ORIGINAL

JOSEPH B. BOWERS, et al.	:	IN THE
Claimants		HEALTH CLAIMS
vs.		ARBITRATION OFFICE
MICHAEL H. SANDLER, M.D.	:	OF MARYLAND
Health Care Provider		HCA No, 91-079

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Deposition of BRUCE J. AMMERMAN, M.D., was taken on Monday, November 30, 1992, at 3301 New Mexico Avenue, N.W., Washington, D.C., commencing at 3:15 p.m., before SUSAN FARRELL SMITH, Notary Public.

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APPEARANCES:

ZEV GERSHON, ESQUIRE

On behalf of the Claimants.

DANIEL C. COSTELLO, ESQUIRE

On behalf of the Health Care Provides,

REPORTED BY: Susan Farrell Smith

C O N T E N T S

NUMBER	DESCRIPTION	MARKED
1	Curriculum vitae	(post-marked)
2	Letters	(post-marked)

(Original exhibits attached.)

Thereupon --

BRUCE J. AMMERMAN, M.D.

a Witness, called for oral exmination by counsel for the Claimants, having been duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:

EXAMINATION BY MR. GERSHON

Q Doctor, please state your full name for the record.

A Bruce Jorge Ammerman. My middle name is spelled J O R G E. 3301 New Mexico Avenue, N.W., Washington, D.C.

Q Doctor, my name is Zev Gershon; I'm one of the attorneys for the Claimants in this case. I will be asking you a series of questions. If at any time you do not understand one of my questions, please tell me so or ask me to rephrase it. If you do answer, I will assume you understood the question and I will hold you to your answer. Do you understand?

A Fair enough.

Q Doctor, do you have a CV, a current curriculum vitae with you?

A Yes, just a moment.

Q We will have this marked as Deposition Exhibit No. 1.

Doctor, you've been handed a copy of your curriculum vitae. Is it up-to-date so as far as you know? Any corrections or additions you would like to make?

A Nothing substantive.

Q Doctor, have you written any articles which pertain to issues in this case?

A Let me see that for a moment if I may.

Q (Complies.)

A Not particularly, not specifically, no,

Q Doctor, you're board certified in neurosurgery?

A Yes.

Q You passed the boards the first time around?

A Yes.

Q Doctor, have any of your hospital priviliges ever been suspended, denied or revoked?

A No.

Q Have any of your state licenses ever been suspended, denied or acted unfairly upon?

A No.

Q Doctor, where do you do most of your surgery?

A The majority is at Sibley Memorial Hospital.

Q Do you have any teaching responsibilities at this time?

A Yes.

Q Where is that?

A George Washington University.

Q And how often are you at GW?

A At least, generally once or twice a week, and then more depending what surgery I'm doing.

Q And what are your teaching responsibilities when you are at GW?

A They are really two fold. I'm clinical professor of neurological surgery at GW. And in that sole, basically there are two areas of responsibility. One is in the ongoing teaching of the neurosurgical residents, both in conferences, in the operating room and on the floors. And the second is I'm in charge of the neurosurgical lecture series for our medical students, the third and fourth year men and women who rotate through neurosurgery. And that's

an every other week one hour commit t throughout the year as well as coordinating my eight or nine or ten colleagues to do their fair share also.

Q So you personally give a lecture once every two weeks for an hour?

A Yes, I will be doing it tomorrow at noon.

Q Have you ever given a lecture on meningioma?

A Yes.

Q In order to prepare for that lecture, have you reviewed medical articles or literature or what-have-you?

A I suspect I did many years ago when I would have prepared such a thing, but that would have been more than a decade ago.

Q Since you've given a lecture on meningioma?

A No, since I would have prepared anything formally. After you give these kind of talks over and over and it's part of your practice, the preparation is in my head. I don't have to sit down and do it.

Q Oh, okay. Fine. Did you review any medical articles or textbooks in preparation for today's deposition?

A No.

Q Doctor, do you have your file in front of you?

A Yes.

Q If I can see that.

A Sure.

MR. GERSHON: We will mark all the letters as Deposition Exhibit No. 2 and have them in chronological order.

Q Doctor, have these been all the records you've been provided with in this case?

A Well, I was provided with, but I don't think I still have, the CT scan of March 1986.

Q Okay. So in addition to all the medical records you have in front of you, you reviewed the CT scan of March '86?

A Yes.

Q Any other CT scans you reviewed?

A Not as I recall.

Q Where is that CT scan now?

A I have no idea. I don't know if I returned it, I I have no recollection one way or the other. It's not been

recent; it's been a while ago.

Q Doctor, was there ever an index with these medical records?

A What you see is what you get. I asked the same question myself.

Q Doctor, did you make any notes upon your review of the medical records?

A No.

Q Doctor, how much time did you spend upon reviewing the material?

A I would guess a few hours. I don't have a specific recollection. You may have a record for billing purposes. I don't recall specifically.

Q How much an hour do you charge for reviewing medical records?

A Three hundred dollars,

Q For giving a deposition?

A Five hundred dollars for the first hour and three hundred dollars for every hour or fraction thereafter.

Q For testimony in the circuit court hearing or a health claims arbitration hearing?

