

IN THE SUPERIOR COURT

IAN SVEILICH, ADMINISTRATOR)
FOR ESTATE OF JILL VERCELLI,)
)
Plaintiff,)
)
v.) Docket No. CV13-6010293-S
)
MIDDLESEX HEALTH SYSTEM,)
INC., D/B/A MIDDLESEX)
HOSPITAL PRIMARY CARE, INC.,)
ET AL.,)
)
Defendants.)

- - -
THE VIDEO TELECONFERENCE DEPOSITION OF MARK SHOAG, M.D.
OCTOBER 30TH, 2017
- - -

Video Teleconference deposition of MARK SHOAG,
M.D., as if upon Cross-Examination before Christine A.
Schirripa, a Registered Professional Reporter, Certified
Reporting Instructor, and Notary Public in and for the
State of Ohio, on Monday, the 30th day of October, 2017,
at Northeast Court Reporting, LLC, 5075 Taylor Drive,
Suite 1, Bedford Heights, Ohio, commencing at 12:24 p.m.

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By Mr. Dugan 65

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(Whereupon, Defendant's Exhibits 1-3 was marked
for identification.)

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MARK SHOAG, M.D.,

called by the Defendants for the purpose of
Cross-Examination, as provided by the Ohio Rules of
Civil Procedure, being by me first duly sworn, as
hereinafter certified, deposes and says as follows:

MR. BIONDO: Okay. Just for the
record, we've marked three exhibits so far.
The first, Exhibit 1, is a renote of
deposition dated September 8th, 2017.

Defendant's 2 is the -- I'll call it
the doctor's expert file that was sent to us
on August 17th, 2017, by the Koskoff firm,
and this document contains -- there's some
emails in here, there's some correspondence,
there's index to records, and I believe
there's a bill in here as well.

Exhibit 3 is a copy of the Doctor's CV.

- - -

CROSS-EXAMINATION

BY MR. BIONDO:

Q. Doctor, I'm going to show you what has been



1 marked as Exhibit 3. Is this your most up to date CV?

2 A. Yes, it is.

3 Q. Doctor, I would like to start just going
4 through your CV a little bit. Tell me a little bit about
5 your practice that you have right now. Where are you
6 working right now?

7 A. So I work -- my office is 11900 Fairhill. I
8 work primarily at Select Hospital, which is roughly 50
9 percent owned by the Cleveland Clinic and 50 percent
10 owned by the Select Medical Company.

11 I would say 90 percent plus of the patients I see
12 right now are hospital patients. That's sort of become
13 more and more prevalent as every year has gone by. It
14 was -- I had a huge private practice, which I sold at the
15 end of 2008, and I've sort of phased out my private
16 practice to the point, where I said, the overwhelming
17 majority of my patients now are hospital patients.

18 Q. So is your practice now what I would call as
19 a hospitalist?

20 A. Primarily, yes.

21 Q. So these are patients primarily admitted to
22 the hospital by other providers, and then you, then, take
23 over their care in the hospital-based setting?

24 A. That's correct.

25 Q. And that's been the case from, did you say,



1 2008 or 2009?

2 A. So 2009 the sale of the practice went
3 through. Obviously I -- when I first sold the practice
4 -- I was in private practice for a very long time. And I
5 had a fair number of patients who wouldn't go anywhere
6 else and I had more -- some of these patients I just kept
7 on as private patients. I've tried to dwindle that
8 number as the years have gone by. Now, it's, I would
9 say, 90 to 95 percent of my practice is hospital
10 patients.

11 Q. When you sold the practice -- was the name of
12 the practice on your CV that you sold?

13 A. No.

14 Q. What was the name of that practice?

15 A. So I billed under Mark Shoag, M.D., but there
16 was a group of four of us, it was Dr. Rizzy Guyer, Bonnet
17 and myself, (phonetic) and it had some name like Advanced
18 Internal Medicine or Practice of Internal-something. I
19 don't remember the name at this point, but it was one of
20 those things that you put on the door. We basically each
21 billed as privates, but we shared the staff and the, you
22 know, office expenses, that kind of stuff.

23 Q. The patients that you retained after the sale
24 of the practice, where did you physically see these
25 patients?



1 A. At this 11900. I have an office at that
2 Select Medical Facility.

3 Q. So even through today?

4 A. Yes.

5 Q. Okay. Other than yourself -- did you call it
6 Select Medical? Is that the name?

7 A. Yes. It's called Select Specialty Hospital,
8 something like that, but the billing address is 11900
9 Fairhill Road, Cleveland.

10 Q. Okay. Do you have any staff that works
11 there, nurses or medical assistants?

12 A. So I have -- I mean, there's a lot of staff.
13 I fortunately do not have to pay any of them, so I don't
14 know if they are officially mine, but, you know, if I
15 need -- I mean, there's obviously nurses in the hospital
16 and if I need a medical assistant, secretary, that sort
17 of thing, I have access to that.

18 Q. Okay. I'm sorry if I'm not getting this. Is
19 the address that you gave, is that the actual hospital
20 itself?

21 A. Yes.

22 Q. Is there an -- within the hospital, do you
23 have an office there as well?

24 A. Right. Exactly. I mean, the first floor is
25 primarily offices and I have an office.



1 Q. Is it a clinical office or is it more of an
2 administrative office?

3 A. It's both. I mean, there's exam rooms
4 attached to it. The truth is at this point, almost all
5 of my clinical work is in hospital, but I have -- I mean,
6 so right now, I probably see patients one or two
7 afternoons a week at most and it's just a few patients
8 that I have left over. I have an exam room, I have -- I
9 mean, I can function. In other words, if I need a
10 medical assistant, there's a medical assistant available.
11 If I need a secretary, there's a secretary. But most of
12 my use of the office is more for administrative, doing
13 records on the patients I have in the hospital.

14 Q. Understood. Okay. I'm just going through
15 your CV. You received your M.D., that was in '81;
16 correct?

17 A. Yeah. It's kind of hard to remember these
18 things.

19 Q. Your residency was internal medicine, I
20 assume?

21 A. Yes.

22 Q. And you're board certified in internal
23 medicine; correct?

24 A. Yes, sir.

25 Q. Are you recertifying or are you



1 grandfathered?

2 A. I'm grandfathered. I don't have to.

3 Q. Tell me a little bit about your teaching
4 positions that you hold currently.

5 A. Sure. So right now I'm affiliated with the
6 Cleveland Clinic system. Like I said, my staff
7 privileges are at the Cleveland Clinic. I used to be
8 affiliated with University, but the two of them are
9 mortal enemies in Cleveland.

10 My teaching is all practical teaching at this
11 point. In other words, I round with interns, residents,
12 I have some nurse practitioners. It's not paid. I did
13 have a paid position at one point with The University at
14 one of their satellites called St. Luke's where I did
15 formal didactic teaching.

16 Q. When did that end?

17 A. That was in the late '90s, 2000s, something
18 like that.

19 Q. So from the late '90s to now, whatever you've
20 been doing, it's by way of rounding with residents or
21 interns?

22 A. Exactly.

23 Q. And is that primarily based through the
24 hospital?

25 A. Yes.



1 Q. The research that you have on your CV, these
2 articles, I take it, are from your training?

3 A. Yes, and they're remote. They're related to
4 metastatic breast cancer and don't really have anything
5 to do with this case.

6 Q. Do you have publications that deal with
7 issues that are relevant to the issues that we'll be
8 discussing today?

9 A. No, sir.

10 Q. What states do you hold licenses?

11 A. Ohio.

12 Q. Have you ever held a licence in any other
13 state?

14 A. No, sir.

15 Q. Has your license in Ohio to practice medicine
16 ever been subject to any type of investigation or
17 discipline?

18 A. No, sir.

19 Q. The hospital that you've held privileges at
20 through the years, have your privileges ever been subject
21 to any type of disciplinary action?

22 A. No. I mean, boy, sometimes if you didn't
23 fill the chart out, the discharge, you didn't dictate
24 summary on time, they would say, Okay, you can't admit
25 for six hours until you get the discharge summary done,



1 but other than that nonsense, no.

2 Q. I'm referring to issues related to the
3 clinical practice of medicine.

4 A. No.

5 Q. Do you advertise in any witness, expert
6 witness sites or publications?

7 A. So I personally don't advertise. Like 15
8 years ago, there's an organization called TASA that asked
9 if they could list me and I think I'm still listed with
10 them. I get one or two cases a year, but I don't pay to
11 advertise.

