State of Ohio,) SS:
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

- - -

JACK ROGERS, et al.,)
)
Plaintiffs,)
)
v.) Case No. 390671
) Judge Thomas P. Curran
UNIVERSITY MEDNET, INC., et al.,)
)
Defendants.)

- - -

THE DEPOSITION OF RICHARD J. BLINKHORN, JR., M.D.

TUESDAY, APRIL 10, 2001

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The deposition of RICHARD J. BLINKHORN, JR., M.D., a witness, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Janet M. Hoffmaster, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, commencing at 3:15 p.m., the day and date above set forth

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APPEARANCES:

On behalf of the Plaintiffs:

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(Thereupon, Plaintiff's Exhibits 1 and 2 to the deposition of Dr. Blinkhorn were marked for identification.)

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RICHARD J. BLINKHORN, JR., M.D.

a witness, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. ROBERTS:

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

A. Richard John Blinkhorn, Jr.

Q. And you are here at Metro Hospital and you've been offered as an expert in the case of Jack Rogers versus University Mednet; is that correct?

A. True.

Q. Have you been an expert before in other medical malpractice cases?

A. Yes.

Q. About how many times?

A. You talking about reviewing records, depositions, trials, which?

Q. Start with the biggest number which is reviewing records.

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A. Dozens. Probably less than 50 -- maybe 50. Well, wait a minute. Maybe more than 50.

Q. How did you get involved in those kinds of cases?

A. This case?

Q. No, those kinds of cases, how did you get involved in reviewing?

A. Basically what happens, an attorney will call and ask if I would review a case and then I would get the records and usually a cover letter of some sort, tells me who is the defendant and the other side. And then I would review the records and make a decision about whether to take the case or not.

Q. Do you ever review cases for plaintiffs' lawyers?

A. Yes.

Q. Do you know the percentage of cases you reviewed for plaintiffs' lawyers?

A. Probably a quarter.

Q. Of those cases have you taken any cases?

A. Yes.

Q. Do you know how many you've actually given a deposition in?

A. Three to five probably.

Q. Have you ever testified in court for a

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plaintiff?
A. Does videotape count?
Q. Sure.
A. Yes.
Q. Trial depo or trial testimony.
A. Yes, yes.
Q. About how many of those?
A. Couple.
Q. Two or three? Four?
A. Two for certain come to mind. Maybe a third. It has been a while.
Q. Within all types of cases of infectious disease is there a certain type that you more often become involved in as an expert on the standard of care?
A. No.
Q. Looking at your CV it looks like you focus primarily in the area of tuberculosis --
A. Thank you.
Q. -- right.
A. It is a subspecialty interest.
Q. Most of your publications seem to be related to public health and tuberculosis; is that right?
A. True.
Q. Tell me what your typical clinical practice is over the last few months.

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A. Over the last few months, attending the general medical wards, infectious disease consult service, telemetry unit, private practice in infectious disease.
Q. Your cover letter, your report of March 1,2001 indicates you are the interim chairperson in the department of internal medicine, and how long has that been true?
A. Since August of --
Q. Of 2000?
A. -- 2000.
Q. Are you a candidate for permanent chair?
A. No.
Q. By intent?
A. Choice.
Q. By choice?
How much of your time do you *think* you spend doing administrative work as department chair?
A. 30 or 40.
Q. How much of your time do you spend doing research?
A. Minuscule. Rest is clinical.
Q. Are you called in on certain types of patients typically here in the hospital for infectious disease?
In other words, do you specialize in your

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clinical practice in upper respiratory infections, chest infections?
A. That wouldn't be typical of an infectious disease practice, no.
Q. What kinds of cases do you typically see?
A. Well, let me answer it by telling you that the structure here is the infectious disease consultant is scheduled for a month and covers the entire hospital, all services. So you would be called in to see anywhere from 60 to 90 cases a month from all over the hospital, all disciplines, except pediatrics. I rarely cover pediatrics except when the pediatric ID person is out of the country; surgery, medicine, OB, gynecology, neurosurgery, et cetera.
Q. Okay. But it is primarily for patients who have been admitted?
A. That's the inpatient side of this, and then I have a private practice in infectious disease where people would be referred for more ambulatory type problems.
Q. Where do you see them?
A. In the clinic. I see my patients down in the tuberculosis clinic.
Q. Are all your private patients tuberculosis type patients?