A I would generally charge -- again it would depend where it is, how much time it would take from my practice, But generally assuming it is within a reasonable, reachable area, it would be eighteen hundred dollars for my time away from the office.

Q Do you know how much you have billed in this case so far?

A I do not.

Q Do you remember when you were first contacted in this case?

A Yes.

Q My best guesstimate from looking at the letter sent to me by Ms. Dodd dated September 17, 1991, when I received the first information, so I would have spoken to her sometime in September of 1991.

Q Do you remember what she told you about the case at that time?

A Mot specifically, other than there is a case in which there is a question of a patient who had had a meningioma and subsequent treatment: and would I review the records, and give her an opinion whether I found the case

was properly handled or not. And I said to her, send me the records and I will look at them.

Q Am I correct that you're going to be rendering in this case standard of care opinion as well as causation testimony? Or are you limiting your opinion to just causation testimony?

A I think both.

Q Okay.

A My understanding is both.

Q When did you render your opinion to Ms. Bodd about this case?

A I don't specifically recall the date, but it would have been sometime in either late September or early October of 1991.

Q And am I correct your opinions have not changed since that time about this case?

A NO.

Q Do you know whether or not any health care providers were deposed in this case?

A It is my understanding that Doctor Long was.

Q He was an expert, if you will, as well as a

treating health care provider?

A Right.

Q Any of the Defendants, were they deposed, do you know one way or another?

A I don't know.

Q You've reviewed medical malpractice cases before?

A I have.

Q On how many such occasions?

A I would guess probably a couple of dozen occasions.

Q In those occasions have you additionally reviewed depositions of Defendants in those cases?

A It would depend. Sometimes yes, sometimes no.

Q Did you ask to review the deposition of the Defendant Doctor Sandler in this case?

a No.

Q Do you have any idea what Doctor Sandler says about this case?

A Only that which is contained within the medical records.

Q Doctor, of those couple dozen of occasions that

you reviewed records to render an opinion in a medical malpractice case, have they been largely on behalf of the defendant? As opposed to the plaintiff?

A I suspect the majority have been probably for the defendant, yes.

Q Do you remember ever reviewing a case on behalf of the plaintiff?

A Sure.

Q Was that plaintiff one of your patients?

A No.

Q Was that plaintiff outside of Washington, D.C.?

A No.

Q In that case were you testifying on behalf of the plaintiff against a local neurosurgeon?

A And facility, yes.

Q But in particular a local neurosurgeon?

A Yes.

Q Have you ever given a deposition before today?

A Yes.

Q In a medical malpractice context?

A Yes.

Q On how many such occasions?

A I'm going to guess it's probably been a couple of dozen also. There's some that have not gone on to trial, but I would guess a couple of dozen.

Q If you've reviewed a couple dozen and you have given a couple dozen depositions, is it fair to say that most of the cases that you review you end up giving a deposition in?

A Not necessarily. I spoke with an attorney this morning who had called me on a patient I had seen way down the road who had been in an accident, regarding that specific issue whether I thought there was -- her case had been mishandled or not as I had been the last guy who had treated her and she was happy with my care.

I said, send me records, I will look at them. I reviewed them. The case was handled from a neurosurgical standpoint at least properly; I couldn't comment on the others, and that's a case I have a feeling I will not give a deposition in. Although that was -- could fall under what I would consider reviewing a case, because that's what I was reviewing it for.

Q Let me ask you, have all the medical malpractice case depositions that you have given a deposition in been as a result of your review of medical records in the case?

A I am not sure I understand the question, but let me see if I do. I can't recall ever an instance where I gave a deposition where I had not had a chance to review records.

Q Okay, but it wasn't in a case that you were asked to render an opinion on behalf of the care in the case? In other words I don't understand why is it that you think you have reviewed only a couple dozen medical malpractice cases, and you also believe you have given a couple of dozen depositions in medical malpractice cases?

Seems like every case you've reviewed for medical malpractice, you end up giving a deposition?

A No, that's not true; that's why I was "crying to explain. I am giving you guesstimate numbers.

Q Right.

A For example the case that I discussed this norning, I reviewed a case, and I have done others, I don't think that's ever going to come to a deposition.

Q Okay.

A I am not concerned about whether the numbers are particularly jiving or not. There are some times that I am asked to review a case and I will do so for one side or the other. And it does not go any further, at least it doesn't go any further as far as Bruce Ammerman is concerned. Others do.

Q I guess then as far as the numbers are concerned, a majority of time that you review a case in a medical malpractice context, you end up giving a deposition?

A I think that's probably true.

Q You've testified before in a Circuit Court hearing or a Health Claims Arbitration hearing?

A Yes.

Q On how many such occasions?

A You are limiting yourself to medical malpractice cases?

Q Correct.

A I'm going to, again it's a guesstimate, I would guess it's more than a dozen.

Q Again the majority OR behalf of the defendants?

A The majority have been on behalf of the defense, yes.

Q Have you worked with Wharton, Levin and Ehrmantraut before?

A Yes.

Q On how many such occasions?

A I would guess probably half a dozen.

Q And is that both before Mr. Ehrmantruat joined the firm and since he's been in the firm?

A Yes.

Q Okay, good. If I'm correct your father, Doctor Ammerman, also did a fair amount of work for Wharton, Levin and Ehrmantraut?

A I can't answer it, I don't know. You would have to ask him.

