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.	)	

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

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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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APPEARANCES:

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I N D E X

E X H I B I T S

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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 renotice 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.

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CROSS-EXAMINATION

BY MR. BIONDO:

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

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

A. Yes, it is.

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

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

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

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

A. Primarily, yes.

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

A. That's correct.

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

2008 or 2009?

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

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

A. No.

Q. What was the name of that practice?

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

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

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

Q. So even through today?

A. Yes.

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

Q. Your residency was internal medicine, I assume?

A. Yes.

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

A. Yes, sir.

Q. Are you recertifying or are you

grandfathered?

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

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

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

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

Q. When did that end?

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

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

A. Exactly.

Q. And is that primarily based through the hospital?

A. Yes.

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

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

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

A. No, sir.

Q. What states do you hold licenses?

A. Ohio.

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

A. No, sir.

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

A. No, sir.

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

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

but other than that nonsense, no.

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

A. No.

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

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

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

A. I think so, yes.

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

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

Q. Okay.

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

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

Q. Does she take a salary?

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

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

A. I've given many.

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

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

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

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

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

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

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

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

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

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

A. I think so.

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

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

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

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

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

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

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

Q. Okay.

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

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

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

Q. Do you know where in Connecticut?

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

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

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

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

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

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

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

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

A. Cases reviewed.

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

A. Yes.

MR. BIONDO: Sean, do you mind me sort

of looking through this stuff?

MR. McELLIGOTT: No, that's fine.

Q. So what is this letter about Paul I see? It's talking about Paul. I'm just kidding.

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

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(Whereupon, a recess was taken.)

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

A. Yes, sir.

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

A. Yes, sir.

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

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

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

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

A. Yes, sir.

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

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

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

Q. Was that a deposition or trial testimony?

A. Deposition.

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

A. I think two years ago.

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

A. It was here.

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

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

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

on the Middlesex Hospital Primary Care chart.

A. Yes.

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

A. Sure.

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

A. No, sir.

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

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

Q. Okay.

A. -- from somebody in the firm.

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

A. I think so.

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

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

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

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

Q. What was your rate in approximately 2015?

A. 300 an hour to review.

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

A. That's correct.

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

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

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

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

Q. Okay.

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

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

Q. Will be for those depositions?

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

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

A. Right.

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

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

Q. Okay. In preparation for today?

A. Exactly.

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

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

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

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

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

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

Q. I honestly have no idea.

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

MR. BIONDO: Sean, is that accurate?

MR. McELLIGOTT: Is what accurate?

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

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

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

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

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

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

A. Yes.

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

review in this case?

A. No, sir.

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

A. No, sir.

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

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

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

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

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

A. That's a hundred percent correct.

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

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

Q. Now, the deposition transcripts that were

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

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

Q. Yeah.

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

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

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(Whereupon, Exhibit 4 was marked for identification.)

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

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

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

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

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

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

A. No.

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

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

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

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

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

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

A. I agree with that.

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

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

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

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

Q. You haven't on this case?

A. No.

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

A. No.

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

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

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

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

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

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

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

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

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

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

culture. I'm talking about the urinalysis.

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

Q. How about protein?

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

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

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

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

A. Right.
Q. Okay.
A. I mean if you totally have a negative dipstick and you have a positive culture, in other words, it looks like 100,000 E. Coli, your dip sticks are probably outdated or somehow the specimen got confused.
I mean, if you have -- I mean in general -- not in general. The overwhelming majority of the time you have a positive culture, your dipstick urinalysis should be abnormal.
Q. So the dipstick is normal and you have a positive culture so when you said -- you're talking about contamination issues? Is that what we're getting at?
A. No. I'm just saying if you have no infection, right, no infection your dipstick should be normal. If you have infection, your dipstick should be abnormal.
Q. What would be a potential reason to have a normal -- a positive culture and a negative urinalysis?
A. Again, the two are hard to -- I mean it shouldn't be. I mean I've seen it. Look, I've seen people -- you know, if you go to your doctor's office, some of those dip sticks have been in there since 1955. They lose their ability to detect things. Sometimes people get dip sticks and what's recorded is somebody

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

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

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

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

A. Agree.

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

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

true.

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

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

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

A. I would say that's probably true.

Q. And -- withdrawn.

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

A. Well, sure.

Q. Can you give me a for example?

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

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

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

A. Yes.

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

A. Sure.

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

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

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

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

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

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

A. I agree with that.

MR. McELLIGOTT: Plaintiff's objection, object to the form.

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

rare?

A. I agree with that.

Q. Would you agree with the terminology exceedingly rare?

A. I agree with that.

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

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

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

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

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

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

make the initial referral, no.

