday or two or three times a week, would have been in 1999.

Q. Okay. Again, that would have been in New York?

A. New York City.

Q. All right.

Are you familiar with Chapter 400 of Florida Statutes which is the chapter that dictates the -- sort of the rules of the game as it pertains to nursing homes?

A. Yes. I mean, I know there's federal guidelines and it's 483, and then there's the Florida, which is 400, and it's the rights to adequate and appropriate health care. I am familiar with it and, in fact, I would probably be incorporating that into my opinion, too, because they were mentioned in the surveys which I had

looked at.

Q. Yes, sir.

Let's discuss a little bit about -- let's talk about Emerald Health Care itself. How many beds is that facility?

A. I had looked at that material briefly and I don't know if I remember it exactly. I don't know if it was like 75 or 150. I saw somebody had discussed it, but I didn't write that down.

Q. Okay.

What kind of facility is it, if you know?

A. It was my understanding it was a skilled-nursing facility. Now, I don't know if they had -- I think there might have been separate units in there, but I don't remember now. Some of this came up in the deposition transcripts, but I didn't take notes on it.

Q. And which surveys did you review?

A. The surveys that I reviewed, and I will list the dates, are March 26, 2007; May 29th, 2007, October 8, 2007; December 26th, 2007; February 6, 2008. And I'm looking at one of the pages in my notes: February 7th, 2008; April 16th, 2008; May 19th, 2008; July 10, 2008; August 27, 2008; October 16th, 2008; February 9,

2009; March 30th, 2009; April 20, 2009; April 24, 2009; June 5th, 2009; and there were also some re-visits, and that's what they were called, they were not called surveys, and that was February 8th, 2008; March 21st, 2008; March 11th, 2009; July 9th, 2009.

Q. And it's your understanding that all those dates either pertained to surveys or re-visits?

A. That is true.

Q. When was Miss de Guzman's residency at Emerald?

A. Her residency began on October 8, 2008, and she was discharged on November 7th, 2008.

Q. You were reviewing surveys that occurred after she was discharged from the facility?

A. Yes, before and I think there's one during and then after.

Q. Okay.

Why was she admitted to Emerald Health Care, sir?

A. From what I was able to determine from the records, they felt that she needed a skilled nursing level of care, but also she was to be getting rehabilitation therapy, which she did get,

and this is because she had recently been hospitalized at Lakeland [sic] Regional Medical Center for a right-hip fracture which had been surgically repaired there.

Q. How long had she been hospitalized at -- you say Lakeland [sic] Regional Medical Center?

A. And the correct title might be Lakeland [sic] Regional Medical Center and Heart Institute, but she was admitted on September 24th, 2008, and she was discharged on October 8th, 2008, and my notes are in the first page of your collection.

Q. Yes, sir.

Why was she hospitalized before her admission into the nursing home?

A. She had apparently been at home and was trying to go to the bathroom and had fallen, and it was discovered that she had broken her right hip.

Q. What sort of medical intervention did she need at the hospital for that hip?

A. She underwent surgery and they repaired it surgically.

Q. As we sit here today, do you know what type of surgery she had?

A. According to the operative report it was

an open reduction and then internal fixation of the fracture and they used a Gamma Nail.

Q. Yes, sir.

Were there any postoperative complications based on your review of the records?

A. There were some. I didn't list all of them, but I believe that she had -- she may have had a urinary tract infection at the time. I think maybe her blood pressure had dropped and they had to address that. They may have noted anemia. I don't know if it was a complication necessarily related to the fracture, and I'm not sure even if the other things were directly related to the fracture or the fracture repair.

And then also she was noted to have a -- a change in her mental status during the time that she was at Lakeland [sic] Regional Medical Center.

Q. Based upon your review of the records, what was the reason that was attributed to her change in mental status at the hospital?

A. I had seen a consultation note which was directly addressing this, and this is also in my notes, which would be your first page, and this consultation had arrived -- well, this consultant had arrived at the impression that the change in

her mental status was a confusional state which was related to the hip fracture and probably more specifically to the medications that were being utilized for the treatment or -- or for the -- let me just say it more clearly. The medicines were not treating the fracture itself, but medicines were treating the sequela of the fracture and that may have caused the mental-status changes.

Q. Did you see any indication that her health-care providers at the hospital determined that she had toxic encephalopathy?

A. Yes. In fact, in that very same note that I just referenced it actually said: Mental status changes mostly likely due to confusional state secondary to toxic metabolic encephalopathy in this patient with an acute right hip fracture, status post-sedation with medications.

Q. What is toxic encephalopathy?

A. The idea of toxic encephalopathy to say simply is that the encephalopathy, which is some sort of change in mental functions, is due not to a structural problem with the brain itself, but due to a toxin which is in the system of the person who is also the owner of that brain, and that the toxins then are interfering with the

brain's function, but not necessarily permanently damaging the brain. So it can be an electrolyte abnormality, it could be a medication that somebody is ingesting. In this case the consultant said it was a medication.

Q. Did you have any reason to dispute that opinion based upon what you reviewed?

A. I have no reason to quarrel with that assessment.

Q. Did Miss Perez de Guzman have any dementia?

A. She did have a history of dementia. At times they actually said, and they being the health-care providers, said that she had Alzheimer's disease.

Q. At the same time in the hospital records did you see where the dementia was described as advanced?

A. I did see that phrase advanced dementia.

Q. In your opinion, as a geriatric physician, what does advanced dementia mean to you?

A. In my opinion, it -- it means exactly what it says, that it is a -- a more -- I don't want to use the word advanced twice, because that

doesn't explain it, but it is a more severe type of dementia than having mild dementia or no dementia at all. However, it is not a specific descriptor of the dementia.

So as a geriatric physician, if I would hear something like that, I would certainly not discount it, but then I would want to know in what areas has the patient's mental function deteriorated. And then, from there, I would get a better sense of what advanced actually means.

Q. What is Alzheimer's dementia?

A. It's a degenerative disease of the brain. It's a neurologic disease and it is a -- at this point in time it's not something that everybody's going to get, but it's -- if you're older, you are more likely to get it than if you're younger, and it progresses, but can progress slowly.

Q. How does Alzheimer's -- how is Alzheimer's disease manifested in patients?

A. Well, it depends at -- at which point that you get them, but I guess the way that a health-care provider would try and understand Alzheimer's disease is to see what areas are being affected. And what I mean by that is, there could be memory problems or judgment problems, but not

necessarily hallucinations or seizures. They may not have motor problems necessarily.

But also what's important is not just to see that they have a memory problem and then maybe one other thing such as language, being able to read or speak, but that it affects function, and this is just so people don't think they have Alzheimer's disease because they forget the name of their famous -- of their favorite rock-and-roll band from 30 years ago. It's -- it's a dementia which makes it difficult for a person to function in the world without assistance, so that's one component. It has an impact on the way one lives in the world.

And also you have to look at the trajectory. And the reason I say that is with Alzheimer's disease, it is a gradual decline. It is not an abrupt change. If somebody suddenly changes in a bad way as far as mental functioning, you wouldn't be thinking of Alzheimer's disease. You would look at something else, such as toxic encephalopathy or a stroke.

Q. Do you have any understanding, based upon your review of this material, how Miss Perez de Guzman's Alzheimer's dementia manifested itself?

A. I do. There's different parts.

There was a physician's note I had seen which may have been written prior to coming to lake -- oh, in here it says Lawnwood, okay. I'm sorry if I said that wrong -- but prior to coming to the hospital she was seen by Jacob Samander, S-a-m-a-n-d-e-r, and I recall that the doctor was looking at behavioral problems.

Now, that is one thing which can happen with someone who has dementia, but it could be a reflection of them not feeling in control of their environment sometimes. And when people don't understand their environment because of dementia, they may have behavioral problems.

What I was looking for in the records was something more specific that might explain why she is being described as having dementia, and there was at Emerald Health Care a psychiatric consult done in October of 2008 where a mini mental-state examination was conducted and various modalities were looked at.

So it's a long way of telling -- of saying I did find a very comprehensive mental-status examination in the medical records.

Q. And that was records specifically at

Emerald?

A. That was at Emerald.

When she was at the hospital, there was that acute confusional state and I did want to see if there was an examination which could have -- which was done on her when, perhaps, she was not on the -- the influence of medications. This would be on my page of notes that has the word "mental status" in the upper left-hand corner, and that would be page four.

Q. And based upon your review of the examination that was done while Miss de Guzman was at Emerald, what conclusions do you have regarding her Alzheimer's dementia, if any?

A. Yeah. I have no reason, based upon that, to change my opinion that she had Alzheimer's dementia. What this particular assessment told me is that advanced -- a phrase like advanced dementia may not be as descriptive as what was obtained by the psychiatrist. And what I mean is the psychiatrist who conducted this test on October 14th, 2008, which is about, you know, close to the middle of her stay at Emerald Health Care, determined that she didn't have severe dementia, that she did not have severe dementia,

that she had moderate dementia, and that she was able to accomplish various tasks.

For instance, if they -- if they asked her to repeat a phrase and the phrase is no ifs, ands or buts, she was able to hear that, she was able to follow the instruction, and she was able to then recite "no ifs, ands or buts," so she got scored as being able to carry that out.

I was also impressed -- and the reason I'm saying I'm impressed is that because she had been described as advanced dementia, and yet she was able to carry out a task in which she was invited to read a piece of paper that had the words "close your eyes" on it, and she looked at it and she closed her eyes, so that impressed me 'cause I wasn't expecting, based on what I'd seen, that she'd be able to do that.