Q Do you know whether or not he's reviewed medical records before on behalf of defendants?

A He has.

Q And you don't know whether or not it's been for anyone from that firm is what you're saying?

MR. COSTELLO: I'm going to object,

A That's not the question you asked me.

Q Do you know whether he has reviewed medical records for anyone from that firm before?

MR. COSTELLO: Objection.

A In a medical malpractice case specifically, I don't know. You would have to ask him specifically.

Q Do you have similar ties to NCRIC as your father does?

MR. COSTELLO: Objection.

A You have to clarify what you're asking me.

Q I'm assuming you're aware your father is an important member of NCRIC? You surely know that?

A Well, I think any of those of us who are insured by NCRIC are important members of NCRIC,

Q Well, he's more than just that. I mean, you're not aware of his involvement aside from being insured by NCRIC?

A I am aware of his involvement in NCRIC, yes.

Q And that's more than just being insured by NCRIC?

A He plays a role in NCRIC, yes.

Q Do you have a similar role to that of your father

in NCRIC aside from being insured by NCRIC?

A I have a role with NCRIC.

Q What is your role?

A I serve on two committees -- well, one committee, One is the board of governors and one is the claims committee.

Q Have you rendered before an opinion in a medical malpractice case on behalf of an ophthalmologist such as Doctor Sandler on standard of care?

A Yes.

Q Do you remember the name of that case?

A Oh, yes. It was Keaverly versus Zimmerman.

Q Where was that case from, do you know?

A It was D.C., and my recollection is federal court, but that's only a recollection; but it was D.C.

Q Okay. Do you know if you have rendered standard of care opinions on behalf of other experts aside from neurosurgeons or ophthalmologists before?

A Yes.

Q What other specialties have you rendered standard, of care opinions on before?

A Trauma situations in which the others involved were not just neurological surgeons; orthopedic surgeons, I think. And medicine. That is, family practice and internal medicine.

Q Okay. Has any of the other cases you have reviewed, given depositions or testified in involved meningiomas before?

A Yes.

Q Do you remember when that case was or --

A Well, it hasn't really gotten to me yet. I don't know that I have given a deposition in the case. I reviewed some records in a patient who had been treated in Frederick, and the issue was -- the patient did have indeed meningioma, and the issue in that case was a delay in the diagnosis of the meningioma. It has not gone to court. I do not recall much more than that: that was Frederick, Maryland.

Q You haven't given a deposition yet, basically is what you're saying?

A Not as I recall, but I did review the records,

Q Relatively recent case?

A Within the last year.

Q Do you know the defense attorney or the plaintiff's attorney?

A Not offhand, no, I'm sorry; but I knew it was Frederick. I remember the woman who --

Q The patient's name?

A Eichorn.

Q I C H?

A I don't know.

Q Doctor, have you ever personally been sued before for medical malpractice?

A Yes.

Q On how many such occasions?

A Three.

Q Two lines or less, what was the first case about?

A First case was a patient I had seen for an independent medical examination for disability for the District government, who then sued me and the mayor and others. It was a pro se case; that we prevailed on without going to court.

Q Okay.

A The second was a patient I operated on subsequent to a motor vehicle (sic) who developed a postoperative complication. That we prevailed upon by getting Rule 11 sanctions against her attorney; that was a ease dropped with prejudice.

Q Okay.

A The third case was a women I had seen and treated after a minor accident, referred by her attorney, whom when she was not satisfied with the settlement sued me, her attorney and GW where she received physical therapy. That was a pro se case and it went nowhere. And that's been my score card.

Q Has your group ever been sued before aside from the cases that you have personally been named?

A I can't speak for my father, those in which we have -- I don't recall whether the PC was particularly named to any or all of the three cases I have personally been sued in; I don't know.

Q And has a hospital you've practiced at ever been sued before because of some alleged act of negligence on your part?

A Not that I'm aware of.

Q Doctor, do you know if the defendant has any other experts in this case, aside from yourself?

A You lost me.

Q Do you know whether or not you are the only expert going to bat for Doctor Sandler?

A I don't know whether any of the other treating physicians or other physicians who had been involved in Mr. Bowers' care will be called as experts.

Q How about independent experts, do you know if they have any other independent experts aside from yourself?

A I don't know.

Q Do you know Doctor Long?

A Yes.

Q How do you know Doctor Long?

A Number of ways. Through neurosurgical organizations, through dealings with him as chairman at Johns Hopkins, we have had patients in common, I have sent patients over there.

Q And you told me you knew that Doctor Long had been deposed in the case. Do you know what Doctor Long's

opinions are about this case?

A Only as I have -- in one of the records sent over was a statement of his opinion, which in a nutshell was that there was delay in diagnosis of the tumor.

Q Obviously, you disagree with that opinion?

A I don't disagree that there was a delay in diagnosis; there was a delay in diagnosis. I think where I would be in variance with Doctor Long would be for the reasons for that delay in diagnosis.

Q We will get to that in a minute, Do you know Doctor Frishberg, I believe is his name, an ophthalmologist in the Rockville/D.C. area?

A I don't know any ophthalmologist named Frishberg.

Q Maybe I am mispronouncing it, but I think that's hi name. Have you asked to see any other CT films aside from the '86 one that you did see?