12 Q. Is that the only entity that you are aware of
13 that lists you as an expert witness?

14 A. I think so, yes.

15 Q. I saw -- I think there was a bill that's part
16 of Exhibit 2 and on the letterhead of the bill is
17 American Medical Legal Consultants, Inc. What is that?

18 A. That's me. My accountant said -- I've had
19 that for, like, I don't know, decades. My accountant
20 said when I started doing expert review -- and actually
21 now I bill everything, all my clinical practice through
22 that company. Just allows me to write stuff off for
23 taxes and that kind of thing.

24 Q. Okay.

25 A. Except -- I guess my wife is listed on it.



1 She's not a doctor or anything. It's just like a
2 shareholder incorporation form, but it's really just me.

3 Q. Does she take a salary?

4 A. No. Just when you incorporate in the State
5 of Ohio, they need two people to sign for it.

6 Q. I like to go over your testimonial history.
7 You've given depositions before; correct?

8 A. I've given many.

9 Q. I'm sure you've answered this before.
10 Approximately how many depositions have you given to date
11 in medicolegal cases?

12 A. So I've been doing this since '95. I don't
13 really have a list, but several hundred. I don't know
14 the exact number.

15 Q. Approximately how many times have you
16 testified in court?

17 A. I would say probably about 15. Fifteen to 20
18 max.

19 Q. Okay. Have you reviewed cases for the
20 Koskoff firm prior to this case?

21 A. I don't know if this was the first. I know
22 I've reviewed a couple others for him, but I don't know
23 prior -- I mean I don't -- I think I've done one other
24 deposition for them so this probably is not the first
25 one.



1 Q. Okay. I'll show you -- and this may clarify
2 that for you a little bit. Part of Exhibit 2, there's an
3 email from the Koskoff firm from Lyndsey Hanson to you
4 where she said -- I'll read it for everyone's benefit.
5 It says, I've been asked to obtain an updated W-9. The
6 information we have on file from past matters does not
7 match your current invoice dated 6/15/15.

8 So does that refresh your recollection that there
9 were matters prior to this one?

10 A. I mean, like I said, I think there is
11 something prior, but I haven't done a ton of work for
12 them. I think I looked at something in the order of
13 three, four cases for them.

14 Q. Okay. I think you said there may have been
15 one prior deposition?

16 A. I think so.

17 Q. Approximately how long ago was that? Was it
18 last five years?

19 A. Yeah, I would say it's within the last five
20 years.

21 Q. Okay. Have you ever testified in court for
22 the Koskoff firm?

23 A. I mean I don't know all the principles in the
24 court. The only time I remember testifying in
25 Connecticut was a case with -- the attorney was Mary Ann



1 O'Connor, and I don't -- I don't know if there was some
2 merge. I think they got my name through her, but I don't
3 know if she's affiliated with Koskoff at this point.

4 Q. Okay. Have you worked with -- other than
5 Mary Ann O'Connor or anyone at the Koskoff firm, have you
6 worked with any other Connecticut attorneys?

7 A. I think I have, but, I mean, I can't really
8 -- I honestly don't recall. I mean not -- certainly not
9 a ton.

10 Q. Okay.

11 A. Actually, no. I do remember the name. So
12 I've worked with a gentleman named Charles Price. I
13 think he's in downstate Connecticut, Bridgeport,
14 Stanford, New Haven, something like that.

15 Q. Do you have any recollection of any of the
16 names of the cases that you've worked on, whether it be
17 the Koskoff firm or Attorney Price?

18 A. You know, I should remember the case of the
19 one that I did with Mary Ann O'Conner because that went
20 to trial in Connecticut.

21 Q. Do you know where in Connecticut?

22 A. It was in the New Haven area. I don't
23 remember exactly where. It was in the New Haven area,
24 but I honestly don't remember the names. I just don't
25 retain that.



1 Q. Do you have any recollection of giving
2 testimony as an expert in a case where the subject of a
3 fistula was at issue?

4 A. You know, I honestly can't recall doing that,
5 no.

6 Q. How about cases where there was a recurring
7 urinary tract infection?

8 A. Off the top of my head, I don't recall that.
9 I'm not saying it's impossible, but I just don't recall.

10 Q. I know you've answered this question before
11 too, but to update my records, as far as the percentage
12 of your work plaintiff versus defendants, what's your --

13 A. Sure. In the past it's been like 95 percent
14 plaintiff and in the last two, three years, there have
15 been a -- there's two very large defense firms that keeps
16 sending me a lot of stuff. I was actually on the
17 opposite side from them on a matter and so now it's
18 probably 75/25 plaintiff.

19 Q. Now, is that for cases reviewed or is that
20 for testimony?

21 A. Cases reviewed.

22 Q. As far as the testimonial history goes, are
23 we still closer to 90, 95 percent?

24 A. Yes.

25 MR. BIONDO: Sean, do you mind me sort



1 of looking through this stuff?

2 MR. McELLIGOTT: No, that's fine.

3 Q. So what is this letter about Paul I see?

4 It's talking about Paul. I'm just kidding.

5 MR. BIONDO: He's smiling. You can see
6 it.

7 - - -

8 (Whereupon, a recess was taken.)

9 - - -

10 Q. We spent a few minutes going through your
11 file and I think what I've been able to ascertain,
12 there's an index of records that were sent to you from
13 the Koskoff firm that's part of Exhibit 2, which I
14 believe is also the first two pages of each of these
15 binders that are on the desk.

16 A. Yes, sir.

17 Q. And also I'm looking for it here. In one of
18 these binders, there is a -- whatever you want to call it
19 -- flash drive which is a digital version of the same
20 documents?

21 A. Yes, sir.

22 Q. Other than the medical records. Are there
23 any depositions on this drive?

24 A. No, I think that's just the records.

25 Q. And I think you had told me off the record



1 that you prefer to have paper so you would have ask them
2 to send over the paper copy and they did that for you?

3 A. Yes, sir.

4 MR. BIONDO: And, by the way, while we
5 were off the record, Sean, thank you for
6 clarifying that one issue.

7 Q. There's another case that you had testified
8 on. There was a prior case. Why don't we just put that
9 on the record.

10 A. Again, I don't remember the name, but it was
11 a meningioma case.

12 Q. Was that a deposition or trial testimony?

13 A. Deposition.

14 Q. And that was just last year or two years ago?

15 A. I think two years ago.

16 Q. Was that deposition conducted in Connecticut
17 or did the attorneys come out here?

18 A. It was here.

19 Q. Guys, does anybody want me to list off the
20 records that are in this index?

21 MR. McELLIGOTT: I think we have it. I
22 don't think he wants you to. I think you're
23 good.

24 Q. Doctor, while we were off the record, I think
25 you had told me that we're going to be focusing our time



1 on the Middlesex Hospital Primary Care chart.

2 A. Yes.

3 Q. I'm going to put all of the other hospital
4 records to the side. If you need them, just let me know.

5 A. Sure.

6 Q. Just for to record, Doctor, there's no
7 markings or highlighting in these records; correct?

8 A. No, sir.

9 Q. Now, I was looking for the initial
10 transmittal of the file materials to you. Do you have a
11 letter or an -- where these documents all came over to
12 you?

13 A. I mean if I did, I don't have it anymore. I
14 thought it was a phone call that I got from them --

15 Q. Okay.

16 A. -- from somebody in the firm.

17 Q. Okay. This may help put us in time a little
18 bit. Part of Exhibit 2 is that June 15th bill, again,
19 from American Medical Legal Consultants, and the date of
20 the bill is June 15, 2015. Is this your first bill on
21 this file?

22 A. I think so.

23 Q. I don't see any other bills in this file that
24 was produced to us. Are there any other bills that
25 you're aware of?



1 A. No. Except I am going to bill for my
2 preparation time for today.

3 Q. Right. Again, just trying to get a handle.
4 So the bill here is \$1,975. Is that a flat rate or is
5 that some type of hourly rate?

6 A. It's some kind of an hourly rate.

7 Q. What was your rate in approximately 2015?

8 A. 300 an hour to review.

9 Q. And that was for your review of basically all
10 the documents that are listed in the index that's part of
11 Exhibit 2?

12 A. That's correct.

13 Q. Now, I notice here that in August of 2017 you
14 were sent nine deposition transcripts. Do you have a
15 bill for reviewing these transcripts?