And then they also asked her to write a sentence on a piece of paper of her choosing, and she was able to write that. So she was doing well as far as language. She did well in other things that were asked of her. She was not perfect. She did have dementia, but she was assessed based on that as having moderate dementia as opposed to severe dementia.

Q. What were some of the findings that were positive for dementia?

A. Well, what she couldn't do. And when it came to orientation, and I don't remember what answers she got wrong specifically, but when they were asking her what's your name and where are you and what's the day, she was not able to give everything accurately.

There was another area, and this is what I had spoken to before, all of these had headings -- it's orientation, registration, attention, language, construction, recall -- when she's asked to name three objects, and that would be, you know, they're showing her objects, and she would name them, she couldn't do all of them. She did some of them. When she was asked to recall certain objects after a period of time, she could not recall all of them. She recalled some of them. So there were pieces that were missing.

Q. Is it common when evaluating people for -- or staging their Alzheimer's dementia -- for them to have some days that are better than others? In other words, their cognitive function might be better on Tuesday than on Friday?

A. See, now you are ready to become a

geriatrician because you realize that there are other factors, and that's why everybody needs to be understood, and that means individualizing the care and then seeing their environment.

So yes, sometimes people will do better based on the time of day, or when the medications are taken, or whether they've had enough sleep, or if they're comfortable and familiar with an environment or an -- an examiner. So you look at them over time and you also take into account the setting under which they were functioning.

Q. Okay.

While Miss de Guzman was at the hospital, did she have any difficulty taking in food?

A. There was a concern about that, and when I say there was a concern, I mean there's several notes that are describing dysphasia or at least a suspicion of dysphasia.

And dysphasia would be a difficulty in swallowing. To say it simply, a problem with getting the food down the tube that connects to the stomach, as opposed to not having a taste for food or enough saliva to dissolve the food or enough teeth to chew the food.

So I saw the word dysphasia in there, and

they were concerned to the extent that they did a test which is called the Modified Barium Swallow. This is on the first page of my notes. And what they do is they have the patient swallow barium, and barium is something which then can be seen on an X-ray and you watch it like a little movie. You watch as the barium flows down the tube. And they can do different consistencies, and some dysphasia was noted.

At certain parts they said there was minimal pharyngeal dysphasia, and the recommendation was made at that time as to what consistency food she should be given and also a recommendation that she double swallows. So that is the -- the idea that after you swallow, swallow a second time in order to move everything through, so that had been looked at.

Q. Was she actually determined to be at risk for aspiration?

A. There were times, yes. I saw that there was that determination. I don't know if that was consistent, but I have no reason to disagree with that assessment.

Q. Did the hospital recommend that Miss Perez de Guzman receive a PEG tube?

A. There was -- I think there might have even have been a nasogastric tube. I think there was a discussion with a -- for a PEG tube, which would be a gastrostomy tube, a tube inserted directly into the stomach. I think the family did decline to have that done.

Q. The family refused the PEG tube, but said that they would agree to an NG-tube, or a nasogastric tube?

A. I think it was agreed to, but I don't believe -- I think by the time she had been discharged from the hospital, it was no longer there.

Q. Well, in fact, was Miss de Guzman repeatedly pulling the nasogastric tube out in part because of her dementia, or do you recall seeing anything in the records that would say that?

A. It does -- I do recall something like that, and I would just, you know, try and explain it.

She -- the dementia probably had a component as far as pulling it out, but she probably also may have been pulling it out 'cause it was uncomfortable because she was aware of it,

and the dementia then took away the ability, I guess, for someone to explain to her why it was necessary. So it was probably the combination of the dementia and the discomfort of having something in her nose.

Q. While Miss Perez de Guzman was at the hospital, was it agreed that she be placed in hospice care?

A. She -- there were these on-and-off entries into hospice or palliative care, so I did see at some point there was notes being written about hospice, but I think that was retracted prior to discharge.

Q. Did the health-care providers at the hospital recommend that Miss Perez de Guzman be placed in hospice care?

A. Somebody did. I don't remember which health-care provider did. I think it might have been a neurologist, but I don't know for certain without looking at the records again.

Q. Based upon your review of the records, what was the rationale as to why hospice was recommended while Miss Perez de Guzman was at the hospital before she came to Emerald Health Care?

A. Here I would try and fill in a blank, a

metaphorical blank in the records.

The record that I recall seeing, which I think was written by the neurologist, may have had the diagnosis of end-stage dementia and then was followed by the word hospice.

The blank that I would be filling in to explain that is that someone who saw her at that time felt this was not just advanced dementia, but the very last stage of dementia, and that the kind of thing to do, the compassionate thing to do, would be to let her just drift away into the next world rather than, you know, subjecting her to further treatments because her dementia had reached the final stage and her quality of life had deteriorated.

Now, to say it again, I'm filling in the blank for the neurologist who only wrote, you know, four words: End-stage dementia and hospice, but that's my sense of what the thought was.

Q. What is hospice?

A. Hospice is not -- some people think of hospice of actually being a building, and it could be, but you can deliver hospice care in the hospital, and I have done that as well. It is the consent that a person is terminal, that they're

close to the end of their lives and that treatment would -- treatment of a disease may be more burdensome than not treating, and that the intent is to keep them -- keep the person comfortable, maintain their dignity, of course take away pain, and not subject them to aggressive treatments and not to hospitalize them in certain cases. If they get sick, sometimes a decision is made not to even feed them, not to take a temperature, all this gets worked out. And you -- you let them pass away in a setting which would be, I guess, more human than a hospital room, and it could be a special building called a hospice or it could be their own home.

Q. Was Miss Perez de Guzman nutritionally comprised by the time she was discharged from the hospital based upon your review of the records?

A. Based upon my review of the records, when she entered Emerald Health Care, which would be at the same time -- the same day as she's discharged from the hospital, that's October 8th, she was already in a -- a condition where she was below her ideal body weight, which would go along with nutritional compromise.

Q. Was there any additional information in

the laboratory studies that you saw that would support the conclusion that she was nutritionally compromised when she entered Emerald Health Care?

A. There might be, and the reason I'm saying that, I did not see, when I looked at records of Emerald Health Care, studies of her albumin, her pre-albumin, or her total protein, but I -- if they were obtained, I would have expected them to be low. I think just the way she was being assessed at the time that she was nutritionally compromised.

Q. Before she came to the nursing home?

A. Well, before she came to the nursing home -- well, by the time she came to the nursing home, she was nutritionally compromised. I can't tell you much more than that because I didn't take any notes on that, but I have no reason to argue that she was at optimal nutritional state when she entered into Emerald Health Care.

Q. Do you have any opinion as to what her hydration status was at the time she entered the hospital -- I'm sorry -- at the time she entered Emerald?

A. Yeah. When I was looking for hydration, I didn't see any descriptions that she was

dehydrated. In fact, I didn't really see that even being followed there.

So at this time I have no opinion one way or another about her dehydration status upon entering Emerald Health Care or even during her time there.

Q. Okay.

But did you see anything in the lab values from Lawnwood Regional Medical Center that would have told you anything about her hydration status?

A. I might have looked at it, but I didn't write it down, and that might have been the blood urea nitrogen level. I don't actually remember if I had seen them.

Q. Did Miss Perez de Guzman experience any skin breakdown while she was at the hospital?

A. Yes. And I'm flipping back between my -- my pages, but probably do find them now.

By the time she left the hospital, she did have a sacral pressure ulcer. I think it was being described as a stage II at the hospital.

When she entered Emerald Health Care, they didn't stage it on the first day, but it's -- from what I saw, I -- I do not believe that the

pressure ulcer formed at Emerald Health Care. I believe that she came in with it, and it very likely may have formed at the -- at the hospital.

Q. More likely than not, did the sacral pressure wound develop at Lawnwood Regional Medical Center?

A. Yes, I would say so.

Q. How long had she had a pressure sore to her sacrum before Miss de Guzman was admitted into Emerald Health Care?

A. I don't believe she had it prior to admission to the hospital, but I don't know that for certain, but I don't think she did. I think most likely she developed it there. I just don't know without going through the records. Again, I can't tell you on what day it was first identified.

Q. Well, had she had it for only a couple of days before she came into Emerald Health Care, or had it been as long as a week or longer?

A. Well, she was only -- likely she was only at the hospital for about two weeks, but I can't tell you whether -- I really can't tell you much more than that. It was sometime during the hospitalization.

Q. Okay.

And you testified that you saw some notes in the hospital that she had a stage II wound to her sacrum?

A. Yeah. I think it was -- might have been on October 7th, but I didn't make a note on that, but I think they had described it as stage II.

Q. Okay.

What is a stage II wound?

A. It's not a -- it's a break in the skin, you know. It's beneath the dermis. It's not a full-thickness wound. There's still, you know, another layer it can go. So it's a whole, but not full thickness. It's not a stage III or a stage IV. It's not as deep as it can go, but it's certainly an ulcer.

Q. Do you have an opinion as to what the stage of Miss Perez de Guzman's sacral wound was at the time that she was admitted into Emerald Health Care on October 8th?

A. No. My opinion concerning that area is that Emerald Health Care failed to stage it, but, you know, then my criticism would flow in that as far as assessment, but in all the places where I looked in the records for description of the wound

on October 8th, 2008, at Emerald Health Care it says "open area" or even less than that. I mean, there's less of a description than "open area." There is no -- I could not find any staging of the sacral pressure ulcer on October 8th, 2008, so I don't know what the stage was.

Q. Well, you've reviewed the records from Emerald Health Care and you've reviewed the records from the hospital, correct?