A No.

Q Did you ask to see that one, or were you just provided that one?

A I don't specifically recall, but generally my interest would be if there was a specific test upon which

an issue is based, I would like to see those films myself,

Q Doctor, can I just have briefly a summary of your opinion of why you believe Doctor Sandler met appropriate standards of care?

A Yes, sir. Let me, if I may, and in no particular order, when Mr. Bowers saw Doctor Sandler on March 7 of 1986 his history was such that Mr. Bowers presented with a long history of diplopia dating back, according to records that I have reviewed which at times had improved, to 1979.

He was basically seen because of his diploplia. And after he saw the patient, he recommended two things basically and that is a CT scan, and that Mr. Bowers return to see Doctor Sandler in two months, so that he could follow him up and see how he was doing. Also that he felt that this was most likely related to diabetes and would get better, but asked the patient to come back and see him in two months.

Performed a CAT scan which showed no clear evidence of pathology, and then corresponded with Doctor Cohen, Miriam Cohen, who was Mr. Bowers' cardiologist, also privy to this information, who also discussed with Mr.

Bowers the findings.

And according to Doctor Cohen's discussion with Mr. Bowers, Doctor Sandler -- I'm quoting now because this is important, "Doctor Sandler assured him that the diplopia would get better. I told him if the diplopia does not improve, he certainly should see a neurologist."

And none of that was done. Had either Mr. Bowers returned to see Doctor Sandler for follow-up or follow-ups, and symptoms then developed, appropriate studies, follow-up studies could have and I anticipate would have been done.

Or even if Mr. Bowers had - as he did - neglected to return to see Doctor Sandler, but had followed through with the recommendation of both Doctor Sandler and Doctor Cohen, that is, if it doesn't get better, you need to see a neurologist, the same evolution would have occurred. And the patient's diagnosis would have been established sooner and he would have had his surgery presumably within that same year,

Q Had he had that surgery, presumably within that year, would his outcome have been different?

A As I understand his outcome, which is basically

that he has some residual facial numbness, some twitching or at least at one point he had twitching about his left eye, I'm skeptical that it would have been much different at all. I give Doctor Long great credit in dealing surgically in the surgery in that the patient has very, very little deficit.

And, indeed, I must say that had I done this operation the same year and ended up with no more than facial numbness and twitching of the left eye, I would consider it a great success.

So there is no way of knowing with certainty, but his outcome has been so good that I have no reason to assume it would have been that much less different. Whether the tumor is a little larger or not, one still has to use the same exposure to get to it which accounts for much of what Mr. Bowers is left with.

Q Do you have an opinion that you hold to a reasonable medical probability, as to how big the tumor was when it was resected as compared to the size it was in 1986?

A Only that these are slow growing tumors and was in

all likelihood somewhat smaller in 1986 or 1987 than it was in 1989.

Q And given the fact that it was somewhat smaller, can you say, although not with certainty, nonetheless more likely than not had Doctor Long operated upon it in a short period of time after it was diagnosed that Mr. Bowers would not have his numbness and other neurological --

A I can say that it was likely he would have, and indeed I think we have to go back a little bit. If we go on the assumption, which I think time has borne out, that the diplopia was related to his meningioma, and if the diplopia is related to meningioma - he has diplopia symptoms dating back to 1979 if I recall the date on the record - then we can assume that much of the growth of this, or some of the -- a fair amount of the growth had occurred over those ensuing seven years.

It's very difficult for me to imagine even in the hands of the most skilled neurosurgeon an outcome that would have been substantively different. These are very, very slow growing but they do tend to entwine themselves. And I think the outcome would have been very much the same.

Whether the tumor which is described in the scan is two to three centimeters, or whether it is one and a half to two centimeters, you're basically faced with the same operative challenge.

Q Well, the CAT scan originally was an '86 CAT scan, is that correct, or am I --

A It was March 17 of '86.

Q Okay. You've seen the film. Can you tell me if the meningioma is just in the bone, or is it as well in the brain tissue at that point in time?

A I saw no tumor in brain tissue at all. All I saw was sclerosis of the bone, which of course in retrospect was probably meningioma, at the time could very well have been nothing more than a fibrous dysplasia, some other benign, boney, nonsurgical condition. As best I can tell it is in bone, but one can't tell well because down along the base and along the sphenoid wing one could have a small amount of tumor and not be able to detect that definitely from the sclerosis of the bone.

Q You're not saying that that in effect is what occurred to Mr. Bowers more likely than not?

A No, I'm saying you can't tell.

Q That's just a possibility?

A You cannot tell.

Q Now, in 1989 now -- when he did I believe have his surgery?

A Yes, subsequent to the 9/6/'89 scan. MRI scan,

Q -- are you able to tell whether or not the meningioma invaded the brain tissue at that point in time?

A Let me refer to the operative report. I'm looking for the operative record from Johns Hopkins which I have seen, and there it is.

Okay, I'm sorry, what was the question again?

Q The question was, do you have an opinion more likely than not that the meningioma invaded the brain tissue when it was operated on -- by the time it was operated on?

A It does not appear to have invaded the brain.

Q Okay. Can you tell whether or not the surgery was more extensive in '89 than it would have been in '86?

A No.

