STATE OF MAINE SUPERIOR COURT
Civil Action
ANDROSCOGGIN, ss. Docket No. CV-03-25

BEVERLY TRIPP,
Claimant

v.

TAMC, et al.,
Respondents

DEPOSITION of BARBARA J. LEVIN, R.N., taken pursuant to notice dated December 11, 2003, at the law offices of Berman & Simmons at 85 Exchange Street, Portland, Maine, on February 5, 2004, commencing at 10:08 a.m., before Claudette G. Mason, RMR, CRR, a Notary Public in and for the State of Maine.

APPEARANCES:

For the Claimant: JULIAN L. SWEET, ESQ.

For the Respondents: DANIEL RAPAPORT, ESQ.
MARK G. LAVOIE, ESQ.
RICHARD W. MULHERN, ESQ.

Also Present: Tammy Acker
Ted Westerfield

49693

(Deposition Exhibit Nos. 1-7 were marked.)

BARBARA J. LEVIN, R.N., having been duly sworn by the Notary Public, was examined and deposed as follows:

EXAMINATION

BY MR. RAPAPORT:

Q. Would you state your full name, please?
A. Barbara J. Levin.
Q. Ms. Levin, my name is Dan Rapaport. I represent Dr. Korkut and the Aroostook Medical Center in this case. And this is Tammy Acker, who is a paralegal in our office.
You have had your deposition taken on several occasions?
A. Yes.
Q. How many times in a professional negligence case?
A. Over 20 times.
Q. All right. Just, as you probably heard in other depositions, a couple of ground rules. Please let us know -- let me or anybody else who asks a question know if you don't understand a question; and we'll rephrase it. All right?
A. Yes.
Q. And that's important because you're aware that you have

given an oath to tell the truth as you would in trial?
A. Yes.
Q. And that the deposition transcript may be used either at a panel hearing or a trial --
A. Yes.
Q. -- in this action?
I'm sure you'll be very good at using word answers rather than a huh-uh or a nod of head, but just a reminder. And also I'll do my very best to let you finish your answer before I ask another question. And if you could wait until I finish my question before you answer, that would be helpful for the court reporter and everyone else. All right?
A. Yes.
Q. All right. I saw in the documents that you brought today a copy -- well, it looked like -- well, a CV and a fee schedule. I have made -- marked as exhibits copies from my file. And I just want to know if they are the same or if there are any changes. Exhibit 1 being your CV; is that right?
A. That's correct.
Q. Is that up to date?
A. No. I have the up-to-date one.
Q. You have an up-to-date one, good.
Thank you. How about the fee schedule, which is

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marked as 2?
A. That's changed as well.
Q. Okay. So we need two more.
(Deposition Exhibit No. 8, 9 were marked.)
Q. I'm showing you Exhibits 8 and 9. For the record, please, if you could identify those for us.
A. Yes. This is my curriculum vitae and fee schedule.
Q. All right. Thank you.
I'm showing you Deposition Exhibit No. 1, which is No. 1. You have seen that?
A. Yes, I have.
Q. And that's your deposition notice and request to produce documents for today's deposition?
A. Yes.
Q. And have you brought all the documents you have that fall within -- that you believe fall within these categories?
A. Just about everything.
Q. Okay.
A. There is only one thing I don't have, and that was my billing schedule.
Q. Okay. But now we do have that -- for this case?
A. For this case.
Q. Is that something you have and just didn't bring?
A. Yes.

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Q. Okay. And are you -- will you please provide that to Mr. Sweet?
A. Yes.
Q. All right. Do you remember how many hours you spent to date on this case?
A. No, I don't.
Q. All right. You said just about everything. Is there anything else that you have in your file or that you have reviewed that you haven't brought today?
A. No.
Q. Okay. Can you tell us what you did bring today?
A. Yes. I brought the medical records of TAMC and EMMC. I have various depositions here as well as policies and procedures for TAMC.
Q. Okay. Have you -- in the course of your review of this matter, have you made any notes?
A. Yes, I have.
Q. And have you brought those notes with you?
A. Yes, I have.
Q. All right. I have marked some of those notes, haven't I?
A. Yes, I have.
Q. And is there one -- you have got two white pads of paper and then one white sheet of paper.
A. This ripped off this morning.

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Q. So two white pads. One pad of paper contain notes from your review of the medical records, and the other contain notes from your review of depositions?
A. Correct.
Q. Which is which number-wise if you -- there should be a sticker.
A. No. 5 are the medical records and No. 6 are the depositions.
Q. Have you always written that small?
A. Most of the time, yes.
MR. SWEET: We did it for you, Dan.
MR. RAPAPORT: That was my next question.
(Discussion off the record.)
MR. RAPAPORT: And I understand, Jay, we can get copies after the deposition?
Thank you.
MR. SWEET: Yes.
MR. RAPAPORT: He nodded his head.
MR. SWEET: I'm nodding affirmatively.
BY MR. RAPAPORT:
Q. Did you bring in all correspondence that you have received from the firm of Berman & Simmons in this case?
A. I believe so, yes.
Q. And that's in a purple folder?

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A. Yes.
Q. And that we have -- we have marked that as Exhibit 7?
A. Yes.
Q. Okay. There is a letter in there from Attorney Sweet from September 16, 2003; is that correct?
A. Yes.
Q. Okay. Is that the first correspondence you received from the Berman & Simmons firm in this case?
MR. SWEET: Dan, just for the record, the letter is from September 17.
MR. RAPAPORT: 17, sorry.
MR. SWEET: From my trusted associate --
MR. RAPAPORT: Mr. Bramley.
A. Yes.
MR. SWEET: -- Mr. Bramley.
Q. The letter of September 17 is from Mr. Bramley. Is that the first communication you had from the Berman, Simmons firm regarding this case?
A. First written communication, yes.
Q. Did you have verbal communication before September 17 with the firm about the case?
Did somebody call you?
A. Yes.
Q. And who was that?
A. I think that was Mr. Bramley.

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Q. All right. Do you remember what he told you?
A. He had requested that I review some medical records and to contact him afterwards.
Q. Okay. And after the phone call, you got the letter and the records?
A. Yes, I did.
Q. Looks like you got some deposition transcripts as well?
A. Yes, I did.
Q. All right. When was it -- at some point after September -- after the material you received in the September 17 letter, looks like you received other material?
A. Yes, I did.
Q. Other deposition transcripts?
A. Yes, I did.
Q. And recently some -- some policies and procedures from the hospital?
A. I received the policies and procedures yesterday.
Q. Okay. Can you remember either from looking at your notes or from your memory when it -- at what point, at what time it was -- what date that you first formed an -- opinions about the nursing care in this case?
A. I believe it was sometime in October.
Q. All right. And are you able to tell -- was it after you reviewed the material that was initially provided

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to you in September?
A. Yes.
Q. All right. After you reviewed subsequent material, did you form additional opinions about nursing care; or did they just bolster your original opinions?
A. I'm not sure if I formed additional opinions. I'm not sure because everything -- the materials kept coming to me. And so my opinions didn't really change.
Q. Okay. They didn't change, all right. Was there -- were there any of the deposition transcripts that you were provided and reviewed not relevant to you in terms of forming opinions about the nursing care in the case?
A. Were they not relevant?
Q. Yes.
A. No, they were relevant.
Q. Did you review the deposition transcript of Dr. Paxton?
A. Yes, I did.
Q. Okay. And he was the emergency department physician?
A. Correct.
Q. Was there anything in his deposition that was relevant or significant to you about the nursing care in the case?
A. He didn't address the nursing care. He spoke about the medical diagnoses.
Q. Okay. All right. But -- and was that relevant to you

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about the nursing care?
A. Yes.
Q. All right. Anything else about his deposition? And if you -- feel free to review your notes about his deposition if you want.
A. Review of the films.
Q. Okay.
A. And his contacting Dr. Hersey -- excuse me, his contacting Dr. Korkut for admission, and communications that they had, and the admission diagnosis.
Q. Have you made any marks or notes in the deposition transcripts themselves?
A. No.
Q. You have Mr. Bramley's September 17 letter in front of you. What deposition transcripts were you originally provided?
A. Dr. Hersey, Dr. Korkut, Dr. Watterson, Christine Gallagher, Ralph Lentz.
Q. Did you ask sometime after September 17 for -- to be sent the other deposition transcripts; or were they sent to you without your asking?
A. We spoke about future depositions, and they informed me that these would be forwarded to me.
Q. Aside from scheduling conversations you may have had with the firm of Berman & Simmons, after you got --

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after you got the September 17 letter and the original materials, medical records and those depositions you just read to us, how many phone conversations did you have from -- with anyone from Berman & Simmons?
A. A few.
Q. Five?
A. I don't know.
Q. Would it be less than five or --
A. From this point here until today's date?
Q. Yes.
A. Something of substantial information?
Q. Yes. Not about scheduling.
A. It would be less than five.
Q. Okay. Did you ever write any letter or report concerning your opinions in the case?
A. No, I did not.
Q. I show you what's been marked as Deposition Exhibit No. 2 and ask if you have seen that before?
A. Yes, I have.
Q. All right. And that's the expert witness designation of you in this case?
A. Yes.
Q. And were you sent a draft of that before it was filed; do you know?
A. Yes.

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Q. Okay. Did you make any changes to the draft?
A. Nothing of substantive -- I think there were just a couple grammatical things that needed to be changed.
Q. Do you have the letter from Mr. Sweet with the draft -- enclosing the draft?
I think it's November 7.
MR. SWEET: Actually, it's November 11.
MR. RAPAPORT: I'll get these dates right once.
A. I don't have the draft.
Q. But you have a letter enclosing the draft?
A. Yes.
Q. But you don't have the draft?
A. No.
Q. Can you remember what changes you made to the draft?
A. I believe it had to do with No. 1.
Q. Okay.
A. But I believe it was more of a grammatical issue. There really wasn't -- there really weren't changes because this was reflective of a conversation that I had had with the office.
Q. Okay. Can you recall whether you made any other changes to the draft?
Well, first of all, do you remember what the grammatical change was?
A. I do not.

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Q. Okay.
A. It was pretty insignificant.
Q. Okay. Do you remember if you made any other changes to the draft?
A. I don't recall.
Q. Thank you. Actually, why don't you hold onto that.
A. Okay.
Q. I will ask you some more questions.
A. Thank you.
Q. If you would hand me the purple folder with the correspondence, and I may be done with that folder.
A. Sure.
Q. I'm showing you -- referring, again, to that November 11 letter from Mr. Sweet which enclosed the draft designation, it looks like you had a meeting with him?
A. Yes, I did.
Q. How many times did -- have you met with someone from the Berman, Simmons office about this case?
A. Once.
MR. SWEET: You mean other than today, Dan?
MR. RAPAPORT: Other than today.
Q. One other time?
A. Yes.
Q. He indicates in his letter that you were going to provide him with general standards of the National

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Association of Orthopedic Nurses and American Nurses Association?
A. Yes.
Q. Did you provide those to him?
A. Yes, I did.
Q. Did you bring those with you?
A. No, I did not.
Q. Did you refer to those standards in forming any of your opinions in this case?
A. I didn't refer to the standards because I --
Q. You're aware --
A. Yes. I know the standards.
Q. So did you utilize these standards in forming your opinions in this case?
A. Yes. The standards that I know; that's correct.
MR. SWEET: Dan, I have got them if you're interested in them.
MR. RAPAPORT: Yes, I am, please.
Also, Jay, together with a copy of those standards and a copy of Craig's letter of September 17.
MR. SWEET: Why don't you -- I mean, why don't you give me a list at the end of the deposition; and we'll give you everything you want.
MR. RAPAPORT: Okay. Will do.
BY MR. RAPAPORT:

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Q. Thank you. Actually -- we'll put it there.
All right. So in forming your opinions that there were deviations of nursing care -- acceptable nursing care by the nurses, did you rely on any of the standards -- the copies that you provided to Mr. Sweet?
A. No, I did not.
Q. You didn't rely on them?
Did you use that as one of the bases for why you believed there were standard of care deviations?
A. Yes.
Q. Okay. Aside from anyone at the Berman & Simmons firm, have you spoken to anyone about this case?
A. Yes. Just the person who contacted me initially to review this case.
Q. And who was that?
A. Gail Hendrickson.
Q. And who is she?
A. She's a nurse.
Q. Okay. Is she a nurse consultant?
A. Yes, she is.
Q. Is she in Maine?
A. Yes, she is.
Q. And what -- do you have a business relationship with nurse -- with Ms. Hendrickson?
A. No, I do not.