A. That is true.

Q. Based upon your review of those records, as well as your education, training and experience, even though there was no specific staging done at the time of admission, do you have an opinion as to whether or not Miss Perez de Guzman was admitted into the facility, into Emerald Health Care, with a stage IV wound to her sacrum?

A. The --

MS. COOLEY: Form objection.

A. Yeah. Based on my experience --

MS. COOLEY: Let me make a form objection.

A. -- yeah, when looking at cases like this, my experience has been that if the sending

facility describes the wound on the day it's being sent, that then I'm able to give a -- you know, a reasonable opinion as to what the receiving facility has seen. But I don't recall seeing any information at either facility on October 8th, 2008, so I can't say more than I don't know that.

But if I had to say more, I'd say it was somewhere between either a stage II or a stage IV, II and IV being included in that.

BY MR. SESSIONS:

Q. Okay.

Do you have any criticisms regarding the health care that was provided to Miss Perez de Guzman by the health-care providers at Lawnwood Regional Medical Center?

A. Well, I didn't review the records in enough detail to identify where the standard of care had not been met, if it had not been met, but based on what I saw, I would be critical of the facility for allowing a pressure ulcer to form, but at this time I don't have enough information to tell you where and how they had failed to have done that.

Q. And just to be clear, when you say facility in that instance --

A. Hospital.
Q. -- you're talking about the hospital?
A. I'm sorry, yes, the hospital.
Q. Are there risk factors to developing pressure sores?
A. There are.
Q. What risk factors are you aware of that Miss de Guzman had for the development of pressure sores?
A. I think the main risk factor here for the actual development of pressure ulcers would be her change in mobility status; that she had just fractured a bone and then underwent surgery for that fracture, so her mobility was limited and, therefore, it would be difficult for her to independently relieve pressure from certain parts of her body. So it's the change in mobility which is most important here as far as the risk factor.

The nutritional problems, which we do see identified later on, would not necessarily cause a pressure ulcer, but once a pressure ulcer had been formed, it would make it difficult, more difficult, to heal the ulcer than it would be if she had not been nutritionally compromised.
Q. Any other risk factors that Miss de

Guzman had that you saw in the records that would either contribute to the development of pressure sores or contribute to the non-healing of an existing sore?

A. Well, I mean as far as contributing to a breakdown of the skin, I think there was descriptions of incontinence, but that could be treated by ensuring that whatever excrement passes does not lay on her skin, but if -- if she's incontinent, then that, of course, is a risk factor for breakdown of the skin.

As far as healing, even if she had Peripheral Vascular Disease, the sacrum is not in a peripheral area, so that probably would not be a significant factor here.

Q. How about her dementia?

A. The dementia, in and of itself, is not going to lead to skin breakdown. It would possibly be considered a contributor if a -- if the staff of a facility required her involvement in the treatment plan, and that would be a situation where you are asking a patient, while they are laying in bed or sitting in a chair, to reposition themselves without the assistance of a staff member, and that would mean that the patient

has to have the wherewithal to remember it's time to reposition themselves and also to know how to do it.

So dementia can be a contributing factor, but that can easily be overcome just by having somebody else step in and do the work for her.

Q. Another way it could be a factor would be that once the patient is repositioned by a staff member, that because of the dementia, when the staff member is gone, they change back to their position of comfort, is that correct?

A. Well, I mean, hypothetically, yes --

MS. COOLEY: Form.

A. -- and that can actually occur.

MS. COOLEY: I'm sorry. I'm trying to slip those in so she can hear them.

A. Hypothetically that's correct, and it can also occur with someone who's not demented, so that's why the staff learns the needs of their patients and the requirements to adjust a care plan.

If they had noted that a demented patient is somehow subverting their care, they can -- they have to address it in the records and develop a care, a plan, to take that into account and then

implement that care plan.
BY MR. SESSIONS:
Q. Do you have any criticisms of the health-care providers at Lawnwood Regional Medical Center for the manner in which they provided or attempted to provide for Miss Perez de Guzman's nutritional needs?
A. I did not look at all the components. There might be an area that I might have criticism. At this time I...
What I was able to see is that they were identifying her needs and then building on top of that going on to the next thing. So based on what I had reviewed, at this time I don't have any specific criticisms.
Q. Do you believe that the recommendation that occurred at Lawnwood Regional Medical Center that Miss Perez de Guzman be placed in hospice care at the time of her discharge from the hospital, do you think that was reasonable?
A. Well, I think the way I would approach the answer, and I apologize if it's too long, but -- of an answer, but I'm explaining how I think of things.
When someone -- if you're asking me is a

decision reasonable, what I look at is was the process at arriving at this decision reasonable, and if the process of arriving at a decision is reasonable, then the decision is sound.

So it's reasonable to want your patient not to suffer. It's reasonable for them to want them to be comfortable. But if you're plugging in a variable into your equation which may not be true, you may end up at the wrong answer.

And the reason I say this is, we know that Miss Perez de Guzman, upon leaving the hospital, did not go into hospice. She actually went into a rehabilitation program and she was not actually dying at that time.

So when I look back at, at least, the one person I know was talking about hospice, that individual had used the diagnosis of end-stage dementia to drive the decision to go into a hospice.

Now, that would then be an unreasonable conclusion if end-stage dementia was not in existence and being that another consultant is attributing -- actually, I didn't check the names. I don't know if it's the same consultant or another consultant -- but being that somebody else

had taken into account that perhaps Miss de Guzman's mental-status changes during the hospitalization were related more to the hospitalization and what happens there than it was to the dementia, to put her into a hospice at that time would not have been reasonable.

But in the end -- and I said it might be a long answer -- but in the end when it comes to decisions such as hospices or any medical care, the decision is in the hands of the patient or the person who is deciding on the part of the patient.

So presented with the information that's available, the decision-maker, who is the person who's going to be affected by it, makes a reasonable decision.

So it was a recommendation to go into hospice, which may not have been reasonable, but the decision made by the family would have been reasonable.

Q. Okay.

So Miss Perez de Guzman is admitted into the Emerald Health Care on October 8th, 2008?

A. That is true.

Q. Do you know what time of day she was admitted?

A. Oh, I don't know offhand. I would have to see if they listed that.

Q. Okay.

It would not be unusual to have a patient admitted in the late afternoon to a long-term care facility, correct?

MS. COOLEY: Form.

A. It's -- it's not unheard of. I know the -- it's preferred that they are admitted prior to dinnertime, but it's -- it could possibly happen that it would be around four or five o'clock.

BY MR. SESSIONS:

Q. Okay.

I want you to assume that Miss de Guzman was, in fact, admitted into the facility on the afternoon of October 8th, 2008. Do you know when in the course of her admission the sacrum wound was first staged?

A. The first time that I saw descriptions of the sacral wound, once again, I'm looking at my notes, was on October 9, 2008.

Q. And let me clarify, Doctor, just so there is no confusion, you said the first time you saw a description of the wound was October 9th, but what

you are saying was a staging of the wound.

A. All right. And when I say description, aside from saying just there was a wound, the size, and the stage, but yes, you were correct. The first time I saw it staged and the size and whatever else like the odor was on October 9, 2008.

Q. So the next day after she was admitted?

A. That is true.

Q. Are you aware that the wound was staged by a wound-care nurse?

A. I saw that there was a reference to a wound-care nurse. I was unable to identify all of the individuals taking care of her, but I saw that in a nutritional assessment on October 10th, 2008, the nutritionist was referring to a wound-care consultant.

Q. Okay.

Now, even though the wound was staged by a wound-care nurse on October 9th, was the wound of Miss Perez de Guzman observed and described by a physician on October 8th, if you know?

A. I saw different notes, and at this time I don't know who -- just looking at my notes, I'm not sure who wrote what note, so I can't tell you

it was a physician or someone else.
Q. In any event, you would not be critical if the facility had the wound observed by a physician on October 8th, 2008, the day she was admitted, even if she was admitted in the late afternoon, correct?
MS. COOLEY: Form.
A. No, I'm not critical that they had somebody look at her on that date, no.
BY MR. SESSIONS:
Q. It would actually be a good thing that they had a physician look at her on October 8th and look at the wound on October 8th if you assume that a physician did, in fact, see the wound. That would be a good thing, right?
A. I think it's a good thing if that occurred, yes.
Q. What is slough as it pertains to wounds?
A. Slough is, let's call it, the waste material of the body. It's -- it's -- it's non-viable tissue. It could be dead tissue. It may have various consistencies, but it's laying on top of the wound. It may be obstructing the view of the wound, but it's not going to turn into living tissue. It's going -- the body's

discarding it.

Q. If you observed a wound that had 80 to 90 percent slough on it, what would -- if anything, would that tell you about the stage of the wound?

A. The information I would get from that is the wound didn't form overnight, most likely. It's been there for a while. And as far as the stage, the 80 to 90 percent coverage of the wound might be blocking my view of the wound, but I would say that it's more likely a stage III or a stage IV.

Q. And why is that?

A. Because that's just -- I don't want to be flippant in my answer -- that's what occurs.

If you have a situation where a wound is unstageable because the view of the depth is blocked, then it's considered to either be a stage III or stage IV. And then, when you remove the covers, you will see it's either a stage III or a stage IV.

Q. Yes, sir.

Was Miss Perez de Guzman -- did she have a DNR at the time she was admitted into Emerald?

A. I saw that there were references to a do-not-resuscitate order in her records, but --

and I saw some of them, but I don't remember if it was actually in effect at the time that she was admitted.