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

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

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

A. Right.

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

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

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

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

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

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

A. Sure.

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

A. Yeah, I agree with that.

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

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

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

A. It's a free country.

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

A. Sure.

Q. Anything else?

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

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

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

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

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

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

accepting of what we would consider western medicine?

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

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

A. Yeah.

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

A. Let me find it.

Q. I think it's 1664?

A. That helps.

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

MR. BIONDO: Yeah, absolutely.

- - -

(Whereupon, a recess was taken.)

- - -

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

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

find a, quote, western doctor.

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

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

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

A. I did.

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

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

A. I would agree with that.

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

A. I have.

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

on this visit?

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

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

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

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

A. Correct.

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

A. Yes.

Q. It was basically a normal exam?

A. Yes, sir.

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

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

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

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

A. Correct.

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

A. Absolutely.

Q. Why?

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

Q. Now, on this date, so understand your

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

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

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

A. Agree.

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

A. Agree.

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

A. I did.

Q. Do you have any reason to dispute that or

have a problem with that?

A. Not at all.

MR. McELLIGOTT: Object as to form.

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

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

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

A. Yes. The rest of it is fine.

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

A. Right.

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

A. I remember the organisms.

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

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

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

A. Yeah.

Q. What is --

A. It's a diagnostic-related infection.

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

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

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

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

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

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

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

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

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

A. Agree. Agree.

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

A. Yes, sir.

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

A. Agreed.

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

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

A. I agree with that.

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

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

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

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

A. In this type of situation, yes.

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

A. Yes.

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

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

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

A. None.

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

A. Agree.

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

A. Yes, sir.

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

A. Yes, sir.

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

A. Yes, sir.

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

A. Absolutely.

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

A. Call back?

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

A. 1673?

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

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

A. Yes.

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

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

Q. Right.

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

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

A. Right. That's exactly right.

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

A. Agree.

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

A. Yes.
Q. That's a good thing for him to do?
A. Agree.
Q. And when she comes into the office now, on the 22nd now --
A. Right.
Q. -- it looks like Dr. Ridge got a little bit more information from the patient on this visit. Fair to say?
A. I think a considerable amount, yeah.
Q. And do you recall his deposition testimony once he got some more information, he started doing a little bit more digging around on the computer system to see her medical history?
A. I agree.
Q. I assume that's a reasonable thing for a physician to do based upon new information obtained from the patient?
A. Agree.
Q. Okay. Now, the patient had reported on this visit that she was treating her symptoms of frequency, urgency and burning with homeopathic remedies. I think he wrote sitz bath with tea tree oil and other homeopathic remedies. Do you prescribe at all to any of these type of homeopathic remedies?

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

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

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

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

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

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

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

A. I honestly know nothing about tea tree oil.

Q. I'm not surprised.

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

A. I do.

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

A. So I really have one criticism and it relates

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

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

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

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

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

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

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

urologist, if not, to a surgeon.

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

A. I agree.

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

A. It does.

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

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

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

A. I agree.

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

A. None at all.

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

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

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

A. I agree.

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

A. Agree.

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

A. I'm sorry?

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

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

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

A. Sure.

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

A. To make sure the infection's eradicated.

Q. And did they do that in this case?

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

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

A. Sure.

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

A. Right.

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

A. Right.

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

A. I do remember that.

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

A. I do.

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

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

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

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

Q. Okay. Understood.

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

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

A. Agree.

Q. And you agree right underneath that,

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

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

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

A. I did.

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

MR. McELLIGOTT: Objection form.

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

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

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

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

MR. McELLIGOTT: Object to the form.

You can answer.

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

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

A. That's exactly right.

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

A. Right.

MR. McELLIGOTT: Object to the form.

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

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

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

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

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

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

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

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(Whereupon, a recess was taken)

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

A. Yes.

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

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

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

A. Yes.

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

in this case whatsoever as to standard of care?

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

Q. Okay.

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

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

MR. McELLIGOTT: Objection to form.

Are you asking him to assume that?

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

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

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

somewhere?

MR. BIONDO: From the record.

MR. DUGAN: I object as well.

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

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

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

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

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

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

A. Yes.

Q. Okay.

MR. McELLIGOTT: Object to the form.

You can answer. What page was that?

MR. BIONDO: Unfortunately, Sean, I don't have the Bates number on mine, but it's the phone messages from the 30th and the 31st of March. I don't know if that helps you.

MR. McELLIGOTT: Direct me to where --

MR. BIONDO: Hang on. I'm looking at the Doctor's. I'll find the page number.

MR. McELLIGOTT: I see it. Sorry. Thank you.

MR. BIONDO: So with that, no further questions.

MR. DUGAN: No questions.

MR. NOWOSADKO: No questions.

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(Deposition concluded at 2:41 p.m.)

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(Signature waived.)

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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