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Q. Do you know how she got your name?
A. I believe as a referral probably through my association.
Q. Which association?
A. The American Association of Legal Nurse Consultants.
Q. Okay. What did Ms. Hendrickson tell you when she spoke to you about this case?
A. She had inquired if I would have the time available to review an orthopedics case and requested that I send her a copy of my CV and fee schedule and that I would be contacted by the Berman & Simmons firm.
Q. You have your -- the designation of expert witness in front of you?
A. Yes.
Q. All right. I would like to go through that with you, please.
First line says, Ms. Levin is a registered nurse currently practicing at Massachusetts General Hospital in Boston.
Do you work full time?
A. No, I do not.
Q. How much do you work?
A. 28 hours a week.
Q. And how long have you been working 28 hours a week at Mass. General?

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A. Probably since 1988 or 1999 I switched to 28 hours a week.
Q. And you also have a profession as a legal nurse consultant?
A. That is correct.
Q. And that's full time?
A. No, I wouldn't say that. I have responsibilities that stem off of that that aren't -- that aren't directly part of my business that I spend time on.
Q. Were you a founder of the American Association of Legal Nurse Consultants association?
A. No, I'm not a founder.
Q. How long have you been a member?
A. I believe since 1993.
Q. Have you ever been an officer?
A. Yes, I have.
Q. What positions have you held?
A. I have held numerous positions on the local level, and at the current time I'm the president elect for the national association.
Q. What will your term be as president elect?
A. I begin the end of March this year. On March 30 through March 30.
Q. What were the local level positions you -- offices you have held?

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A. I was president elect, president and past president. I have also held the position of a national conference director.
Q. Are you self-employed in your legal nurse consultant business?
A. Yes, I am.
Q. Can you estimate how many hours a week you spend in that -- in your business?
And we'll get to the other responsibilities.
A. Okay. Probably lately maybe 20 hours a week because my other activities have been more time consuming.
Q. Your other activities for --
A. For the national association.
Q. Okay. How much time do you spend doing that?
A. That can vary between 10 and 20 hours a week. Sometimes more.
Q. How many pending cases do you have now for your -- for your business to review or evaluate to determine whether or not you would be willing to serve as an expert?
No, that's a bad question. Strike that.
How many pending cases do you have?
A. I don't know.
Q. Do you have more -- are you currently working on more than this case?

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A. Yes.
Q. All right. Would it be more than 10?
A. Well, there's cases in the past that I have been contacted about to serve as an expert; and they have laid dormant for a couple years. So I don't know what the status is on those.
Q. Do you have cases -- do you distinguish or separate your cases as open or closed?
A. When they're closed, I destroy the files.
Q. Do you have a number of open files now, no matter what stage they're in, you have been asked to look at it once or you have been designated as an expert or you're still reviewing?
A. Yes, I have some that are open.
Q. Do you know that number?
A. No, I don't.
Q. You don't have any estimate whether it's 10 or 20 or --
A. No.
Q. Okay. And because of your responsibilities with the national association, you think you have less open cases than you have in the past?
A. I think so, yes.
Q. Okay. Would you be able to tell us what the most number of open cases you have ever had?
A. I want to clarify -- quantify that further. Open cases

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as an expert witness or open cases because I'm the consultant?
Q. Expert witness.
A. Well, I don't accept that many expert cases per year. I may be contacted between 10 and 12 times, and out of those I may only accept five of them.
Q. And --
A. So I don't have a grand number.
Q. All right. What -- how do you determine whether to accept them as an expert?
A. If I'm contacted on the plaintiff side, obviously I have to find merit and to be able to support it with identifying the standard of care within nursing practice. If I'm contacted on the defense side, obviously I also have to support that with standards. And there are times for both that I'm not able to participate.
Q. Because if you're looking at it for the plaintiff, you have looked at it and told the attorney or whoever contacts you that it doesn't look like any deviations to you?
A. Correct.
Q. Or if you are contacted on the defense side, you have looked at it and said looks like there are some deviations?

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A. Correct.
Q. I wasn't sure -- I wasn't clear about the word accept.
A. Okay.
Q. Are there any instances where you're called to review a case before you can tell whether there's merit or not merit that you would say, no, I won't look at it?
A. Yes.
Q. What circumstances?
A. If it's a case outside of my nursing specialty such as OB-GYN.
Q. Any others? Any other cases outside your nursing specialty?
Would there be any types of cases that you wouldn't -- that you wouldn't feel qualified to look at?
A. Neonatal.
Q. Is that it?
A. That's all I can think of right now.
Q. Okay. Do you work in a particular department at the Mass. General?
A. Yes, I do.
Q. Which one?
A. Orthopedic trauma department.
Q. How many beds does that have, that department?
A. Currently, we have 30 beds.

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Q. And do you know how many beds the hospital has?
A. I'm not sure exactly. That fluctuates when we open new units.
Q. Do you know anything about the size of TAMC, the Aroostook Medical Center?
A. I understand that it's smaller than Mass. General.
Q. I take it you have never been there?
A. No, I have not.
Q. Have you been to Aroostook County?
A. No, I have not.
Q. Have you ever looked at a case -- a case before involving the Aroostook Medical Center?
A. I don't -- I don't know.
Q. Okay. Based on what you know about the Aroostook Medical Center, would you classify that as a community hospital?
A. Yes.
Q. Have you ever worked in a community hospital?
A. Yes, I have.
Q. When was the last time you worked at a community hospital?
A. I -- oh, thank you.
I believe it was 1991.
Q. What was that community hospital?
A. I worked through a nursing agency at numerous community

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hospitals.
Q. Was that per diem?
A. Yes.
Q. Were they in Massachusetts?
A. Yes, they were.
Q. Do you know any of the names of them?
A. Yes.
Q. Do you know the names of any?
A. Yes. Quincy Medical Center, Brockton Hospital. There was another small one; and, I'm sorry, I don't remember the name.
Q. How many years did you do that agency work at community hospitals?
A. I was there for a total of -- well, I had overlapping years between the different agencies between 1985 and 1991.
Q. All right. And would the agency place you at city hospitals as well as community hospitals?
A. Yes.
Q. In -- and when you were placed by the agency at city or community hospitals between '85 and '91, would you be placed in any particular department?
A. It varied.
Q. What types of departments would you be placed in?
A. I did triage in the emergency room at Quincy City. I

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worked in the telemetry unit. I worked on a rehab floor, orthopedics floor, general med-surg floor, urology, geriatric.
Q. All right. Would -- can you remember when the last time between '85 and '91 was that you worked at a community hospital on a med-surg floor?
A. I don't know specifically. I just know it was 1991.
Q. All right. When you would be placed by agencies, how long would the -- how long would the placements be? A couple of shifts, a week, a month?
A. It varied. I worked a couple shifts a week. I may go to the same place each day for a week, or it may be three different places.
Q. What's the longest a -- an assignment through that agency would be?
A. Well, my assignments were really based on a -- on a daily, as-needed basis. So I may be at Brockton Hospital -- I'll give that as an example -- on the telemetry unit one day, on med-surg the next day. So my patient assignments varied.
Q. Would you be -- could you get placements at different hospitals during the same week?
A. Yes.
Q. Did that frequently happen?
A. It did at times.

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Q. All right. Okay. Why don't we turn, please, to paragraph 1 of the first page of your designation.
Before I ask you, there are six paragraphs -- well, six enumerated paragraphs on your designation of expert witness; is that right?
A. Yes.
Q. And are these the ways in which you believe the nursing staff at the Aroostook Medical Center deviated from acceptable nursing standards with regard to Ms. Tripp?
A. Yes. I have additional opinions.
Q. All right. Do you have -- if you were doing this designation today, would you have additional paragraphs or would you have additional opinions about these areas?
A. Both.
Q. Okay. How many additional opinions do you have?
If you were going to do this designation today and list all the paragraphs of deviations, how many additional ones would there be?
A. Maybe about five.
Q. Five. You don't have those written down -- do you have those written in your notes?
A. Just right here.
Q. All right. You have -- when you say right here --
A. On my yellow sticker.

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Q. So the additional opinions are on the yellow -- on one of those yellow stickers?
A. Yes.
Q. I'll make a note to get that.
All right. Paragraph 1, again, just to see if we can move this along, that's a criticism you have of the nursing care on October 24, 2001; is that right?
A. That is correct.
Q. All right. Is there a particular document that you refer to in the records that led you to the conclusion that the nursing assessment was inadequate on the 24th?
A. Yes.
Q. All right. I'm going to assume that it was -- that it's document Bates stamped 75. But if I'm wrong, you can tell me which one it is.
A. Yes. That's correct.
Q. Okay. And that, again, for the record is Bates stamped TAMC, a lot of zeros, 75?
A. Correct.
Q. And it's entitled Outpatient Record Preprocedure Observation Initial Data?
A. Correct. As well as page 76.
Q. 76. Oh, yes, okay.
And that's -- is that from the 24-hour flow sheet, page 76?

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A. Yes, it is.
Q. Okay. All right. We're there.
At the hospital you work at, do you use this form that's page 75 titled Outpatient Record?
A. We have a different form.
Q. What do you -- what is it called at your hospital?
A. A 23-hour admission form.
Q. Okay. What is a -- what's the purpose of a nursing assessment when a patient is admitted to the hospital?
A. The purpose of an assessment is to establish a baseline and to document such so that way subsequent shifts and care providers have concrete documentation to -- to review when they're doing their assessments.
Q. Okay. All right. I forgot to tell you something at the outset that I'm going to -- I am not going to ask you during the course of this deposition about your opinions about what any doctor should or should not have done. I may ask you from looking at the records what doctors did or didn't do. Okay?
A. Okay.
Q. Have you ever testified either at a deposition or a trial regarding the standard of care of a doctor?
A. I did on one case.
Q. Do you remember when that was?
A. Yes. It was, I believe, back in 19 -- oh, gosh, 1995,

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the standards -- it was a compartment syndrome case and my practice as a nurse dealing with a patient with compartment syndrome and how physicians treat. But I don't -- we just entered a couple statements; but the focus was not about the physician's standards.
Q. Is compartment syndrome a nursing special interest of yours?
A. Yes, it is.
Q. Do you have any other nursing special interests?
A. The field of orthopedics and the field of medical-surgical nursing.
Q. Have you ever testified either at trial or deposition that you felt competent to give the standard -- an opinion with regard to the standard of care of a doctor?
A. On my compartment syndrome case there was a particular issue that came up that I was able to address because I have cared for that type of population.
Q. Was that at trial or deposition?
A. It was at deposition.
Q. Was it that '95 case?
A. Yes.
Q. Do you remember what state that was from?
A. I believe it was in New Hampshire.
Q. Did you ever testify at trial or at a deposition that

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you felt you were smarter than a doctor?
A. No.
(Discussion off the record.)
Q. You feel -- it's your opinion that this nursing assessment, pages 75 and 76, is inadequate?
A. Yes.
Q. In what way in your opinion is it inadequate?
A. There's a lack of neurovascular assessment.
Q. What should the neurovascular assessment have been?
A. Well, let me just explain that when we're admitting a new patient, we do a head to toe assessment from top to bottom. And all of that should be documented here. And your question specifically about a neurovascular assessment would include color, sensation and movement to all four extremities, pulses, capillary refill, strengths. Focusing on the lower extremities, dorsiflexion, plantar flexion abilities, inversion, eversion, bending of the legs, lifting of the legs and sensation of all as I mentioned before.
Q. Okay. All right.
A. Also, with that would be detailed documentation of pain and the amount of pain, inquiring if it was stabbing or radiating, spasms. All of that would be included.
Q. Anything else?
A. Can you go back to your original question?