And there was a reason I'm saying that I got a little confused is that the nutritionist made some comments about advanced directives and did not indicate there was a DNR, and -- but in other cases I saw that there was a do-not-resuscitate request.

Q. Okay.

Was Miss Perez de Guzman admitted into the facility on antibiotic therapy, if you know?

A. I know there was antibiotic therapy, and I think it was for a urinary-tract infection. I don't know -- and I think it got transitioned into the facility itself, but I can't tell you exactly if it was -- if it was being resumed once she was at the Emerald Health Care.

Q. Did she come into the Emerald with or without a Foley catheter, if you know?

A. I think there was a Foley. Once again, I don't want to guess, so I didn't make notes on it. I do remember seeing discussions in the records about an in-dwelling urinary catheter. I just don't know if it was in place at the time of

admission.

Q. I want to focus now on the skin care at Emerald which I understand is one of your areas of criticism, correct?

A. This is true.

Q. And you made reference in your broad opinions that there were problems with, it sounded like, the assessment in the care plan of which the skin care may be one component, is that true?

A. That's true.

Q. Okay.

What issues or criticisms do you have regarding the assessment of Miss Perez de Guzman in the care plan that was developed for as it pertains to her skin-care needs?

A. And this might be the same criticism covering two areas, and that is when looking at how the facility approached this particular problem, I did have the criticism that, at first introduction to her, they did not assess the wound, at least not until the next day. So for the first day where they had the ability to indicate what depth it was, or what stage it was, what size it was, they -- they chose not to.

Now, flowing from that they did develop

on October 8th, 2008, a care plan, and that's the initial care plan. And it's a general care plan, but my criticism is you -- you could start off with general, but you do want to individualize, and it is a -- a missing piece in the care, at least to have that first day go by.

Now, by the second day, they catch up.

Q. Let me -- if I can, sir, I don't mean to interrupt you, but I want to try to keep this as compartmentalized as possible. That helps keep me organized.

You have a criticism that they did not fully assess the wound at the time of admission, correct?

A. That is true.

Q. But acknowledge that by the next day there was an assessment that included staging measurements and things that you described?

A. That's correct.

Q. So when you say that there was a failure to not assess the wound, you are defining assessment as staging and describing measurements?

A. That is true.

Q. Because there was a description of the wound on October 8th, 2008, at the time of

admission, and I would submit to you, sir, there was actually two descriptions, one by a nurse and one by a doctor.

MS. COOLEY: Form.

A. Fair enough. If that's true, my criticisms would still remain the same if they did not stage it and measure it.

BY MR. SESSIONS:

Q. All right.

Assuming that on October 9, 2008, Miss de Guzman's wounds were staged to your liking or to your approval -- and let me ask you that. Do you have any criticisms regarding the staging and descriptions of the wound as it appeared on October 9th?

A. Okay. As far as my feelings about it, this is -- when I looked at the weekly pressure ulcer record on October 9, 2008, I felt that is the way it should be done and it shows me that they are capable of doing it.

Q. So what was the harm, if you assume that your criticism was valid, what was the harm of there being a delay in the assessment of the wound as you described it by one day?

A. Okay, and that's a good area to discuss

'cause I don't think I had given the opinion that there was harm. My opinion is that there is a systemic problem at a facility which may sometimes harm someone and may not harm someone.

In this particular case I cannot identify the harm because I -- because, in a way, if there was harm, they're hiding it from me because I don't know where she's starting from. I just see the story of her skin wound starting on October 9th, 2008.

So the harm would be that deficits like this leave holes in the safety net. Someone may not always fall through that hole, but the hole is still there.

For instance, maybe to make it understandable, if they had identified the resident on October 8th as having elevated blood pressure, but did not measure the blood pressure and record it, and then created a care plan on October 8th to treat elevated blood pressure, and the care plan just said give medicine, they don't know, looking back, where they've been. So they don't know where to go.

So what's done on October 8th is generic, but not usable. So if something goes wrong later

on, they can't look back and go, well, this is where we failed, because they don't actually know what the skin looks like, and the care plan itself is not even responding to the condition of the skin at that time.

So my long way of saying I cannot identify harm, but I am critical of a facility that has a system in place which can cause harm.

Q. As it pertains to your criticism that there being a one-day delay in the assessment of the wound for Miss Perez de Guzman, you cannot say that one-day delay resulted in any harm specifically to her?

A. No. I am not saying that that October 8, 2008, failure to meet the standard of care resulted in harm, but I would say the system that allows such a harm to occur will cause her harm in other ways later on, but not specifically on -- in that compartment on that day.

Q. Okay.

Now we're going to go to the care plan.

THE COURT REPORTER: May I take a five-minute break?

MR. SESSIONS: You know, I think I want to do that too.

(A brief recess was taken.)
BY MR. SESSIONS:
Q. All right. Dr. Starer, we discussed your opinion regarding the facility allegedly failing to assess the wound adequately on October 8th.
It sounds like the next logical progression would be to talk about the care plan as it pertains to skin care, would you agree?
A. That is true.
Q. Let me ask you this: When you reviewed the records, you saw a care plan that was developed specifically to address the skin-care needs of Miss Perez de Guzman, correct?
A. I did.
Q. Is it an appropriate care plan?
A. The care plan -- the initial one that I saw on October 8th, 2008, is appropriate in isolation, but I don't want to remove my criticism that it's not responding to a specific pressure ulcer; however, in general it's an appropriate care plan.
Q. Okay. So let me ask you that. When you say "in general it's an appropriate care plan," what do you mean?
A. Well, it's written to cover potential

skin breakdown and existing skin breakdown, so it takes into account a need for repositioning and pressure-relief mattresses, but it doesn't offer something which is more specific for the needs of the individual, in this case Miss Perez de Guzman.

Q. Did you, in fact, see numerous interventions that were in place to prevent skin breakdown and also promote the healing of existing wounds in that initial care plan?

A. Yes, and I guess maybe to just offer a little more detail in my answer, these are reasonable things to be done: Repositioning every two hours, putting the mattress in and the other things that they say, checking the wounds, but they are not then individualizing the care to Miss Perez de Guzman specifically, and that is that she has had a repair made on her hip and it should be taken into account how you're going to reposition her; that she might not be able to lay exactly on the hip; that she also has -- has a wound on the sacral area and you may not be able to reposition her in that area as well. So she's -- she loses turning surfaces.

It also doesn't take into account what would happen if she was to be put into a chair

'cause every two hours will not be enough for that.

And as we had discussed before, if dementia was going to be an interfering factor, it's not there as well.

So it is a care plan which sort of suggests one size fits all, but you have to then take that framework and adapt it for the person that it's to be utilized for.

Q. Did the initial care plan note that Miss Perez de Guzman had decreased mobility?

A. It did, and it even noted that she had an area, an open area, in the sacrum. I think that's what it said. It seemed to be handwritten, so that's there.

Q. What specifically then would you like -- well, would you have liked to have seen in her care plan that you didn't see in this one which, again, has numerous interventions in place?

A. What I would have liked to have seen is a directive and it could be done in different ways. Doesn't have to be exactly as I say it, but a recognition that because of the sacral wound and the right hip fracture, that caution should be exercised if moving her onto those areas, or maybe

she shouldn't be moved onto those areas at all.

And, also, if she is to be seated in a chair, she really should not be put there for longer than an hour because she'll be sitting right on top of the sacrum. Now, I don't recall seeing anything which addressed that.

Q. You don't recall seeing in the care plan when they say, quote, check for bottoming out, quote, end quote, in bed and chair?

A. Well, I don't know what in bottoming out -- I actually don't know what bottoming out means. Now, if every staff member knows what that means, and I'm the only one who doesn't, that still doesn't actually mean it's what I'm talking about. So I can't comment on a phrase like "bottoming out."

Q. Okay.

What other entries would you have liked to have seen in Miss Perez de Guzman's care plan as it pertains to her skin-care needs?

A. No. I would like to just have something a little more rigorous as to how the repositioning is to take place based upon the condition of her body and the setting in which she's going to be repositioned. The repositioning at least every

two hours would be for the bed if she's laying flat.

Q. Also for the chair, though, correct?

A. No. The chair requires more frequently than every two hours because -- and, once again, I apologize if the answer gets a little longer than it -- than you would like -- when one is laying flat, pressure is distributed over a larger surface area and the brunt of the pressure may be taken by the shoulders, the hips, the sacrum, the heels, the back of the head.

And the every-two-hour minimum is based upon laying flat on a surface. If someone sits up, either by being put in a chair or having the head of the bed put up, then the pressure is going to shift to a smaller area; that is, instead of having the pressure distributed over the entire body, it's actually going to be distributed over the area you're sitting on, which would be the buttocks and the sacrum.

So more pressure in one area is going to require more frequent repositioning, which is why even as we are sitting here right now, nobody's staying in the same position in their chairs for two hours. We're all shifting our weight.

Q. So if they indicated that she should be turned and repositioned every two hours or as needed, would that be appropriate?

A. Well, that's what I'm saying. It's -- a phrase like "or as needed" is a catchall which then assumes that every worker there knows exactly what to do, and that may not be the case. And why take the chance when it's just as easy to spell it out.

And I have seen health-care providers who don't understand that repositioning has to take place more frequently than every hour, so I'm not sure if "as needed" is really going to cover that, and how hard would it have been for them just to write "or every hour when sitting in a chair."

Q. Do you have any other criticisms regarding the care plan for Miss Perez de Guzman as it pertains to her skin-care needs?

A. No, only in that once the care plan's in place, the efficacy of it needs to be re -- needs to be evaluated and the care plan needs to be revised.