16 A. No. I'm going to bill them as part of the
17 preparation for the deposition.

18 Q. Okay. Do you have like a scratch sheet
19 somewhere with a time that you've spent post this June
20 15, 2015, bill?

21 A. I do. I'm sorry. I apologize. I didn't
22 bring it with me.

23 Q. Okay.

24 A. Part of it was because I didn't know how long
25 I was going to talk to Attorney McElligott today and I



1 wanted to add that onto it. The truth is, we only talked
2 for about 20 minute so most of what I have written on
3 that sheet plus 20 minutes will be --

4 Q. Will be for those depositions?

5 A. For the deposition. I mean, obviously, I
6 looked at the records again in preparation for the
7 deposition and the 20 minute phone call.

8 Q. Okay. So prior -- to prepare for today's
9 deposition, I want to kind of get a handle as to what
10 sort of things you reviewed, you reviewed, I assume, some
11 of the medical records?

12 A. Right.

13 Q. Which medical records did you review to
14 prepare for today's deposition?

15 A. So the truth is, I didn't look page by page
16 through all the hospital records again, but I would go
17 through the discharge summary, the H&Ps, some of the
18 radiology. Basically sort of a limited review of the
19 hospital records. The primary care records which is, you
20 know, the primary focus. I read all the depositions page
21 for page.

22 Q. Okay. In preparation for today?

23 A. Exactly.

24 Q. And have you looked at any radiology images
25 for this case?



1 A. I didn't look at any images. I have reports,
2 but I'm not a radiologist. I don't really look at -- I
3 mean, just to be technically honest, I look at chest
4 x-rays, I look at CTs, but I would never trust myself to
5 look at a CT scan, so I don't want to look at the images.

6 Q. Now, I'm flipping through the deposition
7 transcripts. I also don't see any highlighting or
8 notations on these transcripts. Does that meet your
9 recollection?

10 A. Yeah. I try not to mark them up.

11 Q. And the August 16th, 2017, letter that
12 accompanied these transcripts is also part of Exhibit 2.
13 How about your fee for testimony? Do you have a separate
14 fee for giving a deposition?

15 A. Yeah. So I generally have a flat fee of
16 1,500 for deposition. Now, look, the truth is if it goes
17 an hour, I'll refund some of that. I mean if it goes
18 past 5:00, I'm going to bill extra. I just assumed that
19 I got to take off -- I mean I have to assume that I'm
20 going to be tied -- transit time here takes me about 40
21 minutes each way, and then I figure the deposition goes
22 two, three hours. So that's -- whatever that breaks down
23 to. I think you guys may have paid it already. I don't
24 remember, to be honest.

25 Q. I honestly have no idea.



1 A. If not, I'll send Mr. McElligott out a thing.

2 MR. BIONDO: Sean, is that accurate?

3 MR. McELLIGOTT: Is what accurate?

4 MR. BIONDO: He thinks we paid his bill
5 and I have no recollection.

6 MR. McELLIGOTT: I have no idea. It
7 doesn't seem too likely, but --

8 THE WITNESS: That's good for me. I'll
9 send you all the bills, Sean, and you guys
10 work it out. All right.

11 Q. Also in preparation for today, so you
12 mentioned you spoke with Attorney McElligott for about 20
13 minutes this morning. Have you spoken to him in the
14 weeks leading up to today?

15 A. Yeah. I think we had a few like maybe one or
16 two -- I think two relatively short conversations.
17 Again, to be perfectly honest, I -- my opinions in this
18 case are really relatively brief and it wasn't -- I mean
19 it wasn't -- they weren't like horribly detailed
20 conversations. I don't think the total phone time
21 including today would be more than an hour.

22 Q. Okay. So about three phone calls in total?

23 A. Yes.

24 Q. And you have -- I don't see a written report
25 anywhere. Do you have a written report regarding your



1 review in this case?

2 A. No, sir.

3 Q. Do you have any notes that you created with
4 your notes of this case?

5 A. No, sir.

6 Q. Now, also part of Exhibit 2 you were sent --
7 June 12th of 2015 it looks like you were emailed a draft
8 disclosure of yourself as an expert in this case. Does
9 that sound about right?

10 A. Probably. I mean, I obviously don't
11 remember.

12 Q. Now, do you recall whether or not when you
13 looked at the disclosure, you had any suggested revisions
14 or changes?

15 A. You know, I don't recall doing that at the
16 time.

17 Q. Okay. You had -- this disclosure -- I assume
18 you didn't draft this disclosure?

19 A. That's a hundred percent correct.

20 Q. This was drafted by someone at the Koskoff
21 firm, emailed to you, you took a look at it, I assume;
22 correct?

23 A. Yeah. In truth, I probably looked at it
24 quickly.

25 Q. Now, the deposition transcripts that were



1 sent to you in August of 2017, so this is approximately
2 two years after this disclosure was filed, did your
3 opinions in this case change at all with review of the
4 deposition transcripts or did they remain consistent?

5 A. The one thing I would say -- first of all, I
6 think it remained consistent. Obviously there's an error
7 in that.

8 Q. Yeah.

9 A. The one thing I would say is when I read the
10 deposition of Dr. Oh, I felt even more strongly that she
11 shouldn't really be -- I should not be critical of her.
12 I just -- I think she was really straight, forthcoming
13 and I could totally see being in her situation and doing
14 exactly what she did.

15 Q. So that gets us to the disclosure, which I
16 think we've marked and have it somewhere. So as Exhibit
17 1 -- or no, that's not it.

18 - - -

19 (Whereupon, Exhibit 4 was marked
20 for identification.)

21 - - -

22 Q. Doctor, Exhibit 4 is the copy of the
23 disclosure that was filed on this case on June 17, 2015.
24 Apart from some pen marks on there, is that -- I want to
25 just point -- you were talking about the error. On



1 section C where it says that you will testify that Dr. Oh
2 and Middlesex Primary Care, should that say something
3 else?

4 A. Yeah. It should say Dr. Ridge. I don't have
5 any criticism of Dr. Oh.

6 Q. Okay. Other than that one change on this
7 disclosure, if you want to read it over, is there
8 anything else that you think should be changed?

9 A. Let me just take a quick look. No, that's
10 fine.

11 Q. Thank you. I assume, Doctor, you've never
12 met the plaintiff in this case?

13 A. No.

14 Q. Doctor, with respect to your practice of
15 medicine over the last five or so years, we can limit it
16 to when you switched over to the hospital-based setting,
17 do you have any online publications or journals that you
18 rely on or that you review regularly?

19 A. I mean everybody in the -- everybody in
20 medicine today, everybody I know has up to date, you
21 know, somewhere on their computer or cell phone. I mean,
22 the truth is, after 30 years plus as a doctor, I mean
23 most of this -- the risk of sounding obnoxious, most of
24 medicine I kind of know. I don't do a lot of textbook
25 reading, but I think everybody has a copy of Harrison's



1 at least if you are in primary care. Internal medicine,
2 you know, we all get most of the same journals. But in
3 terms of like what I would reference quickly, if I needed
4 to reference something, I would probably look it up to
5 date.

6 Q. What is the difference between internal
7 medicine and family practice?

8 A. Yeah. So I think there's two things really.
9 First of all, I don't do any OB. I always hated OB. I
10 didn't want nothing to do with it. Although I think in
11 today's day and age, the truth is not many family
12 practitioners do OB either, but they're certainly capable
13 of doing it. I think the big difference is, you know,
14 the age, the cut off. I mean -- and rarely I'll see a
15 15-year-old, but I try to keep it from age 16 on up and
16 there is -- I mean I think most family practitioners see
17 kids. I don't want anything to do with kids.

18 Q. If we're talking about the treatment of
19 adults, would you agree that the practice of medicine as
20 to the standards that would be applicable to a family
21 medicine physician would be similar, if not identical, of
22 that to an internal medicine physician?

23 A. I agree with that.

24 Q. Do you consider any text or journal to be
25 authoritative?



1 A. I get asked this all the time. No. I mean,
2 clearly something like Harrison's generally is a good
3 reference. I mean I haven't read every page of
4 Harrison's, so I don't know if -- if you're asking about
5 one general text of internal medicine, Harrison's sort of
6 the gold standard.