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Q. Yes. I'm sorry. Anything else wasn't -- was not a clear question.
There was an -- in your opinion the nursing assessment was inadequate because of the lack of a neurovascular assessment?
A. Correct.
Q. Any other ways in which the nursing assessment was inadequate in your opinion?
A. Yes. They didn't document the medications that the patient had taken on that date.
Q. Any other inadequacies you see?
A. Is this also including page 76?
Q. Well, that's part of the nursing assessment, isn't it?
A. Correct.
Q. Is that part of the nursing assessment on admission?
A. Yes.
Q. Okay.
A. There would be a detailed note written about this patient.
Q. Where would it be?
I mean -- strike that.
Would that be on this form?
A. Yes.
Q. Where on page 76?
A. Under 2130, received patient via wheelchair to room

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2092, as a 23-hour observation.
Q. Well, there is more written than that under 2130, isn't there?
A. Oh, service of Dr. Korkut. See admission info for further information. Yes.
Q. Do you know what admission info they're referring to?
A. The previous page.
Q. 75?
A. I believe so.
Q. So is it your opinion that there was a note written on admission, but it wasn't detailed?
A. Correct.
Q. Okay. What time was the nursing assessment on admission done?
A. At 2130.
Q. Did a doctor do an assessment of Mrs. -- Ms. Tripp on the night of October 24?
A. Yes.
Q. And who was that?
A. Well, she had -- it is Dr. Paxton, because he had seen her in the emergency room.
Q. Okay.
A. As well as Dr. Korkut.
Q. Was any neurovascular assessment done by the nurses in -- by the nurses in the nursing admission assessment

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on October 24?
A. No.
Q. And your basis for that is?
What's the basis for that, because there is nothing on page 74 or five?
I'm sorry. I'm sorry. What's the basis for that? I didn't mean to put words in your mouth.
A. For the neurovascular?
Q. Yes.
A. It's not documented.
Q. In your terminology, in your experience, is there a difference between -- well, strike that.
Was there any neurological assessment done in the nursing admission on October 24?
A. Well, according to page 76, from D -- I'm not sure her last name -- on admission --
Q. I think it's D. Allen.
A. Okay. She had documented circulation, level of consciousness, color, respiratory, neurovascular, range of motion, ambulation.
Q. How about pain?
A. The patient was medicated.
Q. Is there a box in the page 76 for pain under the nursing assessment?
A. Yes. It says medicated.

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Q. Okay. Isn't the -- does -- isn't the fact that she documents under circulation, ambulation, range of motion -- isn't that an indication that there was a neurovascular assessment on admission?
A. No, it's not.
Q. Because it's 2340?
A. No. And I -- I think I mentioned NV was neurovascular. It's nausea/vomiting. I just want to correct that.
No, that's not a full neurovascular assessment.
Q. But it is a neurovascular assessment?
A. It's a partial assessment knowing that you can move your hands and possibly your feet.
Q. Do you know what time the patient assessment was done by the emergency department doctor?
A. From what I recall, Dr. Paxton said he saw her as soon as she came through the door.
Q. Okay. Which -- what time from your record -- from your notes?
A. So somewhere between 5:00 and 6:00.
Q. P.m.?
A. P.m.
Q. All right. And I think we already -- I think you already said that he did do a neurovascular assessment of Ms. Tripp?
A. Yes, he did.

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Q. And what were his findings?
A. That she was unable to do straight leg raises. There was no discomfort with rotation of the hips. She was able to move her joints, lower extremities and had absent Achilles tendon reflexes bilaterally.
Q. Do you know based on your review of the records or Dr. Paxton's testimony -- deposition whether he considered the neurovascular assessment he did in the emergency department normal or abnormal?
A. I believe he found things to be normal.
Q. Okay. And Dr. Korkut also did a neurovascular assessment of Ms. Tripp before the nursing admission assessment, correct?
A. Yes. I believe so.
Q. And do you know that in time -- the time frame -- how long it was between the time he did -- Dr. Korkut did his physical exam and the time the nursing admission assessment was done?
A. I'm just trying to find the page.
Q. It's page 8 and 9, I believe.
A. I know I had seen that.
And then the nursing one was 2130. So they were -- the initial ones were -- were overlapping.
Q. What was overlapping, Dr. Korkut's assessment and the nurse's?

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A. Yes.
Q. All right. Dr. Korkut didn't find any neurovascular or neurological abnormalities, did he?
A. He didn't say so.
Q. Okay. In your opinion that is -- in your -- well, let me ask you this. Do you have an opinion as to whether if a complete -- the complete neurovascular assessment of Ms. Tripp had been done by the nurses on admission that you say should have been done, whether it would have found an abnormality?
A. I don't think so.
Q. Okay. What -- what is the -- the baseline -- the detailed baselines that in your opinion needed to be evaluated by the nurses for future evaluations?
A. You need to assess their sensation and their movement and their strengths.
Q. Okay. All right.
A. As well as anything else I stated before with neurovascular assessments.
Q. In terms of your basis for your opinion in paragraph 1 of your report, is that based on your education, training and experience?
A. Yes.
Q. Is it based on any written standards?
A. Well, nurses have the duty to conduct -- to follow the

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nursing process. And in the nursing process would include the assessment.
Q. Okay. And the rule that you stated, nurses have a duty to follow the nursing process, is that written down someplace?
A. Yes.
Q. In a standard?
A. Yes.
Q. Which one?
A. The American Nurses Association.
Q. All right. Before we move to No. 2, have you told me all the ways in which you believe there were nursing care deviations with respect to the nursing admission assessment on 10/24?
A. I believe so.
Q. Thank you. Paragraph 2. And that -- those opinions in paragraph 2 are about the nursing plan of -- plan of care, correct?
A. Correct.
Q. And that's documents starting on page 69?
A. Yes.
Q. And going through 74?
A. Correct.
Q. Okay. We're on the same wavelength.
Is it your opinion as you -- you state in this

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that your opinion is that the nurses filled to establish an adequate plan of care. Is the basis for that opinion is because they used a plan of care form for long-bone fractures?
A. Yes. This was not specific to the patient and her needs.
Q. Okay. Is there any other way aside from that they didn't -- strike that.
Is there any other way aside from the fact that they used this particular form in which you feel they failed to establish an adequate plan of care?
A. Yes.
Q. Okay. What other way?
A. The nurses have a duty to write their own plan of care for the patient. And in the hospital's policies and procedures, which they did not follow, the policies and procedures state specifically that the nurses are to write a specific plan of care with specific assessments --
Q. Okay.
A. -- in the plan and give a duration of time that would -- that would be included.
Q. Okay. Do you have written down what number -- what policy that is? Does it have a number?
If you don't --

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A. I can pull it out.
Q. That's all right.
MR. SWEET: It's 2006, Dan.
MR. LAVOIE: Is that a TAMC policy?
Thanks.
Q. What does -- if you remember -- we'll pull it later if we need to -- does the policy say anything about forms, what forms should be used?
A. It talks about that nurses can write their own plan of care. So I don't know specifically what form.
Q. Do you know if the hospital had a form for possible -- well, possible thoracic spine fracture?
A. According to the nurses' depositions, they did not.
Q. Did you see anything in the policies and procedures?
A. Specific to this?
Q. Yes.
A. No. But the specific policy stated problems, goals and interventions would be hand documented.
Q. At Mass. General do you use a plan of care form such as the one on pages 69 to 64 -- 74?
A. Ours are a little different.
Q. In what way?
A. Ours are open-ended for us to fill in what the nursing diagnoses are and the assessment in the plan of care.
Q. Does your hospital -- the hospital where you work have

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a form for possible thoracic spinal fractures?
A. No, we do not.
Q. If a patient at your hospital has a potential thoracic spinal fracture, I take it that's the type of patient that would be in your department?
A. Correct.
Q. Is there a form that's used for the plan of care?
A. We design our own.
Q. Handwrite it up?
A. Yes, we do.
Q. Have you ever worked at -- well, when you were working at the community hospitals from '85 to '91 through the agency, did you ever work at hospitals that had -- that didn't have all the nursing plans of care that a hospital like Mass. General has?
A. Yes.
Q. Do you know if at those hospitals -- the community -- those community hospitals a nursing plan of care for a condition that they didn't have a specific form for, whether the closest form was used?
A. It was not.
Q. And what would -- was there a -- do you remember what the reason for that would be?
A. We were to design our own for the patient's specific needs.

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Q. So if you were to design -- oh, you would design your own when there wasn't a specific form?
A. Correct.
Q. All right. You state in your -- it is stated in the designation of expert witnesses here that in many respects the care provided for by the plan used was either irrelevant to or contradicted for suspected thoracic spine fracture?
A. Yes.
Q. Correct?
A. Correct.
MR. SWEET: It's contraindicated.
MR. RAPAPORT: Contraindicated. What did I say, contradicted?
MR. SWEET: Contradicted.
MR. RAPAPORT: Contraindicated. I'm sorry.
BY MR. RAPAPORT:
Q. Let's take the first -- looking at the form on page 69, the column, problem, what -- what problems are under a column -- on a formal nursing care plan what's under the problem column?
A. You identified problems that -- for your patient or potential problems that may occur with the patient.
Q. Okay. On paragraph 1 there, what problems would be irrelevant for a patient with a potential -- a

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suspected thoracic spine fracture?
A. Well, most of this would not be here.
Q. Because it would be under paragraph 1 because they would be irrelevant; is that why they wouldn't be there?
A. Yes.
Q. Is there anything -- any problem under paragraph 1 or No. 1 that would be relevant to a patient --
A. Well --
Q. Excuse me -- for a patient with a suspected thoracic spine fracture?
A. Yes.
Q. Which ones?
A. Potential neurovascular damage.
Q. And with a patient with a suspected thoracic spine fracture, would you be of the opinion that is the most serious potential damage?
A. Yes.
Q. Anything else in paragraph 1 that would be relevant to a suspected thoracic spine fracture?
A. No.
Q. Okay. Would the goal be the same -- next column, goal. Would the goal be the same as on this form for a patient with a suspected thoracic spine fracture?
A. The goal would be different.

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Q. Okay. Would any part of that goal be the same for a suspected thoracic spine fracture?
A. No.
Q. None, all right.
What would the goal be for a suspected thoracic spine fracture problem?
A. The patient will not develop neurovascular changes.
Q. Any other thing -- any other goal?
A. The patient will remain neurovascularly intact.
Q. All right. Anything else?
A. No.
Q. Okay. Target date is what? What does that -- what's that for?
A. They gave themselves a duration time to re-evaluate the patient. And they utilized the date of 10/29/01.
Q. Okay. Last column, nursing intervention. They have got nine separate interventions listed?
A. Yes.
Q. Would -- would any of those, first of all, be contraindicated for a patient with a suspected thoracic spine fracture?
A. Yes.
Q. Which ones?
A. No. 1.
Q. Okay. Anything else?