Now I see that ten days passed before I see another care plan, and my criticism would be that the October 8th care plan stays in place,

even though it seems, from what I was able to find in the records, that her wound might have deteriorated during that time and the care plan was not revised to address it.

Q. Let me ask you this: You would agree that there was a wound-care nurse that was tending to Miss Perez de Guzman's needs at least beginning on October 9th, 2008, correct?

MS. COOLEY: Form.

A. I don't disagree with that. I just don't know for certain who's writing which notes on October 9th, 2008. And -- and I said that there was a nutritionist who identified a wound-care consultant on October 10th, so, to me, it does make sense that there would have been a wound-care consultant either there on October 10th or October 9th.

BY MR. SESSIONS:

Q. Did the facility ultimately bring in a wound-care physician to assist with the treatment of this wound?

A. It does appear to me that at least by October 15th, 2008, there is a physician from looks like a group called Quality Surgical Management.

Q. Would it be appropriate, in your opinion, to bring in a physician to provide wound care to a patient who is admitted into a facility with a stage III or stage IV wound?

A. I think if they don't have someone available within their facility, then it certainly is appropriate to bring somebody in from an outside facility.

Q. Did you see where the facility, as part of their care plan, where you -- initially utilized a low-air-loss mattress to reduce the pressure to the sacrum?

A. Yeah. I don't know when it was actually introduced, but I have no reason at this time to doubt that it was used.

Q. And, again, is that an appropriate intervention for a patient who is admitted into the facility with an existing sacral wound?

A. Yes, it is.

Q. What else would you have liked to have seen the facility do as it pertains to Miss Perez de Guzman's skin-care needs?

A. Well, I would have liked them to at least have some structure in place so that all who were caring for her would know what was being done.

That has to do with communication.

You know, some record as to how often she's being repositioned and what position she's being put in, I didn't see such a record.

And just maybe to get a little ahead of the questions, in the absence of documentation, care can still be delivered or care may not be delivered. I didn't see the documentation that she's being repositioned every two hours or how she's being repositioned. Every once in a while I think I might see a general statement, but my criticism is, by the time they got to the second care plan, which is October 28, 2008, they drop off the -- the one directive they have as far as repositioning. They -- instead of say reposition every two hours in general, they don't say anything about frequency anymore. That disappears.

So the care plan creates a new risk for the resident in that those who are utilizing the care plan have no directive anymore except what they think is the right thing to do.

The care plan on October 28th, 2008, just says turn and reposition frequently throughout the shift and PRN, which is even more general than

reposition every two hours in PRN. It really is up now to the kindness of the caregiver, the staff member, and that can be problematic especially when there's no other tool within a facility by which to guide people.

Q. Well, are you familiar with the policies and procedures of the facility as it pertains to turning and repositioning residents?

A. I did not -- I think I had asked about -- one of the attorneys -- I think there might have been a brief conversation about policies and procedures, but they were not provided to me, so I don't know. I don't know what the policies and procedures say.

Q. So when you say there's no other information that would offer guidance, you don't know that for sure because there could very well be a policy and procedure through which all of the employees are trained at the facility that pertains to specifically turning and repositioning residents?

A. Well, I will certainly agree that if they had a reasonable system in place such as every two hours an announcement was made overhead that all patients are to be on their left side, and then

two hours later another announcement was made over an intercom, all patients turn to your right side, that's a start, but that still may not cover an individual residency, but I don't know if there is some sort of program which is external to the medical records which would have substituted for something within the medical records.

Q. Have you ever heard of a facility having such an announcement over the intercom?

A. I've heard -- actually, yes. I actually have heard of it. I didn't make that up.

Q. Let's talk about the progression of the wounds, of the sacral wound, at Emerald Health Care 'cause you mentioned that you saw evidence that the wound had worsened by October 15. What are you referring to?

A. What I'm referring to is the description of necrotic tissue which I think the -- the Quality Surgical Management people had written about. Now, I don't recall seeing that earlier. It might have to do with them not documenting it, but, certainly, by October 15th, whether or not the necrotic tissue had been present at the time of admission, someone had decided that it was time for that wound to be debrided.

So even in the absence of the best documentation at Emerald Health Care, you can see that something had changed 'cause she required surgical debridement by October 15th, 2008.

Q. Okay.

Did you track the measurements of the wound during the course of Miss de Guzman's stay at the facility?

A. Yes, and if I had read it correctly, and we go from the very beginning to the very end --

Q. Yes, sir.

A. -- the first time I saw it measured was October 9, 2008, where they say the length was ten sonometers, the width was six sonometers and the depth was two sonometers.

And then on November 5th, 2008, the depth -- the length is four sonometers, width is 2.5 sonometers and the depth is half of a sonometer.

Q. Based upon those measurements, would you agree that the wound was improving during the course of Miss Perez de Guzman's stay at Emerald Health Care?

A. I would say that although she may have gotten sidetracked during the course by

November 5, 2008, the wound was smaller.

Q. Did that indicate that it's healing, in your opinion?

A. It shows that she had -- had some healing, yes.

Q. Does the fact that the wound improved by November 5th, 2008, does that lead you to conclude that she was being repositioned off of her sacrum on a regular basis; otherwise, you wouldn't have this healing?

A. I can't necessarily arrive at that conclusion. I can say that there is some healing and certainly the debridement treatments would have helped, but I cannot say that she was being rigorously and frequently repositioned, but I wouldn't be surprised that she was being repositioned.

Q. Well, you would agree with me that if she was not being repositioned at all you would not expect to see the reduction in size, length, width and depth of the wound that you see in approximately a four-week period while she was at Emerald Health Care, correct?

MS. COOLEY: Form.

A. I think the way I would answer that is to

say that I don't think she was consistently repositioned throughout her residency there, but it's possible that towards the end of her residency, they became more rigorous in their repositioning of her.

BY MR. SESSIONS:

Q. Would you agree with this statement, though: You would not have expected the sacrum wound to heal if she was not provided with pressure relief, correct?

A. Some pressure relief, and just to be clear, it didn't heal completely. It was in a healing process, but I would have -- I would not have expected some healing if she had not received any pressure relief.

Q. And I know it's an adjective, but we're talking about a little bit more than "some healing." This is significant healing when you have the length that is almost more than half the size, the width that's more than half the size and the depth that is almost four times improved, correct?

A. Yeah, and I don't think we are disagreeing. I just think I'm using the word healing differently.

When I talk about a healed pressure ulcer, I mean it closed. So when I say healing, it's on its, hopefully, way to being closed, but I can't call it healed until it actually closes up.

Q. Yes, sir.

What other criticisms do you have regarding the skin care provided to Miss Perez de Guzman while she was at Emerald?

A. I think we have covered that.

Q. Okay. I'm giving you a chance to look at your notes to make sure.

A. Right. There might be other components about skin care, but it's not going to be -- when I say other components, there may be other notations I made within the notes, but as far as the criticisms, I think we have spoken about them.

Q. Okay.

The next specific criticism that you mentioned, I believe, had to do with Miss Perez de Guzman's nutrition, is that correct?

A. This is true.

Q. What are your criticisms regarding the nutritional care provided to Miss Perez de Guzman while she was at Emerald?

A. That similar to the general criticisms I

gave of pressure ulcer, there was also a failure to properly coordinate and organize and communicate the care concerning nutrition for Miss Perez de Guzman. So during the time that she was not receiving the nutrients that she was supposed to, she declines within the facility.

Q. Okay.

And is that decline that you just described, is that the harm that was the result of this alleged failure to properly address her nutritional needs?

A. Yes. The decline is going to be a change in her function. It will be a, I guess a simple way of saying that, a downward spiral from which she was not going to be able to pull out from and eventually result in her death.

Q. In your opinion, what was the cause of her death?

A. I do look at the death certificate and the cause of the death which is listed there as end stage senile dementia and adult failure to thrive.

I believe that she does have a functional decline. I believe that she does have a nutritional problem. I believe that is a

contributing factor and is consistent with the death certificate, although I think there could be some confusion as to how the certificate of death is constructed. I think it can be explained.

Q. Let me just ask you a basic question: Do you dispute the opinions set forth in the death certificate?

A. I am not necessarily disputing it. I say there's -- the way it's written would be confusing not even to someone reading it, but maybe even when pointed out to the writer, his or herself, but it can be explained.

Q. What is adult failure to thrive, in your opinion?

A. Well, I would use -- I'm not going to rely on my opinion. I use a -- the definition, and I think it's the National Institute of Aging provides a definition. It's a situation in which somebody is having poor nutrition. They may have decreased appetite. They may have weight loss. They may become inactive, but it's really based in not getting the nourishment that they need to thrive, and the reason for not getting the nourishment can vary.

Q. Doctor, isn't it true, though, that

failure to thrive is a diagnosis that is provided by physicians in the appropriate case?

A. I don't know if it's a diagnosis the way hypotension would be a diagnosis, as opposed to an observation of certain entities; that is to say it's a syndrome which doesn't necessarily tell you what caused it, but it's a recognition that there is a change.

Q. And aren't there specific markers that are in the medical text and medical literature that must be present for someone to use a diagnosis such as -- or a description such as failure to thrive?

A. I don't know if we are thinking of the same thing about markers, but what I -- it's been my experience and based on what I've read, it has to do with, perhaps, a marker of poor nutrition or -- or decreased appetite or weight loss or inactivity, but I do not believe there was actually a laboratory test that one can obtain.

Q. No, no, I agree with that, but are you aware of any marker such as in the anticipated life expectancy of an individual before you provide the description or the diagnosis of failure to thrive to that person?