7 Q. Okay. With respect to this case, did you do
8 any review, whether it be in Harrison's or anywhere with
9 respect to the area of medicine that we'll be talking
10 about?

11 A. No. It's sort of weird because my son is a
12 fifth year urology resident at Cornell and so when I was
13 getting -- when I was reading through this stuff, I
14 thought to myself, well, if I have any question, I always
15 have an easy reference, but I never had to call him on it
16 either.

17 Q. You haven't on this case?

18 A. No.

19 Q. Have you spoken with any other health care
20 provider regarding the opinions that you're going to give
21 in this case?

22 A. No.

23 Q. Doctor, what is your definition of a UTI?

24 A. By definition the last, you know, letter in
25 UTI is infection, and so what you're talking about is an



1 infectious process that involves the urinary tract and by
2 infectious process you mean where there's enough bacteria
3 to cause the disease. Inactive inflammatory process
4 related to -- generally in the urine, you're talking
5 about bacteria.

6 Q. With respect to making the diagnosis of a
7 UTI, what do you need to clinically rule in a UTI?

8 A. I mean the only way to diagnose is really --
9 I mean a definitive diagnosis made is by culture. You
10 get -- look, you get a rough idea pretty much by the
11 patient's clinical presentation and dipstick of the
12 urine, but the definitive diagnosis is made by culture.

13 Q. To make a definitive diagnosis you also need
14 positive findings on urinalysis?

15 A. I mean you should. That's the way it's done.
16 I mean there are obviously circumstances where cultures
17 can be difficult to make the diagnosis, particularly if
18 somebody is on an antibiotic already but that is how you
19 make the diagnosis.

20 Q. With respect to the urinalysis in the setting
21 of a confirmed UTI, what are the positive indicators that
22 you would expect to see?

23 A. Generally what you would like to see is
24 greater than 100,000 colonies of --

25 Q. I'm sorry. I'm not talking about the



1 culture. I'm talking about the urinalysis.

2 A. Oh, so like when you dipstick a urine -- I
3 mean, look, ideally a normal urine is clean. There's no
4 white cells, there's no -- chemically, it's negative,
5 that kind of thing. If you have high nitrates, you have
6 high white cells, you have high leukocyte esterase, those
7 kinds of things. That's all suggestive. But, again,
8 there's a reason it's -- a dipstick is not the way you
9 definitively diagnose. It's suggestive but not a proven
10 way of doing it.

11 Q. How about protein?

12 A. Again, I mean generally in an infection,
13 there's protein, but there's so many causes of
14 proteinuria in the urine that it's the same kind of
15 answer.

16 Q. I guess what I'm looking at here, can you
17 have -- in your eyes, can you have a positive culture but
18 a negative urinalysis and have a diagnosis of UTI -- of a
19 true UTI?

20 A. So in general, one of those things has got to
21 be -- I mean, if you have a completely negative dipstick
22 and you trust your dipstick --

23 Q. For the record, so when I'm saying
24 "urinalysis" and you're talking dipstick, it's the same
25 thing?



1 A. Right.

2 Q. Okay.

3 A. I mean if you totally have a negative
4 dipstick and you have a positive culture, in other words,
5 it looks like 100,000 E. Coli, your dip sticks are
6 probably outdated or somehow the specimen got confused.

7 I mean, if you have -- I mean in general -- not in
8 general. The overwhelming majority of the time you have
9 a positive culture, your dipstick urinalysis should be
10 abnormal.

11 Q. So the dipstick is normal and you have a
12 positive culture so when you said -- you're talking about
13 contamination issues? Is that what we're getting at?

14 A. No. I'm just saying if you have no
15 infection, right, no infection your dipstick should be
16 normal. If you have infection, your dipstick should be
17 abnormal.

18 Q. What would be a potential reason to have a
19 normal -- a positive culture and a negative urinalysis?

20 A. Again, the two are hard to -- I mean it
21 shouldn't be. I mean I've seen it. Look, I've seen
22 people -- you know, if you go to your doctor's office,
23 some of those dip sticks have been in there since 1955.
24 They lose their ability to detect things. Sometimes
25 people get dip sticks and what's recorded is somebody



1 else's. There's errors that are human errors. It's hard
2 to imagine a normal dipstick with a proven urinary tract
3 infection.

4 Q. Okay. What is the typical treatment for a
5 UTI?

6 A. I mean, it depends on the bug, but, you know
7 -- it depends on the bug, the patient, that sort of
8 thing, in a clinical setting. If you have a UTI and
9 somebody's got a fever of 104 and they're hypotensive,
10 the treatment is hospitalization and IV antibiotics. I
11 mean in general if you have your normal bacterial
12 infection in, let's say, a healthy outpatient, the
13 treatment is antibiotics, fluids, that kind of thing.

14 Q. I imagine probably with just like any type of
15 infection there are UTIs that are relatively benign and
16 then there are UTIs that can be on the other opposite end
17 of that scale where things can get pretty serious?

18 A. Agree.

19 Q. Okay. So if a patient is -- doesn't have
20 fever, doesn't have any abdominal symptoms, but does have
21 a positive culture and maybe has some burning with
22 urination, they may have a UTI but it's on the low grade
23 side of things?

24 A. Right. Low grade in terms of how you need to
25 intervene and in what manner. I would say roughly that's



1 true.

2 Q. Are there times in your practice -- by the
3 way, I know you're more hospital based now, are you
4 seeing, as a first line provider, patients with UTIs now
5 or is that more so in the past?

6 A. I mean obviously much more in the past, but I
7 still do, yeah.

8 Q. I imagine -- well, I shouldn't imagine
9 anything, but is the majority of UTIs that you see now,
10 are these patients that are admitted to the hospital for
11 some other reason and then there's a secondary finding of
12 a UTI?

13 A. I would say that's probably true.

14 Q. And -- withdrawn.

15 Are there times, Doctor, where urinalysis is
16 performed and based upon the patient's symptoms and the
17 urinalysis before cultures are received that antibiotic
18 therapy may be initiated?

19 A. Well, sure.

20 Q. Can you give me a for example?

21 A. Look, if somebody's like really uncomfortable
22 and they've got all the classic symptoms, your dipstick
23 is highly suggestive of a UTI, the patient lives 40
24 minutes away or whatever, I mean, you have familiarity
25 with the patient, I mean, lot of times doctors will give



1 a prescription and then say, you know, either start it
2 now I'll call you if there's any problem or, you know,
3 hold off a day, here's a script, I'll call you with a
4 culture, but, no, that's not inappropriate medicine.
5 That happens all the time.

6 Q. Okay. And then I assume you then, once you
7 get the culture back, you have to make sure you are on
8 the correct antibiotic, and, if necessary, you would make
9 a change?

10 A. Yes.

11 Q. Do patients generally speaking -- I'm not
12 talking about this case, but do patients, for whatever
13 reason, experience recurrent UTIs?

14 A. Sure.

15 Q. Can you give me, again, some reference points
16 as to what settings that occurs?

17 A. I mean, there's lots of clinical scenarios
18 ranging from minor to major. I mean, you have people who
19 have, for example, an issue with stones or some foreign
20 -- or somebody that is a breeding ground for bugs and
21 they'll get recurrent UTI infections. It goes to the
22 other sort of extreme where you have -- I mean, I have
23 women who, you know, will have sex and get urinary tract
24 infections almost every time. It's probably an
25 anatomical issue, but, you know, that happens. You get



1 people, for whatever reason, that are more predisposed to
2 getting urinary tract infections, they do not drink
3 enough fluid, they -- I mean, I could list seven million.
4 I mean, obviously diabetics, people that are
5 immunocompromised, these people who have indwelling
6 catheters, there's a lot of lists of reasons why people
7 get chronic -- I mean get recurrent urinary tract
8 infections.

9 Q. In a setting such as that, and then I take
10 it, then, do you then those patients over time to help
11 identify or try to identify why it is that they have
12 these recurring UTIs?

13 A. Sure. I mean, for a number of reasons, yes.

14 Q. Okay. Can we agree, then, that in a setting,
15 such as you're describing now, that the diagnostic
16 process for a patient that has recurring UTIs, it could
17 be somewhat of a continuum? You're not going to solve
18 the problem in a single visit or it may take two visits
19 or may take three visits to figure out what's going on.
20 Is that reasonable?