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A. No. 4. Well, 4 doesn't apply.
Q. It's irrelevant, correct?
A. No. 5.
Q. 4 is irrelevant?
A. Correct.
Q. 5, irrelevant or contraindicated?
A. You would need a physician order for that.
Q. Okay.
A. No. 6, No. 7 are -- are irrelevant. No. 8 is irrelevant. And No. 9 is irrelevant.
Q. Okay. Again, maybe I missed it. I want to try to separate from -- irrelevant from contraindicated. Would No. 1 be the only one that would be contraindicated?
A. And possibly No. 5.
Q. When would it be contraindicated -- when would apply ice as ordered be contraindicated?
MR. SWEET: For thoracic spine fracture?
MR. RAPAPORT: Yes. Thank you.
A. You would not be applying ice to somebody's spine.
Q. Okay. Did this patient ever have ice applied to her spine?
A. Not that I'm aware of.
Q. Did this patient ever have her extremities elevated?
A. I don't know.

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Q. Okay. Are there any of the nursing interventions for problem 1 on this form that would be relevant to a suspected thoracic spine fracture?
A. Well, No. 2 is not written correctly; but you would be monitoring the pulses actually of all four extremities. And then No. 3 is relevant.
Q. Would 2 be relevant if it was written correctly? Is that --
A. It would be relevant if you're monitoring the pulses of all four extremities. You're not comparing an unaffected extremity because that's not --
Q. Okay.
A. -- accurate for this case.
Q. All right. In this patient were her pulse -- four pulses monitored?
A. Throughout her hospitalization, I don't know.
Q. Okay. How about 3, assess capillary refill, peripheral pulses, sensation and skin tone. You said those would be relevant to this diagnosis -- Ms. Tripp's diagnosis?
A. Correct.
Q. And were they done in this case during her hospitalization?
A. No. Not consistently.
Q. Were they done at all?
A. I believe, yes.

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Q. Okay. And do you know how often they were done?
A. Very rarely. It was actually noted on the day of her discharge that she didn't have sensation.
Q. So the 27th?
A. Yes.
Q. What about on the 25th and sixth, do you know how often they were assessed?
A. No.
Q. All right. All right. We're down to 3. Any other in that nursing intervention problem 1 that would be relevant to Ms. Tripp's diagnosis?
A. No.
Q. Okay. I want to do this for all six of the problems listed on the --
A. Okay.
Q. -- the nursing care plan. So now we're on problem 2, correct?
A. Yes.
Q. Relevant to her diagnosis?
A. No.
Q. Why not?
A. It's not specific to her diagnosis.
Q. What would it have to say to be specific?
A. Alteration in comfort due to potential spinal fracture.
Q. So pain from a suspected thoracic spine fracture is a problem?

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A. Yes.
Q. How about goal? Again, question relevant to her diagnosis?
A. Yes.
(Discussion off the record.)
Q. Nursing intervention, first, any -- 1 through 8 contraindicated to her diagnosis?
A. No. 3.
Q. Anything else?
A. No. 4.
Q. Anything else? Looks like it's similar to what --
A. That's it.
Q. Okay. Were 3 and 4 done in this case?
A. I don't know.
Q. Any of the nursing interventions in problem 2 relevant to her diagnosis?
A. Yes.
Q. Which ones?
A. No. 1, No. 2, No. 5. I don't know if No. 6 was done. No. 7 and No. 8 -- oh, you said relevant. Yes. So that other one is included, yes.
Q. Okay. And just to see if I can anticipate your -- what you were thinking, not only were these relevant,

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they were all done. And except for, did you say, one of the -- one of them you didn't know; you couldn't tell. Was it No. 6?
A. Right. I didn't know if it had been done.
Q. Right. But the others had been done?
A. Not consistently.
Q. But had been during -- at some time during her hospitalization?
A. There were some times.
Q. Okay. Problem 3, relevant to the diagnosis?
A. No, it is not.
Q. So I guess goal wouldn't be relevant?
A. Correct.
Q. And the interventions that go over onto page 70, not relevant?
A. Correct.
Q. Any contraindicated?
A. Immobilize extremity.
Q. Okay. And was that done in this case?
A. No.
Q. All right. Problem 4, relevant to her diagnosis?
A. No.
Q. Okay. And I guess the same with goal, correct?
A. Correct.
Q. Any of the nursing interventions there be

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contraindicated?
A. Well, actually I think they said not applicable. Isn't that an NA?
Q. NA. So they didn't -- good, thank you.
Problem 5, can you make out what's written under the date?
A. I think that's somebody's initials.
Q. All right. Relevant for her diagnosis, problem 5?
A. Yes.
Q. Okay. So goal would be relevant?
A. Yes.
Q. And under target date, is that a date -- an initial you would assume?
A. Yes.
Q. Any of the interventions be contraindicated for her diagnosis?
A. No.
Q. Same questions with 6, problem 6 would be relevant, wouldn't it?
A. I would change that.
Q. To? To what?
A. Potential for skin breakdown.
Q. Okay.
A. And you can say due to immobility.
Q. Okay.

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A. But not the cast.
Q. Okay. Goal would be relevant to her diagnosis?
A. Yes.
Q. And any contraindications in any of those nursing interventions?
A. Possibly No. 1.
Q. Okay. Was that done in this case?
A. Yes, they were log-rolling the patient.
Q. Was there a doctor's order for that?
A. Yes.
And No. 5 is not relevant.
Q. All right. And that wasn't done, correct, in this case?
A. Correct.
Q. All right. No. 7 and 8 there is some handwriting. What do those mean to you?
Are those additional problems that was part of the plan of care?
A. That is correct.
Q. And were they relevant to her condition --
A. Yes.
Q. -- diagnosis?
All right. For a -- in your opinion for an adequate plan of care for suspected thoracic spine fracture, would there -- would there be other problems

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that should have been in the plan of care?
A. Yes.
Q. Which ones?
A. Potential for development of a deep vein thrombosis.
Q. Goal being not to develop DVT?
A. Correct.
Q. Intervention would be what?
A. Intervention would include monitoring their -- them neurovascularly, applying Teds and pneumoboots and speaking with the physician to inquire if he wanted anticoagulation and mobilizing --
Q. I'm sorry.
A. -- and mobilizing the patient when appropriate.
Q. Did Ms. Tripp develop DVT's?
A. Not during this hospitalization.
Q. Okay. Anything else that should have been on a nurse -- an adequate nursing plan of care for this patient with this diagnosis in your opinion?
A. There would have been more written about the potential for neurovascular involvement.
Q. All right. What should have been written?
A. How often the patient would be monitored, specifically how are they monitoring, and if there were any changes, to notify the physician.
Q. All right. So that would just be a -- I'm sorry. That

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would be more detail in problem No. 1?
A. That would be more detail. And to do -- and included in this would be to include a full neurovascular assessment, the plantar and dorsiflexion, measuring the strengths, bending the legs.
Q. Any other ways that would make this plan of care adequate in your opinion?
A. Well, you need to tailor the plan of care to the patient's specific diagnosis. And her diagnosis was a possible T12 fracture.
Q. All right. When you say you need to tailor, you mean the interventions?
A. Yes.
Q. All right.
A. The problems and the interventions.
Q. You told us how the problems should be more specific. How about the interventions?
A. And the interventions would need to be specific to her.
Q. How?
A. By writing a detailed -- you know, writing the detailed interventions of what needs to be done to assess her neurovascular assessment and also communicating any abnormal findings to the physicians.
Q. And you have told us what those detailed neurovascular assessments are, correct?

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A. Yes.
Q. All right. You -- in the designation of expert witnesses, last line on the first page going over to the second, it's stated, among other deficiencies, the plan of care did not require frequent neurovascular assessments.
Did I read that right?
A. Correct.
Q. All right. At any time during Ms. Tripp's hospitalization at TAMC was there any physician order for neurovascular assessment?
A. Yes.
Q. Who gave that order?
A. Well, first, the -- the initial order was vital signs per routine. And according to Nurse Gallagher, she stated that would include neurovascular assessments being performed every four hours.
Q. Let me just stop you there. Have you ever heard that before, neurovascular assessments being included in vital signs?
A. I have.
Q. Okay. And -- so she -- your understanding is that the nurse testified she understood that upon admission neurovascular assessments were supposed to be done q four hours?

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A. Yes.
Q. And if that -- if that were the case -- if that were done, would that be within the standard of care?
A. Yes.
Q. Okay. And so in your opinion were neurovascular assessments done q four hours?
A. No.
Q. And your basis for saying that is what?
A. The medical records and the nurses' depositions.
Q. We'll get to the nurses' depositions in a minute. The medical records meaning you didn't see documentation of neurovascular assessments q four hours?
A. Correct.
Q. Did you see documentation of neurovascular assessment at any time?
Was there any documentation of neurovascular assessment?
MR. SWEET: Just so we're clear --
MR. RAPAPORT: By nurses.
MR. SWEET: -- any documentation of any neurovascular assessment or any documentation of an adequate neurovascular assessment?
MR. RAPAPORT: I'm asking any neurovascular assessment.
Q. You saw documentation?

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A. Of partial assessments.
Q. All right. I understand you have got an opinion about the adequacy, but I'm talking about whether any part of it was done.
A. Yes.
Q. All right. Is it your -- do you subscribe by the rubric that if it's not documented, it wasn't done?
A. Yes. Pretty much.
Q. And when the -- when you say the depositions, you can -- you were -- part of the basis of your opinion that neurovascular assessments weren't done q four hours by the depositions would be this deposition of Mr. Lentz?
A. Yes. And also Christine Gallagher.
Q. Did they say in their depositions that they didn't do neurovascular assessments or they didn't remember?
A. They stated that they didn't touch the legs. And that means there wasn't a neurovascular assessment performed.
Q. It wasn't a complete neurovascular assessment?
A. Correct.
Q. Why don't we get it out of the way. Why don't you tell me what would constitute a complete neurovascular assessment for these nurses during Ms. Tripp's hospitalization.

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A. Okay. Well, a complete assessment would be performed at the beginning of every shift. And that would include color, sensation and movement of all extremities, strengths, pulses, capillary refill. You would be asking them to lift their arms, lift their legs, with their feet plantar flex, dorsiflex, invert and evert their feet as well as bend up their legs at the knee and lift up each leg if they're able to. And also, you would be noting pain and the type of pain and the number of pain that the patient would be having during this time.
Q. Okay. And maybe we can move ahead a little. Your opinion with respect to the lack of adequacy of the neurovascular assessment, am I correct that that's contained in paragraph 3 of the designation?
A. Yes.
Q. Okay.
MR. SWEET: Dan, would this be a good place to break?
MR. RAPAPORT: Sure. You read my mind. I was going to finish 2 and break.
MR. SWEET: Perfect.
(A short recess was taken.)
BY MR. RAPAPORT:
Q. All right. I'm still on -- on the top of page 2, it's

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the last phrase or the last statement under opinion 2, to increase the frequency of the neurovascular assessments if there is any clinically significant change.

My question is was there a point in time during Ms. Tripp's hospitalization at TAMC when this occurred, when -- when it should have been more -- when the standard of care required more than q four hours neurovascular assessments?

A. Yes.

Q. Okay. Can you tell me when that was, please?

A. That would be on -- on the 20 -- on the 26th, October 26.

Q. Okay. Time; morning, afternoon, evening?

A. In the morning.

Q. After the return from the MRI, or when? Sorry.

A. Yes. That's correct.

Q. Okay. And what did the standard of care require in terms of frequency of neurovascular assessments at that point when she got back from MRI on the 26th by nursing?

A. That you would be monitoring the patient on a continuous basis.

Q. What does continuous basis mean? What does that mean?

Does that mean one-on-one nursing; you're there

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all the time?

What does it mean?

A. No, it's not one on one. But as a nurse, you need to find out and assess if there's the slightest change in a patient's neurovascular assessment because you want to pick up on any potential problems. You want to catch the problems early versus later. And, thus, any of the most subtle changes need to be recorded as well as reported.

Q. Okay. And we know at least from -- at least from Nurse Gallagher's deposition that she says she reported that change, correct?