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A. but I see them there.
Q. Have you ever treated necrotizing fascitis?
A. Many times.
Q. About how many?
A. Dozens.
Q. Have any of your parents developed that under your care?
A. I don't know what you mean by that.
Q. If you're seeing them on a regular basis and treating an ongoing situation, did it ever develop into necrotizing fascitis?
A. On an outpatient basis?
Q. Either one.
A. Never as an outpatient. On the inpatient side the disease can present over 24 to 48 hours. If I see the patient on the first day and they develop it on the second day, is that yes to your question?
Q. As an inpatient?
A. M-hm. That's why I'm struggling with how to answer your question. It is happening under my care but they are here for the problem.
Q. Already started?
A. Yes.
Q. What typically leads to necrotizing fascitis?
A. Probably to get at what leads to it, it can

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occur in probably one of two major settings; one is you have an opening in the skin through which an infection gets into the tissues and the other is you can have trauma to an area and then have seeding, hematogenous seeding from another bacteria.
Q. When you say another bacteria, why do you say another
A. It may vary depending on whether you have a break in the skin that leads to it as opposed to somebody who has, say, blunt trauma and then you have a bacteremia and it seeds into that area. The organisms may vary.
Q. Do you consider that Jack Rogers in this case here had any trauma to his knee?
A. He has trauma to the skin in the sense that I use the term to mean injury. Traumatized.
Q. He also had an opening in the skin, right?
A. Same thing, true.
Q. What do you do when you see your patients with necrotizing fascitis, what do you do?
A. I call a surgeon to operate.
Q. Do more of the patients that you've seen that have necrotizing fascitis get it in the lower extremities?
A. Yes.

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Q. Is there a typical patient that you've observed who gets necrotizing fascitis, an older person, diabetic, in the lower extremities?
A. A diabetic is far and away the most common at risk person.
Q. Why is that?
A. Felt to be due to the fact that diabetes affects the immune system, your ability to fight infection of whatever sort. If you take diabetics in general, they are predisposed to many different types of infections. Soft tissue infections would be the top of the list.
Q. Aren't they more susceptible to polymicrobial infections?
A. Depends where it is occurring.
Q. In the lower extremities?
A. They can have it in the lower extremities, but they can also have the other standard types of single organism infection.
Q. As opposed to the population as a whole don't diabetics more often get polymicrobial infection?
A. What are we talking about now, urinary tract infection, pneumonia, when you say --
Q. Lower extremities.
A. That could be cellulitis, that could be a sore, that could be an ulcer. I think I know what you're

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talking about, but I'm not quite sure.
Q. Okay. I will get back to you on that.
A. Okay.
Q. I was asking in the typical situation, if this is what among patients you've had with necrotizing fascitis:
How would you describe that person?
A. It varies.
Q. Age wise, typically an older person?
A. It's varied.
Q. More often diabetic?
A.
Q. Does it more often begin with an open skin wound?
A. No.
Q. Do you recall what organisms Jack Rogers had when they cultured him on October 26th?
A. He had Klebsiella and I believe Group B Strep.
Q. Is Klebsiella a fairly common strain of bacteria?
A. Yes.
Q. How about Group B Strep?
A. Yes.
Q. Isn't Group B Strep generally an iatrogenic organism that is acquired in the hospital?