Q And can you explain to me the pathophysiology of

why he had his neurological deficit subsequent to the surgery?

A Presumably it's related to peeling the tumor off the various cranial nerves. And certainly the 5th nerve which will cause facial numbness where the tumor was located at Meckel's cave which is where the 5th nerve sits, as well as in either separating tumor from the vertebral artery, and involving some of the 7th nerve; that I can't be certain of. But those seem to be the primary areas, especially the 5th nerve, to give the facial numbness.

Q And in your opinion more likely than not that the tumor would have been peeled away from these nerves even had the operation been done in '86?

A Certainly was done in '89, certainly would have done it in '86.

Q Would the tumor have been present around those nerve that would have been required to be peeled away from those nerves had it been done in '86?

A Oh, yes, I think so. Indeed to quote Doctor Long's excellent operative report, he says, "The tumor mass began at the level of the entrance of the 5th, 7th and 8th

nerve and extended anteriorally from the brain stem reaching almost to the midline, and basically at the level of Meckel's cave and the petrous apex, this was where the tumor appeared to begin," and indeed that's what's running right there. So, even a much, much smaller tumor will involve that area.

Q I get to ask hypothetical questions here. If hypothetically Doctor Long believed that had the operation occurred in '86 rather than '89, Mr. Bowers more likely than not would not have any residual or neurological deficit, do you know why he would be of that opinion?

A No.

Q Would you agree with me that the treating neurosurgeon in this case, which happened to be Doctor Long, would be better able to tell the extent of the tumor, since having been there, than you or any other expert reading records after the fact?

A Well, if you were to -- and I will put myself in the position of a treating neurological surgeon. If two and a half years after an operation one has that kind of memory, I would be very, very impressed. Immediately after

the surgery, absolutely. But as time goes on and we do a lot of surgery, to have independent recollections of more than an occasional detail I would think would be a phenonenal mental exercise. And I know I personally and generally certainly two and a half, now over two and a half years from the time of surgery would rely on the dictated report that I dictated, which indeed he dictated.

And, so, I don't know that two and a half years down the road that would hold. Initially, after the surgery, yes, I would agree.

Q So, as of today, essentially what you're saying is you and Doctor Long would be equally able to tell the extent of the tumor when it was resected?

A From the standpoint of this discription which is excellent, I think any neurosurgeon familiar with the anatomy in the area would be able to interpret this without any difficulty; it's a very well dictated note.

Q Well, as to Doctor Long, he has a good reputation; is that correct?

A Yes.

Q And then in your opinion the reason why, even had

the operation been done in '86 he still would have had his neurological deficit, is those nerve roots you just told about, the tumor would have to be peeled away from the nerve roots?

A Well, basically as Doctor Long describes and where the tumor originated from, whether it was in '87 or '89 or '86, in order to do that, you're operating in the area, specially the 5th nerve which is where the facial numbness emanates from. If that's where it starts, that's where you've got to work.

Q And that would have still been required to be done in '86? The tumor, in other words, the tumor still would have been present around the 5th nerve root in '86?

A I think more likely than not, yes.

Q And the fact that even though you agreed earlier there would have been less tumor in '86 than '89, that amount of less would still necessitate enough peeling away to cause the same facial numbness?

A The issue is not the debulking of the tumor; the issue is stripping the tumor which you have to do or certainly want to do if you can, strip the tumor off the

various cranial nerves or off of the blood vessels which he did. That's where if we're going to get into mischief, that's where we get into the mischief.

Q You've operated on a patient with a meningioma before, I'm sure?

A Yes.

Q On how many such occasions in your lifetime?

A Dozens.

Q Did all your patients have residual neurological deficits to their face?

A No, depends on where the tumor is, and it depends on specifically where the tumor is.

Q Have you had any patients that had a tumor in the same area as Mr. Bowers?

A Yes.

Q And those patients have residual neurological deficits?

A If the tumor was stuck, and I don't have any independent recollection off the top of my head, but in areas where this tumor was located, it is a very common post-operative sequelae if the patient doesn't already have

facial numbness before surgery, to have it after.

Q And of your patients, do you recall one patient who escaped without any neurological deficit subsequent to your surgery?

A I don't recall one way or the other. This is not an area where I have lots and lots of patients and therefore I can recall off the top of my head. I have certainly had patients who have had tumors in this area of the petrous bone and along the clavus and have ended up with some neurological deficit, yes.

Q So, as we sit here today, you remember such a patient who ends up with neurological deficit, but you don't remember any patients who have ended up deficit free, subsequent to your surgery?

A I'm not saying that either; I'm saying I don't recall.

Q Would viewing the CAT scan film of 1989 and comparing it to the 1986 film be of value in determining how much larger the tumor was from '86 to '89?

A I don't think so.

Q Why is that?

A Because I'm not sure how big it was in '86.

Q You cannot tell from the film?

A I could not.

Q Your opinion was that the diplopia more likely that not was due to the meningioma?

A Yes.

Q What is the basis for that opinion?

A Well, No. 1, location of the tumor. No. 2, the fact that all the studies that were done more for diabetes or vascular cause which is the other -- which is by far the more common cause of diplopia, did not pan out.

Q You noted in the records that Mr. Bowers had diplopia since 1979?

A At times, yes.

Q That was, I think -- well, I don't know which record, which records were you looking at?