A. Well, she reported it to one person.

Q. Okay. She claims -- she testified she reported it to Dr. Hersey?

A. Correct.

Q. And was that an appropriate intervention by the nurse?

A. In part, yes.

Q. All right. And when you say part, is it because in your opinion she should have reported it to somebody else besides Dr. Hersey?

A. Yes.

Q. Who should she have reported it to?

A. She should have reported it to her charge nurse as well as Dr. Korkut.

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Q. Why should she have reported it to her charge nurse?

A. Because this is a change with a patient. And she is an LPN. And RN's are the ones who oversee patient care.

Q. Why should she have reported it to Dr. Korkut?

A. Because Dr. Korkut is her primary care physician.

Q. All right. What do you mean when you say primary care physician?

A. For this admission.

Q. He was the admitting physician?

A. He's the admitting physician, yes.

Q. Let me ask you about that. You have been provided the depositions of both Dr. Korkut and Dr. Hersey, correct?

A. Yes. That's correct.

Q. And did you understand from looking at those depositions whether there were -- there was -- each of the doctors had different responsibilities for the patient?

A. Yes.

Q. And what did you understand those to be?

A. That Dr. Korkut had requested Dr. Hersey to consult because of his orthopedics experience; but Dr. Korkut was the admitting physician.

Q. I understand he was the admitting physician. Did you see where Dr. Korkut testified that one -- I'm sorry, Dr. Hersey testified that once he was consulted by

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Dr. Korkut and saw Ms. Tripp, that he assumed primary responsibility for her back?

MR. SWEET: Excuse me.

MR. LAVOIE: Objection, Dan.

MR. SWEET: If you're going to refer to deposition testimony, can you give us a reference so we can refer to the page and line?

MR. RAPAPORT: I don't have the pages.

MR. LAVOIE: She's not going to comment on that anyway. That's not her role.

MR. RAPAPORT: Absolutely.

Q. Let me ask it a different way. Did you understand from -- let's say from Dr. Korkut's deposition. Did you understand that he understood there was a division of responsibility in terms of Ms. Tripp's care, that Dr. Hersey would be primarily responsible for the back with Dr. Korkut lending support, and that Dr. Korkut would be primarily responsible for her other medical conditions? Did you understand that?

MR. LAVOIE: Just for clarification of the question, is that her understanding of Dr. Korkut's understanding?

MR. RAPAPORT: Yes.

MR. SWEET: Actually, the question as I understand it, so we're clear, is is that her understanding of

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what Dr. Korkut has testified to after the filing of the notice of claim in this case?
MR. RAPAPORT: Of course.
MR. SWEET: Okay. Do you understand that's what Dr. Korkut said at his deposition?
THE DEPONENT: Can I see where he stated this?
MR. RAPAPORT: I mean, I'm going to ask her to assume it.
MR. LAVOIE: Let's not do that.
MR. RAPAPORT: Why not?
MR. LAVOIE: I just don't want her to go through the deposition.
MR. RAPAPORT: That's what I said; assume it.
MR. SWEET: Assume it. So where are we going?
BY MR. RAPAPORT:
Q. Let me ask you -- I'm going to ask you to assume that Dr. Korkut has testified that his understanding once Dr. Hersey consulted and saw Ms. Tripp, that Dr. Hersey became primarily responsible for her back; and Dr. Korkut became primarily responsible for her other medical conditions. Just assume that.
A. Okay.
Q. My question is in any of the hospitals that you have worked at have you ever heard of that happening between an internist and a specialist?

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MR. LAVOIE: Objection, form and foundation.
A. I have heard of bringing in consults, and they will be the ones who design the plan of care for the patient. But it's ultimately the responsibility of the primary care physician to oversee all of the care including what that specialty physician is stating and requesting.
Q. And that's what happens at Mass. General?
A. That they will communicate together.
Q. But that the -- no. That -- does it happen at Mass. General that the internist oversees the specialist?
MR. LAVOIE: Objection, form and foundation.
A. The specialist will write their recommendation and write their orders. And the admitting physician is aware of -- of what the recommendations are by the nursing staff communicating that to them. And also the consult would be contacting them to give their recommendation.
Q. I understood when you used the word -- maybe I was wrong -- that when you used the word oversee, you meant supervise. The internist doesn't supervise the specialist --
A. No.
Q. -- does he?
A. No. I don't mean oversee as supervise, but to oversee

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meaning be aware of what the specialist is recommending.
Q. Have you ever cared for a patient with a diagnosed shear fracture of the thoracic spine?
A. Yes.
Q. On how many occasions?
A. I'm not sure.
Q. Less than five?
A. I'll say less than 10, I think. I think less than 10.
Q. Okay. Are shear fractures -- do you see more -- do you more frequently see -- strike that.
Do you see compression fractures more than you see shear fractures?
A. Yes.
Q. Are compression fractures much more common than shear fractures?
A. Yes, they are.
Q. If you know, do you know whether simply because a patient has a shear fracture that means it is an unstable fracture?
A. Correct. Yes.
Q. Okay.
MR. SWEET: So that I'm clear -- the way the question was asked wasn't clear. Are you testifying that your training is that all shear fractures are and

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have to be considered unstable?
A. I understand that all shear fractures are considered unstable; but when I see the diagnosis of a shear fracture, I speak with the physician to inquire about the stability of the fracture. I always do that.
Q. And have you ever been told that a -- by a doctor that a shear fracture may not be unstable?
A. I don't believe so. Because perhaps in that case maybe the patient was already stabilized.
Q. All right. Let's move on. I think we have covered most of No. 3 in the designation.
All right. During -- that paragraph refers from 10/24 to 10/27. My questions go -- are for -- let's take -- up until the last time Dr. Hersey sees Ms. Tripp on October 27, he sees her at some point in the afternoon; and a decision is made about transfer, correct?
A. Yes.
Q. Prior to that, did doctors do neurologic assessments of Ms. Tripp?
A. Partial evaluations were done.
Q. All right. And the doctors were Dr. Korkut and Dr. Hersey, correct?
A. No. Actually, Dr. Hersey.
Q. Okay. Dr. Korkut -- in your review of the records

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Dr. Korkut didn't do any neurological assessments of her?
A. According to his deposition and the medical record he stated that he deferred to Dr. Hersey's evaluation.
Q. Okay. When Dr. Hersey did neurological assessments between the 24th and the 27th up until the last time, did he find anything abnormal in his evaluations?
MR. LAVOIE: I just object, Dan. You're asking did he chart anything abnormal, correct?
MR. RAPAPORT: Yes.
Q. Based on his deposition and his records actually did he chart or did he state that anything was abnormal?
A. Well, he admitted to not performing a full examination of her.
Q. Okay.
A. So he did not chart there to be anything abnormal.
Q. Didn't he write neurologically intact in his notes?
A. Yes.
Q. And what does neurologically intact mean to you?
A. Well, what it should mean is that the patient has good color, sensation and movement, strengths, pulses, capillary refill.
Q. Meaning no neurological problems?
A. That's what it should mean; that's correct.
Q. Okay. Do you have an opinion whether if the complete

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neurovascular assessments that you say should have been done were done by the nurses between October 24 and the afternoon of October 27, there would have been any neurological abnormalities found?
MR. LAVOIE: At what point in time again, Dan?
MR. RAPAPORT: Again, between time of admission and the last exam by Hersey.
A. I believe there would have been.
Q. When?
A. I believe on October 26.
Q. Morning or afternoon?
A. In the morning.
Q. All right. Why?
A. Because the patient was having new symptoms during this time. And you certainly want to catch the patient at the very beginning of having any neurovascular changes. So then the best outcome can be had.
Q. What were the new symptoms?
A. Well, prior to the MRI she was having muscle spasms. And after the MRI, she was having severe pain and electric shocks.
Q. Were muscle spasms new on the 25th in the morning before the MRI?
MR. SWEET: 26th in the morning.
MR. RAPAPORT: 26th, I'm sorry. Thanks, Jay.

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A. Yes.
Q. All right. Is it your opinion that the muscle spasms were a -- are they a sign or a symptom?
They're a symptom, muscle spasms? Is that right?
A. It could actually be both.
Q. All right. Is it your opinion today that the muscle spasms on the morning of the 26th were signs or symptoms of a deteriorating neurological condition?
A. That may have been.
Q. Okay. Because muscle spasms can be a sign or symptom of other conditions besides deteriorating neurological condition, correct?
A. Yes. Specific to an area. And there wasn't documentation to state exactly where the muscle spasms were.
Q. What -- what other conditions can muscle spasms be signs or symptoms of besides deteriorating neurological condition?
MR. LAVOIE: Let me object, Dan. The problem I have with the question is we really don't have a locus for the muscle contractions that I'm aware of. And I think it probably depends on where they are in terms of what they signal.
MR. RAPAPORT: I'll clear it up.
Q. In a patient with a -- with complaints of back pain,

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first of all, muscle spasms in the back, would those be signs and symptoms of medical conditions other than a deteriorating neurological condition?
MR. SWEET: Just so that I'm clear, you're asking her to rule out the fact that this patient was admitted for a suspected spine fracture?
MR. RAPAPORT: No, I'm not asking her to rule out anything.
MR. SWEET: So you're saying patients with a suspected spine fracture who are experiencing muscle spasm, whether in those patients the muscle spasm could be due to something other than the suspected spine fracture? That's the question?
MR. RAPAPORT: I'll accept that question.
A. Well, that's something that I as a nurse would take that information and speak with the physician. I'm not making the diagnosis.
Q. That wasn't my question or his question.
We have a patient with a suspected spine fracture, thoracic spine fracture, who complains of muscle spasms in the thoracic spine. Can -- I take it you have an opinion that those can be related to a deteriorating or -- strike that -- caused by a deteriorating neurological condition?
A. Yes.

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Q. Can they be caused by any other conditions?
A. Possibly.
Q. What?
A. Muscle strains.
Q. Anything else?
A. Not that I can think of.
Q. Okay. Now, let's take if the complaints are -- same patient, same suspected thoracic spine fracture -- spasms in the low back. What could those be caused by?
A. From deterioration of the -- or -- excuse me, involvement of the spinal cord at that time.
Q. Okay. How about muscle strain?
A. Possibly.
Q. Anything else?
A. No.
Q. Okay. How about muscle spasms in the leg, same patient, same suspected diagnosis, causes -- possible causes?
A. Possible causes would be from the spine, impact of the spinal cord.
Q. Anything else?
A. No.
Q. Same questions for -- now, just substitute electric-like shocks down the legs for muscle spasms.
A. Okay.

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MR. SWEET: So that we're clear, you're talking about electric shocks down both legs with movement, okay when lying still?
MR. RAPAPORT: What are you reading from? I'll take from it the nurse's notes when she gets back.
MR. SWEET: I'm reading from the nurse's narrative note on the morning of October 26, 2001.
MR. RAPAPORT: What page is that, Jay, just so I'm --
MR. SWEET: I think it's 75. But I can find it for you.
77, Dan.
MR. RAPAPORT: Okay. I have got it at page 80.
MR. SWEET: No. 0900 -- this is page 77, Christine Gallagher. Back from MRI. In severe pain. Complaint of electric shocks down both legs with movement. Okay when lying still.
MR. RAPAPORT: Okay.
BY MR. RAPAPORT:
Q. Do you have that?
A. Yes.
Q. All right. And we -- with this patient with the suspected diagnosis, possible causes?
A. Involvement of the spinal cord.