A. I -- in my experience, I did not see and have not heard that one has to have a specific life expectancy in order to get the diagnosis. If anything, I've heard the opposite, that once you have been given the diagnosis or have been identified as having the syndrome, then you can begin to prognosticize [sic] what the life expectancy would be.

Q. Okay.

And what is your understanding of what end stage senile dementia is as it appears in this case on Miss de Guzman's death certificate?

A. And that's what I was saying. I think it's explainable, and end stage senile dementia probably here is what they're talking about when they're looking at her cognitive function and seeing it's as advanced as it can be.

Now, if you -- in my experience, there are stages for Alzheimer's disease. It can get a little confusing because some staging systems have five stages and some staging systems have seven stages, but the highest number would be the most advanced stage.

It then it gets a little more confusing, and I'll try and simplify it, that with the

seven-stage system, then they break it down into 7a, 7b, 7c, 7d, and I made some notes on this as well.

But the idea is, whether you're calling it stage V or stage VII, the person has deteriorated to an extent that they're not responding to their environment; that they are not able to converse with you; that they're not even able to move themselves.

And there's also the recognition that one is closer to death as a result of the dementia when one has the advanced stage.

Now, here the phrase is actually end stage, so advanced stage means you're not just at a higher number. You're at the highest number and it can't get any worse. It's the last stage in dementia.

Q. Do you disagree with the conclusion of the physician who signed or filled out the death certificate that Miss Perez de Guzman had end stage senile dementia?

A. I would say that the way she was assessed by the time she came into that setting, and I believe the setting was under the care of the Treasure Coast Hospice, she had met the criteria

for end-stage dementia. When they staged her, she met the criteria.

My only area of potential disagreement, I'm not sure the physician would disagree with me, is the trajectory seemed to be a little off, and that is that shortly before that time period when she's being staged at the highest level, and that would be November of 2008, she wasn't end-stage dementia. It was an abrupt change.

So when I say I'm explaining it, the way I explain it is, she had moderate dementia. She had something abruptly imposed upon her which changed her in such a way that, when evaluated, she presented the same way as an end stage senile dementia patient would present.

Q. And we've discussed this, but actually I think you'll agree, when Miss Perez de Guzman was at Lawnwood Regional Medical Center before she went to the nursing home she was described as having advanced dementia, correct?

A. She was at certain -- yes, she was described as having advanced dementia, and then I had pointed out that by the time she got to Emerald Health Care, she was assessed as having moderate dementia. You had pointed out it might

have been a good day.

Q. Yes, sir.

And then they have the diagnosis as it appears on the death certificate which says end stage senile dementia?

A. That is true.

Q. So these are the three dates that we have or the three time periods we have which Miss Perez de Guzman's dementia is described or staged, correct?

A. I would say that those are the three we're using.

There are other elements in the records which would also reflect upon a mental status, but if we just use those three time points, she is doing something which is either a miracle or a misassessment by the caregivers, and that is she's going from end-stage dementia, to moderate dementia, and back down to end stage.

The miracle would be, and certainly we would always hope for such a miracle, is that somebody can go from end-stage dementia to moderate dementia, to actually improve from a degenerative disease. The explanation is probably something different, though.

Q. More likely than not, in your opinion, what would that explanation be?

A. Oh, and it's -- it's something which I believe the physician also noted in a different set of the records and that would be that this is a woman who had dementia who's living her life and, unfortunately, broke her hip.

And then, in the process of going to the hospital and having surgery, she has that particular burden of change in environment, of medications and treatment, and she has a deterioration in her presentation as far as mental status because of this. But it's abrupt and it's a reversible insult to her cognition.

She then goes into the Emerald Health Care facility, improves, undertakes, in fact, is enlisted to undertake, rehabilitation therapy which would require participation that an end-stage dementia patient could not have, but, while there, Emerald Health Care neglects a different component, which is nutrition, and as she deteriorates from that, she then has a deterioration of a clinical status which then the hospice people see and are classifying as a stage VII dementia.

Q. Which they call end stage, but you're equating it to the seven-stage system?

A. Well, what I did was I like to focus in on the details.

Like before, I was saying seemed phrases like advanced dementia and end-stage dementia are not as helpful to me as seeing what they used to arrive at that.

Similar to my discussion about high blood pressure. Telling me that someone has high blood pressure is not as helpful as telling me what the numbers are.

So what I looked at for Treasure Coast Hospice was their admission note. In fact, they actually have something called an admission eligibility note where they stage her cognition. They use what's called the Functional Assessment Staging Scale and they abbreviate it F-A-S-T, it's FAST. And they score her as a 7d, which by -- so it's the number seven and the letter d. And by that point, on November 7, 2008, they're describing a person who cannot sit up without assistance, and if that person speaks at all, speaks with a single intelligible word.

Q. What date was that, sir?

A. November 7th, 2008. It's on my notes where it says Treasure Coast Hospice.

Q. And when did Miss Perez de Guzman pass away?

A. She never actually gets any better after that and she passes away December 18th, 2008.

Q. So going back now to the nutritional care that Miss Perez de Guzman received at Emerald, what was her weight at or near the time of her admission?

A. When she comes in, she's already low in weight and her weight on admission on October 9th, 2008, is 97.8 pounds.

Q. And then what track record of weights do you see while she's a resident at Emerald?

A. I see that she does not gain weight. If she loses weight, it might be another two pounds. The weight record shows her as weighing 95.6 pounds on October 26th, 2008.

Q. Is that the last weight that you have of her?

A. There might be other weights after that, but I saw that it hovered around that number.

Q. So based on those two weights, she experienced approximately a two-pound weight loss

while she was at Emerald Health Care?

A. This is true.

Q. Was she evaluated by a nutritionist while she was at Emerald?

A. She was.

Q. Is that appropriate?

A. Absolutely.

Q. Did the nutritionist identify appropriately, in your opinion, Miss Perez de Guzman's nutritional needs?

A. She did, and she actually came back a second time. And here's what I mean 'cause I was -- I kept alluding to an October 10th note.

The nutritionist on October 9, which is the day after admission, and it's reasonable to have the assessment done the day after, on October 9, 2008, the nutritionist says that Miss Perez de Guzman is at nutritional risk and that she has a low body weight and she has hypermetabolic needs.

And this is correct. The nutritionist is correct, that not only is Miss Perez de Guzman below her typical weight, she's got something which is going to be, in a way, almost competing with her, the rest of her body, for nutrients, and

that is the wound itself. Hence, the hypermetabolic need. She's trying to heal the wound, so she's going to need even more nutrients than if she didn't have a wound.

Q. Specifically what nutrients would she need to heal a wound?

A. Oh, protein and calories. The nutritionist responds to that as well by saying that there should be fortified foods and oral supplementation to meet these needs and to promote weight gain.

So really the nutritionist is appropriately recognizing that Miss Perez de Guzman needs these food substances in order to heal a wound and also to begin to gain weight.

She probably also needs a little extra to heal the broken fracture, but it's going to be subsumed into all of this.

And I have no disagreement with what the nutritionist is saying or what they recommend.

And I apologize if I'm starting to answer questions you haven't asked yet, but when looking at the records, I didn't see anything that would suggest that the nutritional supplement had not been ordered in recognition of what the

nutritionist said.

And as far as the October 10th note, nutritionist assesses again --

Q. October 10th?

A. October 10th, 2008, I believe.

-- the nutritionist wrote an addendum on the bottom of the note saying that the wound-care consultant had identified a stage IV ulcer 'cause I had spoken about that a few times. And a nutritionist revises the recommendation to take into account that this open area is actually a stage IV and, once again, reiterates the importance of the hypermetabolic needs. Subsequent to that, I didn't see any revisits from the nutritionist.

Q. What criticisms, then, do you have about the manner in which Emerald Health Care provided for the resident's nutrition needs?

A. My criticism has to do with my experience, and it's going to sound like such common sense, but my experience, that food only works if it's ingested. So the recommendations by the nutritionist are sound, but giving the foods to the patient or resident is only going to work if the food is consumed. And here I see this

ongoing pattern of failing to individualize the most simple and basic of things and that is feeding to the needs of Miss Perez de Guzman's.

Q. What do you see in that regard?

A. Once again, it's the similar framework with the pressure ulcers, but I think that the harm is quite obvious.

Miss Perez de Guzman could eat and she did eat when the food was properly presented. This is my notes that say "eating" in the left -- upper left-hand corner. They dutifully tracked her intake at every meal; breakfast, lunch and dinner.

Q. Is that appropriate?

A. That is appropriate, but tracking something and not acting on it is not appropriate. Health-care providers are not to be voyeurs, just watching something fall apart in front of them. They have to take the information, understand it, communicate it and organize all the health-care professionals so the person thrives. They have to treat not just the chart, which they did very well here, but also the patient or resident who belongs to that chart.

So there are few times she eats

everything which is presented to her, and that's great, but there are a lot of times she's not, and you don't let it go day after day after day after day and address it -- and not address it because she's already underweight, she's got increased needs and she's going to start falling behind. And after a month of not getting what you need, she is going to get beaten down, and she's going to change and not for the better, for the worse, and that's quite obvious.

Now, just to say -- I know -- once again, I know I may talk a little bit too much, but I want you to hear my opinion -- she can eat if you do it the right way. So you can't walk away from it. It's clearly documented in the records what she needs, and yet they're not giving it to her. They're not even including it in the care plan, yet others are observing it and saying quite clearly this is what she needs. So that's what makes it a tragedy.

It's recognizable what the problem is. It was doable and they failed to do it, and she's the one who suffers.