21 A. I agree with that.

22 MR. McELLAGOTT: Plaintiff's objection,
23 object to the form.

24 Q. Can we agree, Doctor, that in a primary care
25 setting the presentation of a colovesicular fistula is



1 rare?

2 A. I agree with that.

3 Q. Would you agree with the terminology
4 exceedingly rare?

5 A. I agree with that.

6 Q. Okay. Do you yourself -- and I want to talk
7 about, for a moment, prior to 2009. So when you were an
8 office-based physician, not in a hospital setting, and I
9 may be testing your memory here, I'm sorry, do you have
10 recollection of treating -- making a diagnosis of a
11 patient that was suffering from that colovesicular
12 fistula?

13 A. I honestly don't recall. I don't recall
14 making one off the top of my head.

15 Q. If you had made one, is that something that
16 you would probably remember?

17 A. I would think yes. I mean, I know I -- let
18 me put it this way: I know I have seen patients with
19 colovesicular fistulas, but for myself making the
20 diagnosis, I can't recall doing that.

21 Q. Okay. Do you have recollection of referring
22 patients where there was suspicion of some sort of an
23 abnormal anatomy or fistula tract and that diagnosis was
24 ultimately made?

25 A. I don't recall personally being the one to



1 make the initial referral, no.

2 Q. Okay. In the hospital base, does that change
3 if we then talk about the hospital-base setting now?

4 A. Yeah. Obviously in a hospital setting,
5 you're dealing with -- in a hospital setting, things that
6 are rare as an outpatient are less rare, let's put it
7 that way.

8 Q. You're seeing the patients in the hospital
9 setting that are more acutely ill versus the outpatient
10 setting?

11 A. Right.

12 Q. Okay. Can we agree that in the outpatient
13 setting, that if a physician has a suspicion of a
14 fistula, a reasonable thing to do would be to recommend
15 or to consider a referral to a urologist?

16 A. That's obviously what I would do. I think if
17 I suspected any fistula involving the urinary tract, I
18 think not only would I do that, I think that's the
19 standard of care.

20 Q. How do you define, by the way, Doctor, the
21 physician/patient relationship?

22 A. I'm not exactly sure what you are asking me.
23 I don't generally -- I'm not laughing at you. I just --
24 I heard that -- I mean I don't generally like do that
25 exercise in my head. It's like if I'm seeing somebody, I



1 guess I'm asking them as a doctor and they're the
2 patient.

3 Q. In your mind, whatever that relationship is,
4 is it a two-way street?

5 A. Sure.

6 Q. The physician has obligations but patients
7 have obligations as well?

8 A. Yeah, I agree with that.

9 Q. With respect to patient's obligations, what
10 obligation would you say your patients have with respect
11 to their care?

12 A. So I think they need to intellectually be
13 honest with me, I would hope they follow my instructions,
14 and I mean I think that's basically it. Tell me the
15 truth and follow what I tell you, and if you don't like
16 what I'm telling you or you have no intention, tell me.

17 Q. If they don't want to follow your advice to
18 be honest and say I disagree, I'm going to go a different
19 path, is that what you're referring to?

20 A. It's a free country.

21 Q. When you say "intellectually honest," are you
22 talking about reporting their symptoms, their history,
23 things along those lines?

24 A. Sure.

25 Q. Anything else?



1 A. No. I mean, when you asked me -- I've been
2 doing this long enough in practicing medicine. I have
3 patients that come in -- I've seen enough who come in
4 falsifying complaints trying to get narcotics, trying to
5 get -- you know, I would hope that if you tell me you
6 have abdominal pain, you have abdominal pain.

7 Q. Do you have experience, Doctor, whether it be
8 in the office-based practice that you have or now in the
9 hospital side of things, with patients that had an
10 aversion towards western medicine?

11 A. At this point, I've seen everything under the
12 sun. Yes, sir.

13 Q. Okay. So if you have a patient that is more
14 on the holistic side, do you have to treat those patients
15 differently?

16 A. So look, in terms of the interaction, you try
17 to handle people in whatever way you can handle them to
18 try to get them to cooperate. I mean, I try to do the,
19 you know, physical and the appropriate care the way I
20 would with anybody else, but, obviously, there's
21 challenges in dealing with people who -- let's put it
22 this way, may or may not accept traditional practice.

23 Q. Would you agree that a patient that has,
24 again, nonwestern medicine or holistic beliefs, that they
25 can be more of a challenge to manage than someone who is



1 accepting of what we would consider western medicine?

2 A. I'll agree with that. I think that's true.

3 Q. Now, turning to Ms. Vercelli, if you want to
4 pull out your notes, feel free.

5 A. Yeah.

6 Q. What is your understanding as to why she came
7 to see Dr. Ridge in Middlesex Hospital Primary Care on
8 March 9th, 2011?

9 A. Let me find it.

10 Q. I think it's 1664?

11 A. That helps.

12 MR. KILEY: Jim, can we just take a
13 two-minute break?

14 MR. BIONDO: Yeah, absolutely.

15 - - -

16 (Whereupon, a recess was taken.)

17 - - -

18 Q. All right. So, Doctor, before we took the
19 break, I think I was referring you to the March 9th,
20 2011, office note from Middlesex Hospital Primary Care,
21 and I think my question was what was your understanding
22 or is your understanding as to why this patient came into
23 the office that day?

24 A. So it was -- I mean it says reason for
25 appointment, post-op check, but I think she was trying to



1 find a, quote, western doctor.

2 Q. You're referring to under the history of
3 present illness where it states, Patient presents today
4 to interview me as she is seeking, in quotes, a western
5 medical doctor, closed quotes?

6 A. Right. Basically to establish a new primary
7 care physician.

8 Q. Okay. Did you review Dr. Ridge's deposition
9 testimony as to the initial portion of this encounter?

10 A. I did.

11 Q. Okay. And your practice over the years, and
12 you've already told me you've seen most of everything,
13 not to -- I don't mean to be kidding, but have you had
14 experiences similar to this where you are approaching
15 a -- withdrawn.

16 Your read of this note and Dr. Ridge's deposition
17 transcript, is it safe to say that this was a person like
18 we were describing earlier, someone that may have an
19 aversion towards western medicine?

20 A. I would agree with that.

21 Q. In your years of practice, have you had
22 similar encounters with similar types of patients?

23 A. I have.

24 Q. By the way, what is your take as to this
25 visit? Did she have any complaints, specific complaints



1 on this visit?

2 A. So I mean she complained of dysuria. I mean,
3 it's listed as an assessment, so I have to assume that
4 that was her complaint. I think that was her primary,
5 quote, complaint.

6 Q. Okay. Did you review Dr. Ridge's testimony
7 wherein he stated that she actually didn't have any
8 complaints this day, but he had to put down an indication
9 for the culture?

10 A. I did read that. I mean -- and I don't want
11 to -- I'm not saying that was wrong and this is right.
12 It's just, you know, when you write the assessment -- you
13 know, so that's what's in the assessment. That's the
14 only, quote, complaint in the assessment, is dysuria.

15 Q. Okay. All right. So for the basis of your
16 opinions, at least starting from this point, you're
17 assuming that she was complaining of dysuria on this
18 visit?

19 A. Correct.

20 Q. Now, there is -- an exam was performed this
21 day; correct?

22 A. Yes.

23 Q. It was basically a normal exam?

24 A. Yes, sir.

25 Q. As far as the -- Dr. Ridge, by the way, is



1 there any mention in this note that she had been seen by
2 a urologist about a month and a half prior to this under
3 the history section?

4 A. Let me take a quick peek. Under the general
5 HPI, it does not say that.

6 Q. Okay. And there's no mention that she had
7 undergone a CAT scan, again, roughly six to eight weeks
8 prior?

9 A. Correct.

10 Q. If you were treating a patient who had come
11 in for a first encounter who was seeking to interview you
12 as a potential medical doctor or a recurrent urinary
13 tract infections per the patient's history, would you
14 want to know that that patient had been seen by a
15 urologist who ordered a CAT scan within the last two
16 months?

17 A. Absolutely.

18 Q. Why?

19 A. Well, I mean, I think if the patient is
20 treating with a urologist and they have recurrent urinary
21 tract infections, obviously, the first question that
22 comes to mind is what workup you've done, what workup,
23 you, as the patient, have had, and the second question is
24 where do things stand in terms of follow-up.

25 Q. Now, on this date, so understand your



1 opinion, she was complaining of dysuria, she gives the
2 history of recurrent UTIs. What is your understanding as
3 to what Dr. Ridge did this day?