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Q. Neurological deterioration?
A. Yes. This is neurological deterioration.
Q. All right. All right. Could it be caused by something other than neurological deterioration in your opinion?
A. No.
Q. Is it your opinion that with a patient like Ms. Tripp increase in pain severity was caused by neurological deterioration?
A. Yes.
Q. Can that be caused -- in a patient like Ms. Tripp with the suspected diagnosis have other causes?
A. No.
Q. Can you tell from the records or from the deposition of Nurse Gallagher whether any -- any neurological, either partial -- we know it wasn't complete in your opinion; but was any neurological assessment done of Ms. Tripp after 9 o'clock in the morning on October 26?
MR. SWEET: Dan, I'm just going to object to the form of the question. Are you asking whether any neurological assessment was done on October 26 after 9 o'clock in the morning?
MR. RAPAPORT: Let me rephrase it.
Q. She made an assessment at 9 o'clock in the morning which we just read, correct?
A. Yes.

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Q. And in your opinion was that a partial neurological assessment?
A. Yes. You're assessing the pain.
Q. Okay. Did she make any neurological assessments after that on the 26th?
A. Well, she documented sensation and motion in legs intact.
Q. At what times?
A. And that was at 9:20 a.m.
Q. How about after that, any neurological assessments by her on the 26th?
A. At 6 o'clock she addressed that there were spasms. And 6:30 she stated that there were more spasms.
Q. So those were partial neurological assessments?
A. Well, complaint of spasm.
Q. Is it -- did you assume that Ms. Tripp after 9 o'clock on the 26th continued to have electric-like shocks going down her legs with movement?
A. I believe that she had them a few times, yes.
Q. Is it documented that she had them a few times after 9 o'clock?
A. In her deposition she made reference to this -- to them being -- I forget her words. I don't know if it was every so often or a few times, but something like that.
Q. Did you get the impression -- well, did you form an

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impression as to whether Ms. Tripp had a good memory of her hospitalization at TAMC?
A. Well, she remembered some, certainly not all.
Q. Did you form an impression whether it was a good memory?
A. Well, I don't know if I can quantify that she had a good memory.
Q. Okay. It's true, isn't it, that just because Ms. Tripp had complaints of electric-like shock sensations at 9 o'clock in the morning of the 26th, she may not have had those complaints when she was assessed later; isn't that right?
A. Well, actually there were two notes related to electric shocks. So I'm assuming that she did have them and -- according to Christine's deposition.
Q. So --
A. Sorry. What's your question?
Q. The question is just because she had them at one point she may not have had them every time she was assessed afterwards?
A. That's true.
Q. All right. We know from Christine Gallagher's deposition that on the morning of the 26th after the patient returned from MRI, she spoke with Dr. Hersey, correct?

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A. Yes.
Q. And from looking at the record and the depositions, was there any -- did you have an understanding was there any intervention with regard to the electric-like shock complaints after they were reported to the doctor by either the doctor, the nurses, anyone?
MR. SWEET: Well, Dan, I just want to -- I just want to object to form because, as you know, Nurse Gallagher has testified under oath that she told Dr. Hersey about this symptom; and Dr. Hersey has testified under oath that he was not told.
MR. RAPAPORT: I believe he testified he didn't remember.
MR. SWEET: Okay. So I just -- just for the sake of clarity, I don't want you to assume facts that have really not been established.
Q. This is what I'm getting at. And, again, what I'm getting at is it's your opinion that the nurses didn't meet the standard of care when they told Dr. Hersey because they should have told other people, correct?
A. Yes.
Q. All right. Move it along. If -- if -- if -- assume she told the doctor -- the orthopedic surgeon and he didn't do anything with regard to that complaint. Just assume it. I'm not saying it's true or not true. Did

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the standard of care require the nurse to do other things?
A. Yes.
Q. What?
A. Contact Dr. Korkut, contact the charge nurse and keep going and utilize the chain of command in nursing because as a nurse, we know that when there are significant changes, time is of the essence. We need the patient to be evaluated. Also included in that the nurse should have specifically asked Dr. Hersey to come in the room and evaluate the patient.
Q. During our break I looked at the yellow sticky that you had written with your additional opinions. You had the word advocate written; is that right?
A. Yes.
Q. Does that come into play in this portion of your opinion?
A. Yes.
Q. Explain to me what your opinion is as to whether or not you believe the nurses should have acted as an advocate for Ms. Tripp and what they should have done?
A. The nurses have a duty to act as an advocate for a patient. Each nurse has a duty to care for the patient in a holistic manner from head to toe and communicate any and all changes to the appropriate people. And if

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there isn't -- if they're not getting the response that is -- that is needed, they need to continue and advocate for that patient. And that would include utilizing the chain of command.
Q. Do you know what the chain of command was at this hospital?
A. Well, the chain of command at this hospital or other hospitals is very similar.
Q. And what is it?
A. And that would be to go to your charge nurse, your head nurse, nursing supervisor. Different facilities have different overseers in nursing. And also request that the physician in particular come in and do an evaluation on the patient and inform the admitting doctor.
Q. And if the physician doesn't or refuses, does the nurse -- does the standard of care require the nurse to do something else?
A. Continue on to find -- continue on to find somebody to come in and evaluate the patient because you're most concerned about this patient who has new symptoms.
Q. Ultimately in the chain of command that exists at this hospital -- at the Aroostook Medical Center or any other hospital, ultimately is the -- the decision to -- would the decision to do more with respect to

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the type of complaints that Ms. Tripp had at 9 a.m. on the 26th -- ultimately would that decision to do more be a decision by a doctor, to go up the chain of command?
A. I don't think I understand the question because --
Q. Let's take -- let me -- a decision to transfer. If the intervention should have been -- and, again, I'm not asking you -- if the intervention should have been that Ms. Tripp be transferred out of Aroostook Medical Center on October 26, would that decision be made by a doctor?
A. Yes. And/or the nursing supervisor or head of nursing for the hospital.
Q. The nursing supervisor or head of nursing can make that decision?
A. The nursing supervisor can speak with the physician and make that recommendation.
Q. But a recommendation isn't the same as a decision, is it?
A. No.
Q. The decision would ultimately be made by the doctor?
A. Yes.
Q. All right. Is it correct that nurses can't force a doctor to do anything?
That's a bad question. A nurse can't force a

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doctor to transfer a patient, correct?
A. Correct.
Q. A nurse can't force a doctor to come into a room and see a patient, can she?
MR. SWEET: He or she, you mean?
Q. She.
A. You can't force a physician to evaluate a patient. But if you go with a comprehensive analysis of your patient and explain the reasons why you would want the physician to come in, I would think the physician would go in and evaluate the patient.
Q. Do you agree that it's the physician's job to seek to verify a patient's complaint by establishing the cause and treating it?
MR. LAVOIE: Objection, form and foundation.
A. Can you repeat that, please?
Q. Do you agree it's the physician's job to seek to verify a patient's complaints by establishing the cause and treating it?
A. Well, I think both nursing and physicians can do that together.
Q. A collaborative effort?
A. Yes.
Q. It's the nurse's job to report the patient's complaints to the doctor?

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A. Yes.
Q. And you're saying they both have a role in finding out what the cause is?
A. Yes.
Q. And they both have a role in treating it?
A. Yes.
Q. I think I'm done with No. 4. But just let me --
(Discussion off the record.)
Q. In your legal nurse consultant -- in the American Association of Legal Nurse-Consultants, are there any LPN's who are a member?
A. No. There are not.
Q. Do you have LPN's working at Mass. General in your department?
A. We did. No longer.
Q. When did that change?
A. A few years ago.
Q. Do you know the reason?
A. Yes. Mass. General Hospital wanted to have an all RN staff.
Q. Okay. Paragraph 5, what is your basis for your opinion that the nursing staff assisted in attempting to stand Ms. Tripp to fit her back brace?
A. Because of the documentation that the nurse had written in there.

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Q. And you're referring to -- well, is it page 75 you're referring to?
A. 79.
Q. 79.
A. Yes.
Q. And what does -- since I have written over it, what -- I put a yellow Hi-Liter. What does that say?
A. Stood five minutes with physical therapy. Attempted to fit brace. Unable to tolerate.
Q. So what in there leads you to the conclusion that the nurses helped with that?
A. The fact that the nurse is documenting that, and she knew the time that the patient was standing with the physical therapist.
Q. Didn't Christine Gallagher say in her deposition she was out of the room when physical therapy was there?
A. I can't remember.
MR. SWEET: Do you want to give us a -- do you want to give us a cite, Dan?
MR. RAPAPORT: That's okay.
Q. Well, do you remember -- you don't remember if she testified to that?
A. She stated something, but then I thought she stated that she didn't --
Q. That's okay. That's all right if you don't remember.

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My question is if she weren't in the room when physical therapy did what they did on the 26th, you wouldn't be critical of the nurse, correct, in that -- for that No. 5?
A. I would be critical of her for not telling the physical therapist not to get her out of bed. If she was aware that the physical therapist was there to evaluate the patient, I would be critical that she did not inform the physical therapist not to get her out of bed.
Q. Okay. Was there a doctor's order to get her out of bed to fit her for the mold --
A. There --
Q. -- brace?
A. There had been a conversation that -- that was documented.
Q. Not a conversation. Was there a doctor's order that she be fitted for a brace?
A. Yes.
Q. And that includes getting out of bed?
A. Well, yes.
Q. Okay.
A. Because the physical therapist contacted the physician to ask permission for that.
Q. So with the doctor's order that the patient be fitted for a brace, what did the standard of care require the

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nurse to do on October 26?
A. Speak with the physician to explain the amount of pain that the patient was having just with mobilizing. And you wouldn't take somebody who is having severe pain and these new neurovascular changes and try to get them out of bed.
Q. Okay. Did you read the physical therapist's deposition?
A. Yes.
Q. And she said she didn't get the patient out of bed, correct?
A. Well, she stated that she was relying on her documentation.
Q. Which -- is that right?
Okay. That's your memory. I'm sorry.
You also write in paragraph 5, it was a breach of the standard of care for the nursing staff to fail to contact the admitting physician and the orthopedic consultant in the face of Beverly's complaints of severe radiating pain on the afternoon of 10/26.
A. Yes.
Q. All right. Do you have any memory of whether the doctors -- any of the doctors were aware of her complaints on October 26?
A. I know that there was a question with the pain

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medication. And Dr. Hersey wrote additional pain medication orders on that day.
Q. Okay. On the afternoon of the 26th?
A. Yes. But the treating nurse did not speak with him.
Q. All right. Physical therapist did? Correct?
A. On that afternoon?
Q. It's page 52.
MR. SWEET: In the narrative notes.
MR. RAPAPORT: That's the morning, right?
MR. SWEET: No, no, no. It's morning.
Dan, the point here is that the evaluation which is pages 49, 50 and 51 was completed on the afternoon of October 26.
MR. RAPAPORT: I understand that.
MR. SWEET: Okay. Is that -- I mean, is that the question?
MR. RAPAPORT: No. I'm going to withdraw the question.
BY MR. RAPAPORT:
Q. I'll summarize this. For No. 5, I take it what you're saying is that based on your review of the records of the depositions that while -- well, let me ask you this. Were there times during Mrs. Tripp's hospitalization at TAMC from the 24th to the 27th that Drs. Korkut, Hersey, both, were aware of the

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significant signs and symptoms that she had in your opinion?
A. There were times.
Q. And what you're saying is that there were times that she had these signs and symptoms where the doctors weren't made aware?
A. Correct.
Q. At that time?
A. At that time or even around that time, yes.
Q. And you don't know -- well, strike that.
Are you assuming for the purposes of your opinions in this case that PT or nursing or both actually got Mrs. -- Ms. Tripp out of bed, on the floor, on her feet -- standing on her feet?
MR. SWEET: I'm going to object to the form of the question to the extent it uses the word assuming. And I would point out that we have detailed testimony under oath as to what was done by the physical therapy department on the afternoon of the 26th.
Q. You can answer.
A. I believe that she did get out of bed.
Q. And do you -- are you -- have you formed any opinions as to whether that -- well, how long she was out of bed?
First of all, how long was she out of bed based on

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your review of the records?
A. Five minutes.
Q. And did that in your opinion cause any permanent harm to her?
A. Yes.
MR. LAVOIE: Hold on a second. I object as this being well outside the scope of the competence of this witness.
No offense, Nurse Levin, but I know you're not a neurosurgeon who ought to be commenting on these topics.
Thank you.
Q. You can answer.
MR. SWEET: She answered. The answer was yes.
MR. RAPAPORT: Okay. Sorry.
MR. SWEET: It caused permanent harm.
MR. RAPAPORT: All right.
BY MR. RAPAPORT:
Q. Paragraph 6 refers to the morning of the 27th, correct?
A. Correct.
Q. When Nurse Lentz was on?
A. Yes.
Q. And he failed -- in your opinion he failed to conduct any neurological examination. And your basis is the -- is both the record and his deposition?