Q. Did she have a special diet?

A. She had special diets and it was, you

know, adjusted here and there as far as consistency and the fortification, but in the end it has to go into her mouth, and it's not.

Q. Well, you have a chart here which shows the percentage of the meals, both breakfast, lunch and dinner, that she consumed, correct?

A. That is true.

Q. And you listed these numbers directly from the chart?

A. I did.

(Brief interruption.)

THE COURT REPORTER: One moment, sir.

(A brief recess was taken.)

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

BY MR. SESSIONS:

Q. Doctor, did you see in the nutritional care plan that the resident was to receive supplements as well?

A. I did.

Q. You would agree that the chart showing the intake for breakfast, lunch, and dinner does not include supplements, correct?

A. That is true.

Q. Did you see any indication as to how

often Miss Perez de Guzman was receiving supplements?

A. I did see that they were offered. I don't recall how often they were accepted, how often they were refused, but I did see they were offered.

Q. And what we have now is we have an admission that lasted approximately four weeks, correct?

A. That is true.

Q. What risk factors, if any, did Miss Perez de Guzman have for further nutritional compromise at the time that she was admitted into the facility?

A. Well, the risk factors would have been any underlying problems with swallowing and the cognitive problems which would have interfered with the ingestion of food.

Q. And those are issues that manifested themselves while she was at the hospital before she came to Emerald, correct?

A. Yeah. That was already known, and also the pressure ulcer itself created an extra need for nutrients and that pre-existed.

Q. And, in fact, at the hospital, as we've

already discussed, the physicians talked about putting in a PEG tube to improve her nutritional status, but the family refused, correct?

A. That is -- they did decline that modality, that is true.

Q. Yet, despite these risk factors and despite all these issues, we know that in the four weeks that Miss Perez de Guzman was at the facility she experienced weight loss of no more than two pounds?

A. That is true.

Q. Okay.

Other than the weight loss of two pounds, what harm did Miss Perez de Guzman experience as a result of any deviations from the standard of care as it pertains to her nutritional needs?

A. Because as a result of her decline nutritionally, which may not be reflected necessarily in the weight, she -- again, she has a functional decline, and this is reflected in the change which is noted by looking at the rehabilitation medicine records.

Q. How can you say that any change in her cognition is related to an issue related with her nutrition?

A. Because this is the most likely explanation as opposed to what I was saying before; that a woman who on October 14th, 2008, is able to write sentences; is able to read sentences and act on them then declines so suddenly that by November 7th, 2008, the best she can possibly do is come up with one, single intelligible word.

So the most likely explanation is a woman who day after day after day, meal after meal after meal, is not getting the nutrients that she needs; is suffering from malnutrition; is experiencing a failure to thrive; and this is even noted by the initial visit of the physician from the hospice who is tying the functional decline not to dementia, whether it's called end-stage dementia or moderate dementia, but tying it to the sequence of events which occurred after she fell and fractured her hip.

Q. Are you taking into consideration the fact that she suffered a fracture to a significant bone in her body as a result of that trauma when you say that the decline in cognition is most likely related to her nutritional issues?

A. I'm taking it all into account which I believe is reflected in the records because she

does have a decline in mental status when she is at Lawnwood Regional Medical Center. They attribute that to the medications which she might need for pain.

However, when she is seen at Emerald Health Care, this has improved. And she's at Emerald Health Care to be -- partially to be rehabilitated as a result of the fracture, so I'm taking that into account too. And she is accepted at that time as being someone who could participate in rehabilitation therapy, which one would not expect for someone at end-stage dementia.

So the most likely explanation as to this fairly rapid decline in mental status is not that she's had a new dementia created or that the previous dementia has suddenly gotten worse, but that she's not being provided with the fuel that's necessary in order to make the body run.

Q. As evidenced by the fact that she lost two pounds over a period of four weeks?

A. Well, what happens is there's a point where you just stop losing weight because there's nothing left to lose. So you don't just look at the weight itself, because they're still going to

be weighing the bones, and I don't want to sound disrespectful, but that's what happens.

She -- her optimal weight was 135 pounds. Once she's down to like 95, how much more could she possibly lose? But if you take a look at how little she's eating, there's no question that she is not just malnourished, but she's being deprived an opportunity to increase her nutritional status.

Maybe a simpler and quicker way to say it is, because of the failures of Emerald Health Care, they have maintained her in a malnourished state for a month.

Q. Doctor, she is taking in nutrition every single day, correct?

A. She's taking in a fraction of what she needs, that is true.

Q. Okay.

The nutrition is being provided to her and it's being documented what she actually consumes?

A. That is true. It's being delivered to her and they're documenting how much she takes.

Q. And, on top of that, we know she's also being encouraged and provided supplements?

A. That is true.

Q. Are you aware of the family telling the social-service department at Emerald that Miss Perez de Guzman did not eat for 15 days prior to coming into the facility?

A. I remember seeing a notation similar to that, yes. I don't remember it was 15 days.

Q. What significance, if any, did you put on the fact that it was documented that Miss Perez de Guzman was not eating before she came to Emerald Health Care?

A. If this is actually true, and at this point I don't know one way or the other, but let's assume that is true, 15 days without nutrition is going to be a significant period of time which would lead to a state of malnutrition.

And I am not disputing that when she entered Emerald Health Care she already was in a malnourished state; however, she was in a state where she still was functional to the extent that she could participate in physical therapy, occupational therapy, and speech therapy and do moderately as well on a cognitive assessment. However, Emerald Health Care did not make things any better and they made it worse.

Q. Based upon your experience, can people

with dementia refuse to eat all of their food?

A. If this is a -- does it happen? Yes. Is it their right as a person? Not necessarily, because that would be like saying can an infant -- does an infant have the right to refuse. No, the infant has the right and expectation that someone is going to step in and protect them from their own poor judgment, but that's not actually what happened here anyway.

So if it was a demented patient who doesn't know what's good for them and they refuse the food, we try and work with them and figure out what it was and overcome it. We don't ignore it and walk away and say, well, that's their right, but that didn't even happen here.

Miss Perez de Guzman would eat when fed in a way that was acceptable to her, and that is clearly noted in the records. That's what I said what makes this such a tragedy is that they had the roadmap that they could have followed, but they followed a different roadmap.

Q. What, if anything, did the facility do when they were faced with the fact that she was not consuming all of her food?

A. Sometimes they would do it and sometimes

they wouldn't, and that's what I was talking about, organization and consistency. There seems to be one group that's documenting in one set of the records of Emerald Health Care that Miss Perez de Guzman does well when presented with finger food. They actually say -- that's the phrase they used. They say she's doing well.

It's also noted that when family members feed her, she does well.

It's also clear from the records that she needs special care and time to eat, which has been my experience with certain demented patients. In fact, there's parts of the records where it says it takes 50 minutes, you know, to be with her during a meal. And when that happens, that is terrific and that is appropriate, but it has to happen throughout all the meals throughout the entire stay, and that never gets incorporated into a systemic approach to Miss Perez de Guzman and, as a result, she does not get the nutrients that she needs and is maintained in a malnourished state during her residency there.

Q. And yet we see that her wound condition improved while she was there, correct?

A. There is some -- yes. That got a little

bit smaller.

Q. Would you agree with me that wound would not have healed if she was not getting sufficient nutrition to promote wound healing?

A. Well, I would agree that it got something, but it's -- it's competing and it's -- it -- I don't want to sound silly, but it's almost like you had four people at the table but you only brought enough food for two, and nobody's really getting enough.

So the wound got a little bit, the other parts of the body got a little bit, but it wasn't optimized to the extent that she needed. Maybe the wound would have healed a little faster. And, most likely, if she had gotten the nutrients, she would not have declined the way she did functionally and mentally.

Q. Your specialty is in internal medicine and in geriatric medicine, correct?

A. That is true.

Q. It's not neurology?

A. It's not neurology.

Q. And it's not psychiatry?

A. I'm not a psychiatrist.

Q. Do you have any other criticisms that we

haven't discussed regarding Miss Perez de Guzman's nutritional needs and the manner in which they were provided for at Emerald?

A. No. I think we have covered the criticisms.

Q. So as I understand it, what you would have liked to have seen is the individual at Emerald spending more time with Miss de Guzman and take more effort to see to it that she ate a larger percentage of her meals as documented in the charts?

A. More time and appropriate time.

And although this is not a criticism, it's concluded in my notes and it's just supporting what I had said and that is she is followed by occupational therapy specifically for the several areas and specifically within that the area of feeding. And the occupational therapist writes more than once that Miss Perez de Guzman needs maximum verbal cues and initiation cues during eating. So she actually needs someone in a very simple way to sit there and coach her through the meal.

So it's -- it's really not a matter of delivering the food and leaving her to her own

devices.

And just to be as complete as I can, I think this was echoed in the testimony of one of the family members, Nancy de Guzman, I guess is the daughter-in-law, who had noted at some point that food would be delivered, but Miss Perez de Guzman, the resident, would not be assisted.

And I apologize if I'm going a little further in the answer, but just to catch everything, during the surveys, there are multiple times that deficiencies were found in the area of comprehensive-care plans, but I found it interesting that there was a survey conducted on April 24th, 2009. Now, this is after she's there, but the -- the surveyors found that Emerald Health Care Center failed to meet the Rule 400.022 which is the Florida rule, the right to adequate and appropriate health care. And the area in which they had been cited was that they failed to provide adequate and appropriate services to maintain or improve the eating abilities of one of the residents.