4 A. He did a -- I mean, he ordered a -- he did a
5 urinalysis and he ordered a urine C&S, culture and
6 sensitivity. And I'll just say, just to get to the
7 point, I don't really have any problem with this visit at
8 all. I think the exam was appropriate, the history was
9 appropriate. I think the tests he ordered were
10 appropriate. I just, you know, for the sake of brevity,
11 I don't have any issue with this visit.

12 Q. Okay. So the decision to do a lab culture
13 with urinalysis, all reasonable and appropriate; right?

14 A. Agree.

15 Q. His plan going forward was appropriate as of
16 March 9th, 2011?

17 A. Agree.

18 Q. Dr. Ridge had testified at his deposition
19 that at the end of this visit, he wasn't even sure where
20 things stood going forward in the future, if she was
21 going to be a patient or if he passed the interview or
22 was accepted or not accepted. Did you read that
23 testimony?

24 A. I did.

25 Q. Do you have any reason to dispute that or



1 have a problem with that?

2 A. Not at all.

3 MR. McELLAGOTT: Object as to form.

4 Q. Before we get off this visit, just looking at
5 the urinalysis, is there -- as far as you're looking at,
6 is there anything that is abnormal with respect to the
7 urinalysis?

8 A. I mean, again, technically a normal
9 urinalysis would be everything being negative with a
10 normal pH and that kind of stuff. I mean, when she has
11 small amount of leukocyte esterase, a small amount of
12 blood, you know, those are, quote, technically
13 abnormalities. Is it indicative or diagnostic of
14 anything? No.

15 Q. Okay. How about the color of the urine,
16 yellow, clear, that would be normal?

17 A. Yes. The rest of it is fine.

18 Q. The culture, that was performed throughout an
19 organism or organisms; correct?

20 A. Right.

21 Q. I am looking for the page. Do you have that
22 in front of you?

23 A. I remember the organisms.

24 Q. What is -- again, it's not a memory test,
25 what is your understanding of what the organisms were?



1 A. It was E. Coli and Klebsiella. It was two
2 typical urinary tract bugs.

3 Q. So the significance of the E. Coli, it says
4 greater than 100,000, is there any significance to that
5 number?

6 A. Yeah.

7 Q. What is --

8 A. It's a diagnostic-related infection.

9 Q. What does that mean, diagnostic-related
10 infection?

11 A. So look, if you get -- I mean I know you know
12 this, but if you get bacteria in the urine, let's say
13 10,000 or 20,000, you generally assume that either A,
14 it's a contaminant or B, if it's -- that it is not at the
15 level that would cause, quote, a clinically significant
16 infection, whereas as if the colony count is 100,000 or
17 greater, it's significant both in terms of diagnosing
18 infection and in terms of generally the need to treat it.

19 Q. I've heard people use the term, you know, if
20 it's under 100,000 it's not actionable.

21 A. Right. Again, look, everything in medicine
22 is -- I just want to be technically accurate. I mean,
23 when you're dealing with an immunosuppressed patient who
24 is on three anti-rejection meds for their transplant,
25 then, obviously, your numbers change, but in a, quote,



1 general outpatient setting like this, actionable is
2 100,000.

3 Q. Okay. And what about the Klebsiella? The
4 numbers on Klebsiella are 10,000 to 50,000, so what
5 significance is that?

6 A. You know, it's a little bit hard to know when
7 you have multiple organisms because sometimes one bug may
8 suppress the other and a second bug may -- I mean, it's
9 not quite clear that there's a -- if the Klebsiella
10 number was by itself, it's not quite clear that you would
11 diagnose that or you would likely not diagnose that as a
12 Klebsiella infection. In this setting where it's, quote,
13 multi-organism, you would probably say she had an
14 infection with both E. Coli and Klebsiella.

15 The nice thing about this patient is that they were
16 both sensitive to normal drugs and so it wouldn't really
17 change your actions to what you're going to do here.

18 Q. Okay. So is the -- I want to make sure I
19 understand what you're saying. If we just had a culture
20 report that just said 10,000 to 50,000 Klebsiella, that
21 again, just based on the number, may not be an actionable
22 or you wouldn't treat that number?

23 A. Agree. Agree.

24 Q. Okay. You can agree that the patient was
25 advised of these results; correct?



1 A. Yes, sir.

2 Q. And fair to say that when Dr. Ridge did, in
3 fact, speak to the patient, he learned that she had been
4 placed on an antibiotic by a different physician;
5 correct?

6 A. Agreed.

7 Q. Now, did you read Dr. Ridge's testimony that
8 when he learned of that fact, and I think his note --
9 again, I don't want to paraphrase it, but something to
10 the effect that she had forgotten that she had the
11 culture with him and thus called, I think it was,
12 Mr. Miller, her OB/GYN, when she became symptomatic.

13 Was that a further reason to cast doubt in a
14 reasonable physician's mind as to what his or her role is
15 going forward?

16 A. I agree with that.

17 Q. Okay. What is your practice, by the way --
18 and, again, maybe we need to focus this when you're more
19 of an office-based physician, when you did a culture and
20 the culture came back negative, would you call those
21 patients as well or do they just get a call when it's
22 positive?

23 A. So I think generally you -- I mean, some of
24 it depends on your relationship with the patient. I
25 mean, you have some patients that are more or less



1 demanding, more or less symptomatic. If somebody's
2 telling you they're having horrible burning and you do a
3 urine specimen and it's negative, you'd probably call
4 them anyway, but as a rule of thumb, I think in a, quote,
5 normal situation, you generally call -- I mean you call
6 everybody with positives and much less so with negative
7 cultures.

8 Q. Okay. Is it somewhat common for physicians
9 to tell their patients, If you don't hear from me, you
10 can assume everything is well?

11 A. In this type of situation, yes.

12 Q. Okay. Now, the medication that the other
13 physician, Dr. Miller, had placed her on was Keflex; is
14 that right?

15 A. Yes.

16 Q. How does Keflex react to, if at all, the
17 Klebsiella and E. Coli?

18 A. Well, Keflex is generally effective against
19 Klebsiella. It kills it. It's concentrated in the urine
20 like most cephalosporins. It's a reasonable first-line
21 drug.

22 Q. Up to -- and I think the phone calls to and
23 from the patient regarding this culture are March 11th,
24 2011. Any criticisms of Dr. Ridge's actions?

25 A. None.



1 Q. So nothing else Dr. Ridge was required to do
2 up to that point in time, in your opinion; correct?

3 A. Agree.

4 Q. Moving on from that phone call, it looks like
5 the next patient contact we have in the chart is from
6 March 22nd where it looks like the patient had called the
7 office, Middlesex Hospital Primary Care, to report that
8 she was having recurring symptoms. Do you recall that?

9 A. Yes, sir.

10 Q. And she initially spoke with a nurse; is that
11 correct?

12 A. Yes, sir.

13 Q. And Dr. Ridge called the patient back; fair?

14 A. Yes, sir.

15 Q. All reasonable things for him to do; correct?

16 A. Absolutely.

17 Q. Now, when he called her back -- do you want a
18 page number?

19 A. Call back?

20 Q. I'm on March 22nd. I think you have it.

21 A. 1673?

22 Q. That's the visit so right before that. I
23 think this is it here.

24 So she had reported that she had frequency, urgency
25 and burning; correct?



1 A. Yes.

2 Q. What is the significance, if any, that she
3 did not have any fever or abdominal pain, nausea,
4 vomiting?

5 A. Look, if somebody has a fever and they're
6 having abdominal pain, it's suggestive of a more severe
7 infection. The frequency, urgency and burning are all
8 suggestive of a urinary tract infection. If somebody
9 tells me they have -- again, it's sort of what we talked
10 about before. If somebody tells me they have a fever of
11 104 and they have severe abdominal pain, I probably would
12 consider strongly sending that person to the ER.

13 Q. Right.

14 A. When you get this kind of call, it's more
15 like something you can see in the office.

16 Q. So it's determining a level of urgency of how
17 we're going to deal with this patient, the lack of fever,
18 lack of abdominal pain?

19 A. Right. That's exactly right.

20 Q. So those patients just have a lower urgency
21 threshold?

22 A. Agree.

23 Q. So it looks like, as you just pointed out a
24 moment ago, so that same day, Dr. Ridge made time for
25 this patient; correct?