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A. Yes.
Q. Okay. He gave medication -- 8 mg's of morphine sulfate IV at 7:25 and again at 10:30?
A. Yes.
Q. And, again, was that a breach of the standard of care by the nurse?
A. Yes.
Q. Was there an order that permitted him to do that?
A. Yes.
Q. Why was it a breach of the standard of care for him to do that?
A. Because according to the hospital policy, the nurse has a responsibility to question orders. And to administer 8 milligrams of morphine in IV push is not appropriate for a patient on a floor unit that is not being monitored by telemetry and oxygen saturations. The nurse needs to be aware that the route of IV, IM or subcu, there would be different doses administered to differentiate between the two. And, thus, you would not be administering 8 milligrams of morphine IV.
Q. When you say the nurse needs to question that order, who would the nurse question?
A. The nurse should know from education and training that you would not be administering that amount. You can contact your nursing supervisor if you have questions.

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And also, you can contact the physician to clarify the order for an IV medication.
Q. You used the term needs to question. Were you saying needs to question him or herself or is required to speak with someone else?
A. He's required to speak with somebody about that.
Q. Who?
A. The nursing supervisor as well as the physician.
Q. And ultimately the decision of whether or not these medications are appropriate would be the doctor's -- a doctor's?
A. It may be appropriate, but under -- being a nurse, you don't administer 8 milligrams of morphine at once because you know what the countereffects can be.
Q. But there was an order that permitted the nurse to do that?
A. There was an order stating that.
Q. Okay. So, again, if the nurse questioned her nursing supervisor and the doctor, the ultimate decision of whether the medication could be administered, 8 mg's, would be the doctor's, right?
A. No, actually.
Q. No, it wouldn't?
A. Not according to the hospital policy.
Q. It would be the nurse's?

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A. That if the nurse did not feel comfortable giving a medication or in that dosage, you need to go further.
Q. And the standard of care is that the nurse shouldn't have felt comfortable?
A. The standard of care is that it -- would be that this nurse would question this order and give a smaller dosage of this medication and contact -- obviously speak with the physician, speak with your nursing supervisor to find out what the hospital policy is for administering this medication.
Q. And you may have said this, and forgive me for not remembering. But why is it inappropriate to give this dose, this amount?
A. This is a large amount of medication which can cause respiratory depression and hypotension.
Q. Well, did it?
A. Well, I don't know. We know that she didn't respiratory arrest; but, certainly, she went to sleep until -- for the rest of the time until her next dose.
Q. So it's an inappropriate amount because it can cause respiratory depression and/or hypotension?
A. Correct.
Q. Any other reasons why it's inappropriate?
A. The patient isn't being monitored.
Q. For neurological signs or respiratory or --

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A. No. Oxygen saturation and telemetry.
Q. We don't know what that monitoring would have shown, correct?
A. Correct.
Q. Was a neurological assessment done by -- of Ms. Tripp done by a doctor on the morning of 10/27?
MR. RAPAPORT: Off the record.
(Discussion off the record.)
A. There really wasn't a neurological evaluation.
Q. How do you know that?
A. Because Dr. Hersey stated he had -- he had asked her if she was having any more--- I'm trying to think what he said.
MR. SWEET: If you have a question about what he said, the thing to do is to find his deposition and refresh your recollection.
A. Okay. I'm sorry, what was the question?
Q. Did a doctor do a neurological assessment of Ms. Tripp on the morning of October 27?
A. I don't know.
Q. Okay. Dr. Hersey documented that he did -- well, strike that.
Dr. Hersey documented that Ms. Tripp was neurologically intact, didn't he?
A. Yes, he did.

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Q. Okay. My question is if the nurses -- if the nurse on the morning of October 27 had performed the type of neurological assessment that you say he should have performed, would that have -- do you have an opinion whether that would have been a positive or shown abnormal findings?
MR. LAVOIE: Objection, form and foundation.
A. I believe this would have been abnormal. And during this time the patient was sleeping.
Q. Why do you believe it would have been abnormal?
MR. LAVOIE: Same objection. Dan, can I just have a continuing objection to this?
MR. RAPAPORT: Sure.
MR. LAVOIE: As far as I'm concerned, any question having to do with medical causation is not within the scope of her designation or her competence. And rather than make an objection to every question you ask --
MR. RAPAPORT: That's fine.
MR. LAVOIE: -- if we can agree that I have a continuing objection.
MR. SWEET: Do you remember the question?
THE DEPONENT: Oh, I thought I answered it.
MR. SWEET: No. The pending question is why you believe that a detailed neurological assessment on the morning of October 27 would have revealed neurological

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abnormalities.
A. Because the patient was showing signs of neurological deterioration beginning on the 26th. And certainly, on the 27th as the day progresses, nurse --
Q. 26th was Gallagher; 27th was Lentz.
A. -- Mr. Lentz stated he was unsure exactly how long the changes -- how long he had noted them for.
Q. Okay. In the designation, paragraph 6 --
A. Thank you.
Q. That's all right -- at the bottom of the second page, it's written, use of morphine sulfate made it impossible to conduct any meaningful evaluation of Ms. Tripp's neurovascular status on the morning of the 27th.
That's what it says?
A. Yes.
Q. Is that your opinion?
A. Yes.
Q. So if -- if Mr. Lentz had done a complete neurovascular assessment on the 27th, given the amount of medication she had, he wouldn't -- would he still in your opinion be able to find deterioration?
MR. SWEET: Object to form, Dan. Do you mean before -- if he had done a complete neurological exam before he gave her 8 milligrams of morphine sulfate IV

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push?
MR. RAPAPORT: She's already answered that. I'm talking about after.
MR. SWEET: Oh, after he put her in a coma would it have been a useful examination?
MR. RAPAPORT: I strenuously object and move that the word coma be stricken.
MR. LAVOIE: I don't strenuously object, but I do object.
MR. RAPAPORT: Let me withdraw the question. Let's move on.
BY MR. RAPAPORT:
Q. The last page of the designation says you will continue to review information as it becomes available. And you have already told us the additional stuff you have gotten since then, correct?
A. Correct.
Q. Now, the additional opinions that are written on the yellow sticky, go ahead and -- why don't you read that yellow sticky for us. I think we have addressed most of it.
A. Okay. Pain level, communication, advocate, morphine, neurovascular checks, see LPN and RN depositions, chain of command, documentation, failure to follow physician orders, nursing process, policies and procedures for

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the facility, care plan.
Q. Okay. I think we have addressed those -- is there anything on there that we haven't addressed?
A. Documentation and failure to follow physician orders.
Q. Okay. Tell me -- talk to me -- tell me about documentation and where you believe there were nursing care deviations -- nursing deviations in the documentation.
A. Well, you need to document in full the care rendered to a patient during the day. And the documentation also follows the plan of care that we discussed further. And you would be utilizing that plan of care in your nursing documentation.
Q. And in what way did the nurses fail to follow a physician's order?
A. There were specific orders written to do blood sugars twice a day. And that was not always done. Also --
Q. Holds on. Excuse me. On either the 25th or 26th, were they done twice a day, the blood sugars?
A. Oh, I would have to go back through.
Q. Let me --
A. A couple times they were during the hospitalization. Other times they were not.
Q. Okay. The only -- there were just two -- she was there two full days, two -- she was there part of the 24th,

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all the 25th, 26th and part of the 27th, right?
A. Right.
Q. All right. What other -- any other doctor's orders besides the blood sugars?
A. Yes. There were orders relative to the Tylenol with codeine. There were p.r.n. orders and the -- excuse me, they were not following the physician orders relative to that.
Q. What was the order -- orders relative to Tylenol with codeine?
A. She was written to have Tylenol No. 3 as a one-time order and also -- excuse me. Let me just find the order.
Q. Yes. When you find it, if you can give us the date and time.
A. Okay.
MS. ACKER: Page 38.
A. She was written to have Tylenol No. 3 --
Q. Are we right; is it 38?
A. Yes -- 37 and 38 and 39 -- oh, excuse me, 37 and 38.
Q. Okay.
A. She was written to have the Tylenol No. 3 every four to six hours. And that was written at 2205. And then was given a one-time order at 020 for one time of Tylenol No. 3 at that time. And then in the morning --

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Q. On the 25th?
A. -- was told that she could have Tylenol No. 3, two pills at that time as a one-time order. So she actually had it at -- it was administered at --
Q. Can you tell us what was supposed to have been done and what was done?
A. Right. It was given at 015, Tylenol No. 3, one pill. 0430, one pill. 0630, two pills. So she ended up having overlapping times with her Tylenol No. 3.
Q. Are you saying she was given it more frequently than she was supposed to?
A. Yes.
Q. How many times did that happen?
A. She was also given it at 2220 on the 24th. So just to go back. So she had been given -- she had been given extra doses in between the times that she was able to have the regular doses.
Q. How many times was she given extra doses?
A. At 015.
Q. Once.
A. And 0630.
Q. Twice?
A. Yes.
Q. Okay. Any other -- any other ways they failed to follow doctor's orders?

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A. Yes. The blood sugar that was done on 10/25 at 030. The blood sugar was 308. This was not reported to the physician until 0630 to then be able to be treated.
Q. Okay.
A. The Darvocet order was incomplete; and so the nurses had a responsibility to go back and have that -- that order clarified as to how many pills would be administered.
Q. What Darvocet order?
A. Darvocet N 100.
Q. Ordered by Dr. Korkut or Dr. Hersey?
Are you still on page 38?
A. Yes.
Q. Okay. So the order at 0945?
A. Yes.
Q. Anything else?
A. No. I don't think so.
Q. Okay. What -- what -- what is the other -- what are on the other three yellow stickies?
A. Oh, I wrote needed to speak with Dr. Korkut regarding getting the patient out of bed. No one told Dr. Korkut after patient out of bed with physical therapy complaints of pain. I wrote, communication delayed in reporting the blood sugar. Need to clarify the Darvocet order. I wrote my times for the Tylenol and

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wrote down referral to EMMC and then vital signs on 10/27.
Q. What about the vital signs on 10/27?
A. The patient's blood pressure systolically was greater than 200 at 7:30 in the morning. And, thus, you need to follow up and contact the physician and tell your charge nurse that you have a patient whose blood pressure is that high.
Q. Are you able to tell what happened to the patient's blood pressure for the rest of the time she was at the hospital on 10/27?
A. Subsequent vital signs, the patient's blood pressure after receiving pain medication was coming down.
Q. Okay. All right. We have -- have we covered all your additional opinions?
A. I have one other. But this is --
Q. Please.
A. But this is something I don't have the policy for. And that would be the responsibility of the nurse discharging the patient to a new facility as to what the requirement is at -- at TAMC for documentation of a nursing referral to transfer the patient.
Q. Is there a policy at your hospital for that?
A. Yes, there is.
Q. What is it?