A Those were --

Q Were those optometry records?

A Yes.

Q Optometry records?

A Yes.

Q Do you have an opinion that any of Mr. Bowers' health care providers other than Doctor Sandler breached the standard of care in any respect?

MR. COSTELLO: Object to the form.

A I don't think anybody particulaly breached the standard of care.

Q Okay.

A Other than unfortunately Mr. Bowers.

Q And you're not saying that Mr. Bowers should have had a workup of his diplopia from 1979 on which would have included a CAT scan to find out if there was a tumor there or not?

A Not at all.

Q Why is that?

A Because the patient when he first presented with persistent symptoms, I think appropriately had a scan. If I had performed this scan even a year or two before, my guess is it wouldn't look much different. And my response to the patient, I think we should periodically follow this, repeat it, unless the symptoms go away - now, in his earlier notes his diplopia improved - I wouldn't have gone

any further.

Q Early notes, talking about towards the early eighties?

A Exactly.

Q Do you have an opinion as to why if the diplopia was due to the meningioma and he had the diplopia in '79 that the symptoms went away in the early eighties?

A No.

Q Do you have an opinion one way or another whether Mr. Bowers' symptoms improved or not after he saw Doctor Sandler?

A My understanding is that they did not.,

Q Earlier you gave me two reasons why you thought Doctor Sandler followed the standard of care. One is, as I have it down here, that he was told to return to Doctor Sandler when more studies would have been done. And two is, he was told by Doctor Cohen and maybe Doctor Sandler to see a neurologist, and he didn't do that either; is that correct?

A That is correct.

Q If hypothetically Doctor Cohen believed that Mr.

Bowers did not need to see a neurologist after she initially put that in her note, a month or two afterwards, would that change your opinion at all about this case?

A No.

MR. COSTELLO: Objection.

A No, because Mr. -- regardless of the neurologist which would have been very helpful in retrospect, Doctor Sandler asked Mr. Bowers to return to see him. In fact he specifically, in his note, discusses with him, that is with Mr. Bowers the fact that he thinks it's most likely related to a vascular phenomenon, diabetes, and will get better.

In my experience patients when you tell them something is going to occur and it doesn't, they come back on their own. Doctor Ammerman, you said this would happen and it hasn't happened, what's going on: and we look further.

Certainly if I tell the patient, A, come back and, B, something is going to happen and that does not occur, it would be the unusual patient who would not come back and say, Doctor Ammerman, you told me this was going to happen

and it did not happen: you told me to come back, I'm here, why didn't it happen.

And that's what occurred in this circumstance.

Q In your scenario you're saying why it didn't happen, you are referring to why didn't I get better?

A Exactly.

Q What's the basis for your understanding that it didn't get better or his symptoms continued?

A Well, as I look at the -- when he was seen the next month, that was in April of '86 by Doctor Miriam Cohen, my understanding is he was still bothered by his diploplia and indeed that was her first impression, so a month later it still hadn't gone away. It was at that point that she discussed with him about seeing a neurologist, and my assumption therefore at least at that point, it had not gone away. I don't have interim notes after that.

Q Well, how long after that April visit with Doctor Cohen are you assuming that his diplopia was present?

A Just one moment. Well, Doctor Neal -- correction, Doctor Ronald Cohen, Ronald Cohen, September 25, 1989, he

discusses the patient having continued visual difficulty throughout that period of time. That is up until, this is now September of '89.

Q So, based on your reading of the Doctor Cohen's consult of September '89, your understanding is that Mr. Bowers had continued diplopia from 1986 until he was operated on in 1989; is that correct?

MR. COSTELLO: Objection.

A Well, that is one piece of information. I'm looking for some others; just give me a moment.

MR. GERSHON: Off the record.

(Discussion off the record.)

Q Okay. At least based on Doctor Cohen's note and maybe some other medical records that you have come across, your understanding is that Mr Bowers' diplopia continued from 1986 through 1989?

A At least, well, he had -- I have clear evidence he had diplopia in 1986 when he saw Doctor Miriam Cohen a month later, and in Doctor Aronson's note he describes visual complaint. Me specifically does not use the word diplopia; so, I cannot use that word either. Mad ongoing

visual complaints.

Q And obviously if at some point in time after Mr. Bowers saw Marian Cohen he still had his diplopia, what you're saying is he should have come back to Doctor Sandler; is that correct?

A Absolutely.

Q Okay. And if hypothetically Mr. Bowers' diplopia improved after he saw Doctor Cohen, there would be no reason to return to Doctor Sandler; would that be correct?

A If his visual complaints went away, I think that's correct.

Q Now, let's focus on the CAT scan itself that Doctor Sandler got from Mr. Bowers. Do you know -- well, are you in agreement with the report, the CAT scan report?

A Let me pull it out.

Yes, I think I would accept that.

Q Did Doctor Sandler have a duty to inform Mr. Bowers of the results of the CAT scan report?

A Yes.

Q Did he have a duty to tell Mr. Bowers exactly what's contained in that CAT scan report?

A He had a duty to synthesize the medical information and give the patient in lay terms an answer.

Q Would you agree with me that that CAT scan report at least says there is a possibility of a meningioma?

A It does.

Q Should pursuant to standards of care Doctor Sandler have related that information to Mr. Bowers?