1 A. Yes.

2 Q. That's a good thing for him to do?

3 A. Agree.

4 Q. And when she comes into the office now, on
5 the 22nd now --

6 A. Right.

7 Q. -- it looks like Dr. Ridge got a little bit
8 more information from the patient on this visit. Fair to
9 say?

10 A. I think a considerable amount, yeah.

11 Q. And do you recall his deposition testimony
12 once he got some more information, he started doing a
13 little bit more digging around on the computer system to
14 see her medical history?

15 A. I agree.

16 Q. I assume that's a reasonable thing for a
17 physician to do based upon new information obtained from
18 the patient?

19 A. Agree.

20 Q. Okay. Now, the patient had reported on this
21 visit that she was treating her symptoms of frequency,
22 urgency and burning with homeopathic remedies. I think
23 he wrote sitz bath with tea tree oil and other
24 homeopathic remedies. Do you prescribe at all to any of
25 these type of homeopathic remedies?



1 A. I mean, I like to drink tea. I take camomile
2 to help me sleep, but in terms of using those to treat
3 urinary tract infections, I do not.

4 Q. Do you -- again, I'm trying to gauge, when
5 you get a history like this where a patient says she has
6 recurring symptoms and she is doing these sort of things
7 at home, do you then have concerns that maybe these home
8 remedies are not helping the situation, maybe making
9 things worse? Is that a possibility with situations like
10 this?

11 A. The first thing I try to assess -- I mean I
12 have had a number of people like this. When people tell
13 me they're taking homeopathic medicine, so, obviously,
14 there's two things you want to know. Is there anything
15 they're taking that could be potentially harmful to them?
16 I mean, I have lots of guys with hypertension who have
17 come in and told me they're taking yohimbine for their
18 impotency. It's sold over the counter at GNC and all
19 these other places, and, unfortunately, this medicine for
20 impotency can raise your blood pressure and cause you to
21 have a heart attack.

22 My first thing is any of this stuff -- first of
23 all, do I know about it? Do I -- have I ever heard of it
24 and if I've heard of it, is there anything that can cause
25 damage? And if I haven't heard of it and they're taking



1 it, I -- you know, again, at this point I've heard of
2 most of this stuff, but if I'm worried about it, I can
3 generally try to -- there's actually a PDR of homeopathic
4 medicine, you can look it up.

5 The second thing I want to know is, you know, if
6 I'm going to give you medicine A, B or C, I want to know
7 that you're going to take it. I mean, if they're taking
8 homeopathic stuff and it's not harmful, to the best of my
9 knowledge, I don't really care whether they continue to
10 take their homeopathic stuff or not. What I want to know
11 is if they're going to take the medicine I give them.

12 Q. Can the tea tree oil she said she was -- and
13 if you don't know this, tell me, can that, in and of
14 itself, if you're bathing in it, cause urinary tract
15 infections?

16 A. I honestly know nothing about tea tree oil.

17 Q. I'm not surprised.

18 So I'm assuming from your prior answers that you do
19 have criticisms with Dr. Ridge with respect to this
20 visit?

21 A. I do.

22 Q. Why don't we start there and we'll take it
23 from that. Tell me the criticisms that you have with
24 respect to this March 22nd visit and then we'll --

25 A. So I really have one criticism and it relates



1 to one thing in the history and one thing that Dr. Ridge
2 was good enough to look up. The patient comes in, and
3 one of the things she said, is I assume -- and I know he
4 said in his deposition that he got it from her and it's
5 in the HPI, that she has a fistula formation.

6 Now, people just generally don't come up with the
7 word fistula on their own. Some medical provider must
8 have told her you have a fistula. And it's status post
9 having major intra-abdominal surgery. I mean, she's got
10 this huge scar, she's recently had an appendectomy, he
11 knows from looking at the hospital chart that wasn't a
12 simple appendectomy. She's in the hospital for weeks. I
13 mean, that's not your usual course for an appendectomy.
14 So he knows, per her history, she has fistula. And,
15 again, I know she's an odd bird, but I don't believe that
16 somebody like this would come up with the word fistula on
17 her own. So some medical provider told her she had a
18 fistula.

19 The second thing, and to be perfectly honest, this
20 is really more important to me, there's a CT scan which
21 he looked up, he understood, and the CT scan showed air
22 in the bladder. I'm not saying that -- to be perfectly
23 honest, I'm not saying that Dr. Ridge needs to know even
24 the entire differential of air in the bladder, it's just
25 air in the bladder is a very abnormal finding on a CT



1 scan. I think when somebody comes in irrespective of
2 let's just say she had no urinary tract infections at
3 all, somebody comes in and they got a history of, quote,
4 I may or may not have a fistula, but more important, I
5 have CT with air in the bladder and I recently am status
6 post major surgery, the standard of care is that patient
7 needs to follow with a specialist. The specialist's got
8 to be a urologist. It's not normal -- that's not a
9 normal finding.

10 You know, it's compounded by the fact that she's
11 had these current urinary tract infections, but really
12 the crux of it for me -- and I don't believe that
13 anything else was done wrong here, but the crux of it to
14 me is you get that kind of history, you've got to just
15 make a referral to urology.

16 Q. Okay. That's the criticism for this visit?

17 A. That's it. I wouldn't -- to be perfectly
18 honest, even being somewhat more experienced than
19 Dr. Ridge from reading his history, if a patient comes
20 and they have a history of fistula and they have air in
21 the bladder, I'm not going to try to work that up on my
22 own. That goes above my level of expertise. That's the
23 kind of thing -- I mean I have two choices really. My
24 first inclination would be -- not inclination, my first
25 action would be to send the patient back to the



1 urologist, if not, to a surgeon.

2 Q. And you told us you read his deposition,
3 Dr. Ridge's deposition, and he acknowledged considering
4 that on this visit; correct?

5 A. I agree.

6 Q. And, again, I'm not going to quote it, but
7 the sum and substance was he was going to do the
8 urinalysis, the culture, and then make a decision after
9 that. Does that sum up his testimony as far as you
10 recall it?

11 A. It does.

12 Q. If that, in fact, occurred, do you have a
13 problem with him waiting to get the culture reports and
14 whether it's 48 to 72 hours before making a decision?

15 A. No. I think 48 hours in this situation would
16 not make any difference.

17 Q. Okay. In fact, Dr. Ridge did obtain another
18 urinalysis and a culture; correct?

19 A. I agree.

20 Q. I assume you don't have a problem with those
21 decisions?

22 A. None at all.

23 Q. When that culture came back positive on I
24 think it's the 24th of March, what is your understanding
25 as to what happened at that point?



1 A. So my understanding is the patient was put on
2 Cipro, which is an antibiotic that has a different mode
3 of action than Keflex, and that was pretty much it.

4 Q. And did you recall them in the notes
5 referencing they wanted a test of cure at the completion
6 of the Cipro?

7 A. I agree.

8 Q. And that makes sense from a primary care
9 physician point of view?

10 A. Agree.

11 Q. Why would you want a test of cure? They use
12 TOC; correct?

13 A. I'm sorry?

14 Q. I think that's the abbreviation here for test
15 of cure.

16 A. Yeah. I don't use that abbreviation, you're
17 the first one to tell me that. I saw that, but I wasn't
18 really sure what exactly that meant.

19 Q. Okay. If that's what he means by that, that
20 makes sense to you?

21 A. Sure.

22 Q. So why would a physician want to do a test of
23 cure of the end of the regimen of antibiotics?

24 A. To make sure the infection's eradicated.

25 Q. And did they do that in this case?



1 A. I don't recall that it was done. I may be
2 wrong. I don't remember -- honestly I don't remember
3 seeing that, but if it was done, I certainly defer to you
4 on that.

5 Q. Let me ask you this -- I'll refer you to a
6 page and ask you some questions on it.

7 A. Sure.

8 Q. So you said she was put on Cipro on the 22nd;
9 correct?

10 A. Right.

11 Q. He did the culture, it came back greater than
12 100,000 for E. Coli; right?

13 A. Right.

14 Q. And at the end of the Cipro regimen, do you
15 recall reading in the note that the patient called back
16 to the office indicating that she was, again,
17 experiencing symptoms?