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A. That we would write a full history of the patient and give the nursing plan of care. Now, in this facility in the policies and procedures for TAMC, they talk about a note being written by the nurse when they're transferring a patient to another unit in their own facility. So I don't know what it is to transfer a patient out of the facility.
Q. Okay. Have we now covered all your opinions?
A. Yes. I believe so.
Q. Okay.
MR. RAPAPORT: Can you mark this, please, Claudette.
(Deposition Exhibit No. 10 was marked.)
MR. SWEET: I just want to say for the record that we're still waiting to get the complete nursing policies and procedures from the Aroostook Medical Center. And when we finally do obtain them, Nurse Levin will review them and may have additional opinions. And we will notify counsel if that proves to be the case.
BY MR. RAPAPORT:
Q. Very early on we were talking about your business as a legal nurse consultant. And I think you said or were implying that testifying as an expert witness is just one of the things you do as a legal nurse consultant?

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A. Yes. That's correct.
Q. What other things do you do in your business as a legal nurse consultant?
A. I attend independent medical exams, I do research on various topics. At times I locate experts, not often, though. I spend a lot of time doing research and education.
Q. Okay. Who hires you to attend independent medical exams?
A. Attorneys do.
Q. And the same with research, attorneys hire you to do that?
A. Yes.
Q. And locate experts?
A. Yes.
Q. Who hires you to provide education?
A. Attorneys do.
Q. Education to whom?
A. To attorneys.
Q. To consult?
A. Yes.
Q. And maybe not testify?
A. Yes. One thing I didn't include -- and I apologize -- I also attend court mediations.
Q. Again, attorneys hire you for that?

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A. And a judge.
Q. A judge?
A. Yes.
Q. Okay. And when you're hired by a judge, what is your role at a court mediation?
A. I was there to educate both parties about the issues.
Q. Okay. Have you been hired by a judge to attend a court mediation more than once?
A. No.
Q. Okay. What's -- was that in Massachusetts?
A. Yes.
Q. What -- do you remember -- when was that; what year? Was it within the last few years?
A. No. A longer while.
Q. Is your husband a lawyer?
A. Yes, he is.
Q. How much --
MR. SWEET: Not that there is anything wrong with that, right, Dan?
MR. RAPAPORT: No, not at all.
Q. You provided us -- this came with your documents. This is Exhibit 10. It's a document entitled Cases Testified.
A. Correct.
Q. Are those cases you -- what is that?

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A. I testified in a federal case, and they requested a list of a couple years' worth of cases that I participated in.
Q. When did you prepare this list?
A. Last year, last summer.
Q. Okay. That list -- that document doesn't contain all of the cases in which you have testified as an expert witness in a professional negligence case, correct?
A. Correct.
Q. Okay. I think we have -- there are -- I think we counted 18 cases on there. Do you have -- do you know the number of how many cases you have testified either in court or by deposition in a professional negligence case?
A. At trial, it's a small amount. Less than five.
Q. All right.
A. I believe. Right, less than -- less than five.
Q. How about deposition?
A. I believe a little bit more than 20.
Q. Okay. On your list of cases testified that you just provided to the federal court, in any of those cases did you testify on behalf of a defendant?
A. Yes.
Q. Which one?
A. Benson versus Memorial Hospital, Cannatella versus West

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Boca.
Q. West Boca?
A. Yes.
Q. That's a Florida case?
A. Yes. Hanson versus Agassiz Village.
Q. What -- is that -- what state was that?
A. Here in Maine.
Q. Is Agassiz Village on Thompson Lake?
Strike that.
A. And Grimes versus Hancock.
Q. What state was that?
A. Georgia.
Q. Okay. Georgia. And you have given testimony in cases in Massachusetts?
A. Yes, I have.
Q. New Hampshire?
A. Yes.
Q. Texas?
A. Yes.
Q. West Virginia?
A. Yes.
Q. Virginia?
A. Yes.
MR. SWEET: All the states that are on that list.
Q. Oklahoma?

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A. Yes.
Q. Pennsylvania?
A. Yes.
Q. Rhode Island?
A. I don't know if I have testified in Pennsylvania.
Q. Okay. Reviewed cases --
A. Yes.
Q. -- out of Pennsylvania?
A. Yes.
Q. How about Rhode Island?—
A. Yes. But I haven't been an expert in Rhode Island.
Q. Okay. Any other states that you have testified in cases or -- you mentioned Maine and Georgia. Any other cases -- any other states?
A. New Mexico.
I don't know. I would have to look over a list.
Q. Okay. There may be others?
A. Yes.
Q. How many years have you been testifying as an expert witness?
A. I think since 1995.
Q. Okay. And since 1995 can you tell us what the percentage breakdown is between plaintiffs and defendants?
A. For reviewing a case as an expert it -- as an expert

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versus anything else that I work on?
Q. Let's start with experts.
A. Okay. I review 50 percent plaintiff, 50 percent defense.
Q. How about attending IME's?
A. I'm hired most of the time by the plaintiff attorneys. But there have been times I have been hired by the defense attorneys.
Q. What's the breakdown, 90/10, 80/20?
A. Probably 90/10.
Q. Research?
A. Equal.
Q. Locating experts?
A. Equal. I don't do that very much. I really prefer not to do that anymore.
Q. And education?
A. Both.
Q. Is this -- have you reviewed any other cases for the law firm of Berman & Simmons?
A. No, I have not.
Q. Are you familiar with the Textbook of Medical-Surgical Nursing by Brunner and Suddarth, S U D D A R T H?
A. I know of it.
Q. Is that a -- do you know whether that's a textbook used in nursing schools -- some nursing schools?

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A. Perhaps some.
Q. Was it used in yours?
A. No, it was not.
Q. Do you consider that textbook authoritative in the field of medical-surgical nursing?
A. Well, since I, myself, have not reviewed it, I would not agree to that.
Q. Don't know?
A. Correct.
Q. Your CV --
(Discussion off the record.)
Q. -- on page 2, the present -- well, page 2, my copy, the presentation section, any presentations -- any of those presentations deal with any of the issues that we have talked about today that you have had opinions on?
I'm looking for, like, the conference on orthopedic trauma, lower extremity injuries.
A. No. That was specific lower extremity.
Q. Okay.
A. But certainly the topic of neurovascular assessments was addressed.
Q. In that -- in that presentation?
A. Yes.
Q. Okay. Did you prepare something in writing for that presentation?

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A. Yes, I did.
Q. Do you still have it?
A. Oh, no.
Q. Okay. May 1997, speaker, Florida Legal Nurse Consultants, complications with orthopedic injuries. Would that deal with some of the issues?
A. Yes.
Q. Same question, did you prepare something in writing; and do you have it?
A. I don't have it.
Q. Any other presentations?
A. Legal issues in orthopedic nursing for the NAON conference.
Q. What date is that?
A. April 1999.
Q. Legal issues in orthopedic nursing?
A. Yes.
Q. Did you prepare something in writing?
A. Yes, I did.
Q. Still have it?
A. No, I don't.
Q. NAON is --
A. National Association of Orthopedic Nurses.
Q. Is that it for the presentations?
A. For formal presentations, yes.

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Q. Okay. I think I'm done. I'm just going to take a couple minutes and look at my notes if you want to stretch.
(Discussion off the record.)
(A short recess was taken.)
BY MR. RAPAPORT:
Q. Do you recall on October 24 how Ms. Tripp was transported from the emergency department to the floor?
A. Yes.
Q. How?
A. In a wheelchair.
Q. Okay. You -- in your -- you still accept patients from emergency departments when you're working at the Mass. General?
A. Yes, I do.
Q. Are there other ways that a patient can be transported from the emergency department to the floor?
A. Yes.
Q. What are the other ways?
A. In a stretcher.
Q. Okay. You have received patients on the floor who have unstable fractures?
A. Yes.
Q. In your experience when a patient has an unstable

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fracture, how is the patient -- in the emergency -- from the emergency department, how is the patient transported from the emergency department to the floor?
A. On a stretcher.
Q. Is it an indication to you that -- is it an indication to you as an experienced orthopedic nurse accepting a patient on the floor that if a patient is transferred from the emergency department by wheelchair, is it an indication to you that someone from the emergency department feels that the patient's condition is stable?
MR. SWEET: I'm going to object to form, Dan. The -- the emergency department isn't the one that arranged the transfer. It's Dr. Korkut. He came and did the admit. So the question is misleading and I think intentionally misleading. Dr. Korkut is the one who made the treatment decision here. And you represent him, so you know that.
MR. RAPAPORT: Well, I -- nothing is intentional in that question.
BY MR. RAPAPORT:
Q. Is it an indication to you, a nurse, that whoever makes the decision how the patient is transferred, when it's done by wheelchair rather than stretcher, that the patient is stable?

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A. No. That's not an indication.
Q. Why?
A. Because I don't know who placed the call to obtain the transportation to transport the patient up to the floor. It could have been the secretary who did that versus a health care provider.
Q. Okay. Do you have -- I don't think I need it.
Do you hold certain certifications?
A. Yes, I do.
Q. What certifications do you hold?
A. I have my ONC, which is my orthopedic nurse certification, and my LNCC, which is my legal nurse consulting certification.
Q. How does an orthopedic nurse become certified?
A. You have to work so many hours within the field and become proficient, study and take an exam, a national examination.
Q. How about for the legal nurse consultant?
A. The same.
Q. Okay. And in terms of college degrees, do you have a Bachelor of Science?
A. Yes, I do.
Q. No Master's degree?
A. No, I do not.
Q. There's -- you list in your CV that you -- I think it

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was 2000 you served as an instructor at Northeastern University?
A. Yes, I did.
Q. Was that at a particular lecture?
A. Yes. In their legal nurse consulting program.
Q. Oh, legal nurse consulting.
A. Yes.
Q. Thank you.
A. You're welcome.
MR. RAPAPORT: Nothing further.
MR. LAVOIE: Let me just ask a couple of quick questions.

EXAMINATION

BY MR. LAVOIE:

Q. Among the patients you have cared for with shear fractures, were all of them surgically stabilized; or were some of them placed in braces?
A. I can think specifically of one patient who was not surgically stabilized. And that was because she had extensive spine cancer, and they weren't able to do any surgery. So they had placed a very high brace, almost like a cast, on her.
Q. Are you aware that both surgical stabilization and bracing are accepted means of treatment with patients suffering shear fractures of the thoracic spine?

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MR. SWEET: I'm just going to object to the form, foundation and competence. She's not an orthopedic surgeon.
MR. RAPAPORT: I understand. I just want to understand if she's seen patients treated with both modalities.
A. I have seen patients treated with surgery. And the one patient I mentioned to you, the patient had bone cancer throughout the spine. It was more for comfort measures in her last days prior to her death that she was placed in this brace.
Q. And over the course of all your years in nursing care you have seen just a handful of patients with this kind of injury, correct?
A. With this specific one, yes.
Q. Okay. Thanks a lot.
MR. LAVOIE: That's all I have.
MR. MULHERN: No questions.
MR. SWEET: No questions.
We're all set.
(The deposition was concluded at 12:48 p.m.)
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BARBARA J. LEVIN, R.N.

Subscribed and sworn to before me
this day of , 2004.

Notary Public

Case Name: Tripp v. TAMC, et al.
Deposition Date: February 5, 2004

CERTIFICATE

I, Claudette G. Mason, a Notary Public in and for the State of Maine, hereby certify that the within-named deponent was sworn to testify the truth, the whole truth and nothing but the truth, in the aforementioned cause of action.

I further certify that this deposition was stenographically reported by me and later reduced to print through Computer-Aided Transcription, and the foregoing is a full and true record of the testimony given by the deponent.

I further certify that I am a disinterested person in the event or outcome of the above-named cause of action.

IN WITNESS WHEREOF I subscribe my hand this day of , 2004.

Dated at Falmouth, Maine.

Notary Public

My Commission Expires

June 9, 2005.