A No, not necessarily at all.

Q Why is that?

A What he should have told the patient is that the scan does not show evidence of a tumor, which it does not. That it shows evidence of sclerosis or using whatever term he wishes, which is probably related to fibrous dysplasia, Or to just say it as I might say it, it showed nothing particularly dramatic.

And I don't go around trying to frighten patients because it's very unlikely it's a meningioma. This time it turned out to be; in most patients it won't turn out to be.

And have the patient come back for follow-up. And follow the patient along, and at some time with this type of a situation, likely repeat the scan which would answer

the question. If there was no change over the course of many months or years, it was clearly a fibrous dysplasia as would be the more typical case. If there was a change, then we document it, it could be treated.

Q Do you know the statistics for how often a CAT scan report turns out to be accurate versus inaccurate?

That is, how often in this scenario would it turn out to be fibrous dysplasia versus a meningioma?

A In my experience, the thickening can very commonly be seen with fibrous dysplasia. It's less commonly seen with meningioma, because meningiomas aren't usually involved in the bone initially as this appeared to be.

So, I think the radiologist's discussion that, quote, this is probably secondary to fibrous dysplasia is absolutely accurate and most times would be absolutely correct, and would be the reason I would not be in any way be alarmed. One could have a lengthy differential diagnosis of things that are possibly very likely; and would have asked the patient to come back to be followed up.

Q Assuming as in this case it was the possibility of

meningioma, I believe you said you do not want to tell the patient that because you may frighten them?

A I don't see any need to. In a situation where having seen the films, and I reviewed it, I think meningioma is very unlikely. In the next hundred cases that look like that, it still is going to be unlikely. And if a patient doesn't have signs and symptoms that make me think a meningioma is likely on clinical grounds, I'm going to ask the patient to go back for follow-up evaluation sometime in the future, and quite possibly repeat the scan sometime in the future to see if there has been a change, That's a very good appropriate method of detection.

Q Clearly, in your opinion, diplopia is a sign or symptom of meningioma?

A Diplopia is a nonspecific sign of any process which may effect the ocular motor nerves.

Q Would the location of where this, whether it is meningioma or fibrous dysplasia, on the '86 film clinically correlate to the diplopia? In other words, could Doctor Handler see where it is on the CAT scan and say, ah hah, that could be the cause of the diplopia?

A I don't think so.

Q Okay. And -- well, you just explained the anatomy and pathology, I mean, why can't one see where this area is on the bone and say, well, yes, this is near the nerve and this could cause --

A The portion of the bone that was scelerotic was rather generalized, and I would point out that the patient did not have multiple cranial nerve involvement, which later on he did develop, and was seen in surgery. So, it's sort of like looking at the films and saying, well, anything in that area could be affected. He could have had a stroke from vascular involvement; he did not that have.

It's a much more diffuse abnormality on the CT scan which I think was one of the things that led the radiologist to think this was fibrous dysplasia; it was not typical of a focal lesion.

Q Mad Mr. Bowers been told to €allow-up as you suggest, what would be the time sequence of the follow-up? How soon should he come back to the office?

A Generally to repeat the scan or to be seen back in terms of weeks unless something changed for the bad is not

necessary; but in terms of months would be. Certainly, as was mentioned here to come back in a couple of months would be appropriate. I might or might not repeat a scan that soon: if I had a high index of suspicion, I might.

More likely, I would have said to the patient, I think that we ought to follow this up, assuming that the patient is not perfect at this point, and repeat it some time even a few months from then. The longer one can wait between scans the greater the likelihood of fruitfulness. So, if I wait six months or even a year, I am much more likely to have a definitive answer then a few weeks.

Q And you would have this conversation with the patient whether or not they had diplopia? In other words, just based on the CAT scan finding?

A The diplopia, no, no, no. The diplopia is not the complete issue. I would ask the patient to come back and see me in a couple or a few months, and at that time can then decide -- if the patient comes back and they are asymptomatic and they feel fine and the symptoms which I saw them in my exam is fine, I might not repeat the scan.

Q That's I guess the real question. Let's say they

do come b ck in a couple of months, the diplopia is gone, what would you do with the '86 report?

A I would say to the patient, at the moment I think you're better, I think this is great, this is probably vascular, I'm talking about this specific type of presentation of Mr. Bowers. And if any symptoms return, you should be re-evalued.

But as long as he's feeling fine and all the symptoms have gone away, I doubt very much I would follow-up that scan. Not based on what I saw in that scan, I would assume that it is more likely related to a fibrous dysplasia, a very chronic many, many, many year situation. And if the patient isn't asymptomatic -- if it ain't broke, I ain't going to try to fix it.

Q Okay, What's your understanding concerning Doctor Sandler's opinion of that CAT scan film? Did he think it normal or abnormal?

A My understanding from looking at his medical records was he raised the question whether it was normal or not, recommended following up, and referred the patient to Doctor Cohen. Most reasonable. Unfortunately, the

follow-up never occurred.

Q You're talking of the follow-up with Doctor Sandler?

A Correct. And in retrospect with anybody else who could have confirmed the diagnosis before 1989.