And there was a plan of correction in which the resident, who was noted in the survey, would eat with supervision, and all three meals

would be supervised, and this would be in the plan of care. And the nursing staff were in service in response to the survey to follow the plan of care for every resident.

Now, yes, this is not Miss Perez de Guzman, but it does show that there was a problem after she was there. Miss Perez de Guzman demonstrates that there was a problem while she was there, and her care plan didn't even include what was seen in the care plan of this resident who was surveyed on April 24th, 2009, which is the care plan didn't include references to Miss Perez de Guzman's needs during eating such as finger foods, and verbal cues, and initiation cues while eating.

MR. SESSIONS: Respectfully, Doctor, I'm going to move to strike the reference to a survey that occurred after this residency.

BY MR. SESSIONS:

Q. Any other criticisms that you have regarding the nutritional needs of Miss Perez de Guzman and how they were provided for at -- while she was at Emerald that we haven't already discussed?

A. No. I think we've discussed it.

Q. And then the final -- the specific category that I noted that you told me that you had criticisms about pertained to Miss Perez de Guzman's mental-status needs, is that correct?

A. Yes. It was really that I was addressing how her mental status had been altered because of the malnutrition, so we probably began -- we probably had already discussed that; that she had not optimal mental status while at Emerald Health Care, but had a moderate deficit which then changed as a result of the failure to provide her with nutrition that she needed. And then, from that, she goes into a situation in which she's not going to recover and in the hospice system, and then eventually passes away.

Q. Is there anything specifically that Emerald did regarding Miss Perez de Guzman's mental health-care needs that you would opine was a deviation from the standard of care?

A. No. The opinion that I would give, as I had said before, they were not giving her body the fuel it needed, and the brain would be part of the body that is deprived of fuel, and the best explanation for why Miss Perez de Guzman deteriorates in the way she did when she did is

not the natural progression of the dementia, but the failure to meet her nutritional needs.

Q. Do you know why the initial psychiatric assessment was performed at Emerald on October 14th?

A. I think it -- I don't remember the exact reason. I thought it had to do with the adjustment of medications or behavioral problems, but I don't recall.

Q. Okay.

And Miss de Guzman passed away on what day?

A. She passed away on December 18, 2008.

Q. And she was discharged from Emerald on what day?

A. She's discharged from Emerald Health Care on November 7th, 2008.

Q. So it's your opinion at the time she was discharged from Emerald on November 7th, 2008, that she was past the point of no return nutritionally and that then she could not have been provided with what you would call appropriate nutritional care to otherwise improve her condition?

A. I would say that she had been turned into

a different type of person which now puts the family in a very difficult position.

As I said before, she is seen by a doctor in the hospice setting who notes that she's not communicative. You know, this is someone who before was able to write sentences and read things. She didn't follow even simple commands. And the family is now presented with a choice as to what to do, and it's a very difficult choice. Are they going to try and get nutrients into her through a tube, or are they going to let her drift away without the nutrients, and the family had to make a decision.

Q. Why would they need to provide nutrients in a tube if she's capable of eating as you said?

A. She was, but by the time Emerald Health Care had done what they did, she wasn't even interacting anymore. That's -- that's why she was staged -- she was given a stage 7d. So it's a different -- she became -- she became a person who entered for a facility to be rehabilitated, and she exited it looking like a person who was at the end of their life.

Q. At what point in time during her admission at Emerald did she pass the point of no

return, in your opinion?

A. Well, unfortunately, they don't indicate such a point, but I would say the point of no return is the point when Emerald Health Care gives up on her, because once somebody gives up on you, how are you going to return.

Q. When did Emerald give up on her?

A. It seems it would be the point where there are discussions of hospice. I don't have a date on that, but to take someone who would eat finger food who speech therapy is saying is still viable and saying, well, she's at the end of her life, that's giving up.

And just to be as accurate as possible, this goes back to my initial criticisms that there is fragmentation of care. She's being consulted by hospice people, well-meaning hospice people, at the same time that speech therapy is writing that she's successfully completed 17 sessions, and that's in late November, so...

Q. Late November?

A. November 6th, 2008, speech therapy, who doesn't feed her, but just sees what she can do, says that Miss Perez de Guzman has completed the speech-therapy sessions and met the treatment

goals and now just needs to be fed, but she's not being fed.

Q. I ask you again, sir, at what point did she -- did Emerald give up on her or at what point did she pass the point of no return?

A. Well --

MS. COOLEY: Form.

A. -- I don't know what the point of no return would be. That may not be a question I can answer, but I would say as a system Emerald Health Care gave up on her when they did not incorporate the recommendations of the occupational therapist and the speech therapist into their plan of care.

The point of no return would have been no later than November 7th, 2008, but, once again, you have the problem of documentation which makes it difficult to pinpoint any closer than that.

BY MR. SESSIONS:

Q. And if you would, sir, I know we touched on this, but I don't know if I understand it clearly, how did the actions of the folks at Emerald cause or contribute to her death?

A. They ground her down when they should have been lifting her up. They took a person who had the potential to be rehabilitated and they did

not do what they were charged with doing. Instead, they contributed to her debilitation. There was no place to send her to be rescued because this is where she was sent to be rescued. So they created her debilitation and also, perhaps, gave the impression that this was inevitable. And the point of no return is when she's now deprived of the rehabilitation and sent to a hospice.

The natural progression should have been hospital, rehabilitation, home or some other facility. It shouldn't have been hospital, rehabilitation, hospice.

So in a simple way, and I don't want it to sound disrespectful, rather than allowing her dementia to take its progressive course in advancing to end stage, they hastened her demise by depriving her of one of the most essential things a person needs which is nutrition, and from this she did not recover.

Q. Do you have an opinion, with a reasonable degree of probability, as to how much they hastened Miss Perez de Guzman's demise, in other words, how much longer she would have lived but for?

A. Well, I would, by their -- by what I saw in the records, even with some people writing end stage or advanced dementia, nobody was writing, at least upon entry to Emerald Health Care, that she was going to die within six months. I saw this in different places. One place it said she did not have end-stage disease. Another place it was indicated that she was not terminal.

And based upon what I saw, despite the moderate dementia which was described, in fact, probably because it was only moderate dementia, I would have not been surprised she lived another five to ten years. This is a woman who was able to survive a surgical procedure. This was a woman who was considered to be a candidate for rehabilitation therapy. She was not considered to be -- at the end of her life. She was not considered to have a terminal disease.

Q. Are you familiar with the literature that describes the risk that faced -- that elderly individuals face when they fall and break a hip and the prognosis that follows after that?

A. Absolutely. And it is a terrible risk for an older person to break a hip which is why we have to be very vigilant and supportive to make

sure that they do not suffer the consequences of the reduction in mobility or even the consequences of going through the surgical procedure.

However, she survived the surgery, she made it to rehab, and there was no indication that she was on the way down. If anything, from what I was able to see in the notes from Emerald Health Care, they were optimistic that she was on the way up.

Q. Okay.

Doctor, have we discussed all of the criticisms that you have against Emerald Health Care?

A. I believe we have.

Q. So it would be fair to say that with the exception of these criticisms that we discussed, that the other elements of care that you saw in the records of Emerald Health Care were within the applicable standard of care?

A. Either that or there are areas that I have no opinion because I didn't look at them.

MR. SESSIONS: Okay. I have no further questions at this time.

* * * * *

CROSS-EXAMINATION

BY MS. COOLEY:

Q. Doctor, were all of your opinions given within a reasonable degree of medical certainty?

A. Yes, they are.

Q. And it's your opinion, within a reasonable degree of medical certainty, that Emerald Health Care Center caused the death of Miss de Guzman?

MR. SESSIONS: Form.

A. Yes. Their failure to meet the standard of care contributed to her death.

MS. COOLEY: I have nothing further.

MR. SESSIONS: Okay. Thank you. Will you read, Doctor?

THE WITNESS: Sure.

MR. SESSIONS: We'll order.

THE COURT REPORTER: Would you like a copy, ma'am?

MS. COOLEY: Yeah.

(The reading and signing of this deposition is not waived, and the deposition was concluded at 2:00 p.m.)

- - -

CERTIFICATE OF OATH

STATE OF FLORIDA

COUNTY OF ORANGE

I, Heidi Kay-Harmer, Florida Professional Reporter, Notary Public, State of Florida, certify that PERRY J. STARER, M.D., personally appeared before me on the 14th day of April, 2016, and was duly sworn, and he produced a New York State driver's license as identification.

Signed this 21st day of April, 2016.

Heidi Kay-Harmer

Heidi Kay-Harmer
Florida Professional Reporter
Notary Public, State of Florida
Commission #EE875558
Commission Expires: 4/16/2017

HEIDI KAY-HARMER
MY COMMISSION # EE875558
EXPIRES: April 16, 2017

CERTIFICATE OF REPORTER

STATE OF FLORIDA

COUNTY OF ORANGE

I, Heidi Kay-Harmer, Florida Professional Reporter, certify that I was authorized to and did stenographically report the deposition of PERRY J. STARER, M.D., Pages 1 through 128; that a review of the transcript was requested; and that the transcript is a true and complete record of my stenographic notes.

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

DATED this 21st day of April, 2016.

Heidi Kay-Harmer
Florida Professional Reporter

DEPOSITION ERRATA SHEET

Our Assignment NO. JO340759
Case Caption: IN RE ARBITRATION OF: THE ESTATE OF ESTELA PEREZ DE GUZMAN VS. PORT ST. LUCIE MGT, LLC, ET AL.

DECLARATION UNDER PENALTY OF PERJURY

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

Signed on the day of , 20 .

PERRY J. STARER, M.D.

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