18 A. I do remember that.

19 Q. Okay. Do you recall reading Dr. Ridge's note
20 from March 31st where he wrote, She just finished
21 antibiotic therapy on an antibiotic. Her culture showed
22 should have worked. We'll have to send her back to the
23 urologist, Dr. Frink. Do you recall that?

24 A. I do.

25 Q. I assume from what you told me thus far, you



1 don't have a problem with that, what I just read to you?
2 That makes sense for you?

3 A. Yeah. Let me say yes, but my answer is -- I
4 want to qualify that. I think the key here is -- the
5 answer is that's it's absolutely correct that the patient
6 needed to go back to the urologist, no question. I think
7 the key is really not so much what her urine showed, what
8 her culture showed, what the course of her antibiotic. I
9 think when you have a patient that tells you they have a
10 fistula and you have a CT scan that shows air in the
11 bladder, irrespective of what's going on in the urine,
12 the standard of care is you need to follow up with the
13 urologist.

14 Now, had that referral been made on the 31st, that
15 would have been fine. I wouldn't have waited until the
16 31st, but if the referral had been made on the 31st, then
17 I would still have no criticism.

18 Q. Okay. Understood.

19 I want to ask you then, I assume you read
20 Dr. Ridge's testimony -- withdrawn.

21 Going back to the notes, I just read to you
22 Dr. Ridge's note where he said, She needs to go back to
23 Frink?

24 A. Agree.

25 Q. And you agree right underneath that,



1 Dr. Ridge documents his phone call with a patient and
2 again, the sum and substance, the decision, the plan
3 changes to we will do one more round of Cipro and the
4 patient agrees if she becomes symptomatic again, she'll
5 return to from a frank?

6 A. Look -- I'm sorry. Let me let you go ahead.

7 Q. So did you read Dr. Ridge's explanation as to
8 why it went from she's going to see -- she needs to see
9 Frink to we're going to try Cipro one more time and then
10 if anything happens, if she becomes symptomatic again,
11 she'll agree to go back?

12 A. I did.

13 Q. And, again, hypothetically speaking, if what
14 Dr. Ridge testified to at his deposition, which is, I
15 think he said, I told her I want you to go back to the
16 urologist, Dr. Frink, she refused, she wanted to try one
17 more time with antibiotics and agreed, you know, if
18 anything happens after that, I'll go see him then. If
19 that, in fact, happened, the patient refused and
20 ultimately then the physician has a plan B and said, All
21 right, we'll do this and then she's going to agree to go
22 -- if this continues, would you be okay with that?

23 MR. McELLIGOTT: Objection form.

24 A. I'll be perfectly honest, if he tried to get
25 her to the urologist and basically she said no, pending



1 one more week of antibiotics, and he was doing the
2 antibiotics as an attempt to get her to the urologist, I
3 think that's reasonable and I can understand how he did
4 it.

5 If he didn't try to get her to the urologist --
6 okay, if he did not try to get her to the urologist,
7 again, irrespective of the urine, knowing what he knew on
8 the CT, from the CT, and, quote, this history of the
9 fistula, if he did not try to get her to the urologist,
10 that would be a deviation of the standard of care.
11 That's really the crux in a nutshell. Did you try to get
12 the patient to the urologist? Did you explain, you know,
13 why you need to go to the urologist? If he did -- look,
14 it's a free country. You can't make people go to where
15 they -- if he did that, I understand there's no
16 deviation. If he did not do that, then it is a
17 deviation.

18 Q. Understood. Do you at the time of trial in
19 this case -- and thank you for that, it make this a lot
20 easier. Do you intend to offer an opinion based upon
21 your review of the records as to which one of those
22 scenarios is more or less likely to be true or is that a
23 question of fact that you're going to let somebody else
24 decide?

25 MR. McELLIGOTT: Object to the form.



1 You can answer.

2 A. I'm going to state exactly what I just stated
3 to you.

4 Q. If he did try to get her to the urologist,
5 it's okay. If he didn't try to get her to the urologist,
6 it's a deviation from the standard of care?

7 A. That's exactly right.

8 Q. And you're not going to opine which one of
9 those two scenarios is more likely true?

10 A. Right.

11 MR. McELLIGOTT: Object to the form.

12 A. It's not my job to question the veracity of
13 the doctor. It's just my job to state the medical
14 opinion. You know, the history says -- the history tells
15 you this patient's got to go to a urologist. The flip
16 side of that is patients can do what they want. Doctors
17 need to do what they want -- not what they want, what
18 they can do to get the appropriate care for a patient.

19 Q. Okay. You've laid that out pretty black and
20 white for me right there. Are there any other opinions
21 that you carry in this case with respect to Dr. Ridge or
22 does that sum it up right there?

23 A. That sums it up. That's really it.

24 Q. And you've already told me that you do not
25 intend to offer any opinions that Dr. Oh deviated from



1 the standard of care with respect to her treatment of
2 this patient?

3 A. I think Dr. Oh is functioning as a same day
4 doctor, not as a patient's primary care physician. Her
5 encounter with the patient was reasonable.

6 MR. BIONDO: Guys, why don't we take a
7 five minute break.

8 - - -

9 (Whereupon, a recess was taken)

10 - - -

11 Q. Doctor, so just to wrap up, your disclosure,
12 I know it said Dr. Oh, but it should have said Dr. Ridge;
13 correct?

14 A. Yes.

15 Q. But it also said -- it says Dr. Oh and
16 Middlesex Primary Care, so I'm wondering if there are any
17 other opinions with respect to any other members of the
18 group?

19 A. No, not at all. It's just not written
20 correctly.

21 Q. So the opinions that you have are confined to
22 Dr. Ridge as you just gave them to us?

23 A. Yes.

24 Q. Do you have any other opinions by way of your
25 review of all of the records and deposition transcripts



1 in this case whatsoever as to standard of care?

2 A. I mean, I guess the only other thing, and we
3 sort of touched on it a little bit, but if you're dealing
4 with, quote, a patient who's refusing your care, you
5 should document it. I mean, but in terms of medical
6 issues, no.

7 Q. Okay.

8 A. I mean, I want to say, obviously, when you
9 read the charts, there's other things I have, but there's
10 not within the realm of what I want to talk about or what
11 I'm going to talk about.

12 Q. Okay. So we can agree, though, that this
13 wasn't a patient that was outright refusing care, she
14 just disagreed with a plan and wanted to try something
15 else before she got back to Frink. Can we agree on that?

16 MR. McELLIGOTT: Objection to form.

17 Are you asking him to assume that?

18 Q. No. I'm just saying as a matter of fact, can
19 we agree that this was a patient that wasn't refusing all
20 care, she just, before going back to Frink, she wanted to
21 try one more week of antibiotics.

22 A. Well, that's what's documented --

23 MR. McELLIGOTT: Hold on. That seems
24 to -- you're asking him to assume that based
25 on a deposition or is that in the record



1 somewhere?

2 MR. BIONDO: From the record.

3 MR. DUGAN: I object as well.

4 MR. McELLIGOTT: Can you show him where
5 that -- I think this is very -- you asked him
6 if he was going to find a fact, he said no,
7 and now you're asking him to find the fact
8 that she was refusing certain treatments, so
9 I'm not sure --

10 MR. BIONDO: I'm solely talking about
11 Dr. Ridge's note from March 31st, where
12 they're talking about they'll try Cipro for
13 one additional week, and if that doesn't
14 work, she will go see Dr. Frink at that time.

15 A. I'm sorry, I need to -- what page is that on?

16 Q. You can look at mine, if you don't mind.

17 A. I'll agree with that. I mean, I don't -- let
18 me put it this way: It says in the note, it implies that
19 a deal was made that she would continue Cipro for a week
20 and then if that didn't work, she would see the
21 urologist.

22 Q. Okay. That's what the note says?

23 A. Yes.

24 Q. Okay.

25 MR. McELLIGOTT: Object to the form.



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THE STATE OF OHIO,)
) SS: NOTARY CERTIFICATE
COUNTY OF MEDINA.)

I, Christine A. Schirripa, a Registered Professional Reporter, Certified Reporting Instructor, and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness MARK SHOAG, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to Stenotype in the presence of said witness, afterwards prepared and produced by means of Computer-Aided Transcription and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, employee of or attorney for any party or counsel, or otherwise financially interested in this action.

I do further certify that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Brunswick, Ohio, on this 22nd day of November, 2017.

Christine A. Schirripa, RPR, CRI, Notary Public
My Commission Expires 11-26-21



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