Q Okay. Had the follow-up occurred, though, you're saying the standard of care requires repeating the scan or intervention only if the symptoms persisted,

A If the symptoms went away, the patient came back and saw me a few months later, was absolutely fine, I would say to this patient or one like him, you're doing fine, I don't detect anything on my examination, your symptoms have gone away. If they should recur or any other, I kind of go through the drill with them of things to be concerned about, you are to let me know and further investigation will be undertaken.

Q Would it be fair to say if they do not return until the symptoms recur that they, if they do have meningioma, may progress and therefore there may be more to be operated upon?

A That is a possibility.

Q Most meningiomas are slow growing?

A Yes.

Q Are there any that are fast growing?

A It's unusual.

Q But it can occur?

A Yes.

Q Can one tell from a CAT scan film whether we are dealing with a slow growing or fast growing meningioma?

A Only by comparing them over time.

Q If you were to repeat a scan and a meningioma -- what period of time are we talking about would you feel comfortable to determine whether or not there has been a change in growth?

A Generally, my rule of thumb is six months; at times, a year. On following a patient, if they have any symptoms of meningioma and I have some patients that I am doing that, and are following once a year. Initially I may do it at six months; and then if I don't see much in the way of change or any change, then I am comfortable in waiting a year and then doing it on a yearly basis.

Q Do you have an understanding one way or another

whether Doctor Sandler told Mr. Bowers that he had a normal CAT scan or an abnormal CAT scan?

A My only understanding is as reflected in the notes and in his letter that it showed no pathology, I am not privy specifically to the conversation of what that meant between Doctor Sandler and Mr. Bowers.

Q Well, are you able to infer at least that Doctor Sandler told the patient that there was nothing to worry about?

A I think so, or probably okay, or something along those lines.

Q Did Doctor Sandler have a duty to inform Doctor Cohen about the results of the CAT scan film?

A No. I think it's polite for another physican to write a letter of what I have done or what I have found; but, no, I would not consider it obligatory on the part of Doctor Sandler to write a letter to Doctor Cohen specifically. And often a corner conference will handle that. And sometimes if that's not a referring physican, I may say to the patient, you know, please let your doctor -- if they have any questions, get in touch with me, there's

lots of ways of handling it.

Q Assume though that Doctor Sandler did want to communicate with Doctor Cohen by letter, do you believe that the letter he wrote Doctor Cohen was accurate concerning the CAT scan report?

A Essentially.

Q Do you have any understanding of what Doctor Cohen's conversation was with Doctor Sandler about Mr. Bowers?

A No.

Q Do you know who was primarily responsible to insure follow-up for Mr. Bowers, between the two of them?

A Yes.

Q And who was that?

A Mr. Bowers.

Q When I said the two of them, I was referring to Doctor Cohen and Doctor Sandler. I understand that you believe that Mr. Bowers failed to follow-up for his diplopia.

A Unfortunately he dropped the ball. Between the two of them, Doctor -- let me address them individually.

Doctor Sandler asked the patient to come back, and that was his one shot at it, and he did. Doctor Cohen recommended that Mr. Bowers follow-up with the neurologist, and Mr. Cohen (sic) for whatever personal reasons, having seen other neurologist in the past, decided not to. She went as far as she needed to go.

Q I'm sorry, my question was who do you think between the two of them was primarily responsible for insuring Mr. Bowers to follow-up?

A I don't know if I can really answer the question. I am not sure there is an answer to the question.

Q Okay. And the essence of your understanding that Doctor Sandler told Mr. Bowers to follow-up with him in two months is where in his records?

A In this letter to Doctor Eickoff, March 25, 1986 I have suggested that he return here in approximately two months.

Q Okay. So it's in the letter to Doctor Eickoff --

A That he told the patient, yes.

Q -- that is documented that he told the patient to come back in two months?

A Can't imagine why it would be there other than that is the case. He's discussing to Doctor Eickoff what he told the patient.

Q Do you have an opinion why it is not in his records, that is, in his office notes?

MR. COSTELLO: Objection.

A Only that he did what I frequently do, and that is when I dictate a letter to a referring physican or to another physican, that becomes my office note or my office consultation.

Q Okay. Do you believe Doctor Sandler had a duty to inform Doctor Eickoff about the CAT scan results?

A No more than anybody else. He put the record in as he interpreted it or understood the report to be.

Q And you believe he had an accurate interpretation?

A Yes, I think it was reasonable, yes.

Q Let's see of if I have any other questions except -- let me ask you you if you consider any textbooks in ieurosurgery to be authoritative?

A No.

Q Do you own any neurosurgical textbooks?

A Lots.

Q Which are the ones you frequently refer to?

A None in particular.

Q There is not one that you pull off the shelf more than any others?

A That depends what I'm looking up.

Q How about meningioma? Which textbook would you use?

MR. COSTELLO: For what purpose?

A That's what I was going to say.

Q To look up meningiomas.

A The most common reference that I use with regards to meingomas is Ludwig Kempy's book, Operative Neurosurgery.

MR. GERSHON: I have no other questions.

MR. COSTELLO: I have no questions. We'll read,

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CERTIFICATE FOR READING AND SIGNING

I hereby certify that I have read and examined the within transcript and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary I have listed on the separate ERRATA SHEET enclosed, indicating the page and line number of each correction.

BRUCE J. AMMERMAN, M.D.

DATE