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A. No.
Q. Is there anything really unusual about Group B Strep or Klebsiella pneumonia?
A. Really unusual?
Q. Something you bring back from central Africa?
A. Exotic, you mean?
Q. Exotic.
A. Oh, no.
Q. Would either of those be considered flesh-eating bacteria as we know it on the news and hear about it?
A. No.
Q. When do you think his necrotizing fascitis began?
A. I think it probably began within 24 hours of his presentation.
Q. Presentation on that Monday morning?
A. Yes.
Q. At the doctor's office.
A. Well, when he noticed at home that this drainage was there, he had it.
Q. Have you ever done any personal studies or research on how long it takes for necrotizing fascitis in the lower extremity to begin and then present in the way it did with him?
A. No.

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Q. Why do you say 24 hours?
A. Because that's what I've seen occur in my experience.
Q. Tell us how it begins in the 24 hours and manifests itself.
A. Well, all right, we need to understand the anatomy. The anatomy of necrotizing fascitis is the infection is in the fascial plain.
Now, if you look at an extremity, let's just say in this instance a lower extremity, we are going to be looking at skin, we are going to be looking at structures beneath the skin which we would call dermis, we have subcutaneous tissues and then below the subcutaneous tissues is muscle. Muscle has over the of it what we call fascia.
Q. Like a sheath?
A. It is very much like a sheath and it's very thin and in the normal setting it's not really a real plane. It's a potential space.
And that fascia is there to allow muscles to contract and relax without taking skin with it, so that you have muscles that can sort of slide underneath the fascia and not be tractioned down by overlying tissue.
Now, what happens is you need to understand then that the fascial planes don't have strict anatomic

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boundaries. They can extend long distances before they attach and therefore are not limited, and there are many fascial planes in the body.
You can get an infection started in your leg, go up your leg, go up your abdomen, go up your chest and to your head. These are planes that are not strictly limited.
Now, if you keep that phenomenon in mind, once the organism gains access to that space, or organisms, depending on the mix, there's nothing that limits the infection from spreading along that line. So one of the clinical clues to suspecting necrotizing fascitis which is a surgical emergency is that you see rapid progression.
And surgeons will tell you and I'll tell you myself, but they will tell you they will see the infections extend right in front of their eyes while they are waiting to put the patient on the operating room table. They can't get there fast enough because it is moving so fast. That phenomenon at some point, soft tissue infection reaches that plane. When it reaches that plane there's nothing that limits it anymore in terms of extension.
So when you say 24 hours, you're even on the long side because it moves so quickly. I personally

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can tell you I've seen it spread in front of my very eyes in an amazing fashion.
Q. What type of organism is that you saw spread before your eyes.
A. I can tell I've seen A
Q. Group A Strep?
A. Group A Streptococuss, Clostridium and I've seen it in mixed infections that come up out of the perineum.
Q. Did you ever see Group B Strep?
A. Yes.
Q. And how does the necrotizing as ti begin what ingredients do you need before you get it?
A. You have to have access to that plane. Access to that plane can be from the skin. You have an ulceration, extends down in there, or it can extend up from say damaged muscle, hematoma, where a bacteria goes through your bloodstream, lands in the hematoma, into that off it goes.
Q. How bou a tl d d g necrosis of the kin?
A. That's
Q. Does that give you access to the fascia?
A. Sure.
Q. What else do you need?
A. You need bacteria.

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Q. All right. So where does bacteria come from in Jack Rogers' case, this Group B Strep and Klebsiella?
A. First of all, there is bacteria in nature. You won't find a sterile surface in your home and that's not a critique of you or your wife, please.
Q. I agree.
A. Okay. So in your body there are bacteria that live in your body. Group B Strep is found commonly in lower GI tracts, occasionally in the upper GI tract, but not infrequently in the lower GI tract, found in the urinary tract, can be found in the genitourinary tracts of women.
Klebsiella, Klebsiella can occur in your intestine, more likely upper than lower, but you can find it in the lower intestine. And there are organisms that come across our paths every day from water that get on your skin, sometimes transiently but it is there.
So in any one case if you ever say where exactly did you get that organism, that exercise isn't often done other than to say mixed infections in diabetics and necrotizing fascitis is not unusual.
Q. So you don't know where exactly his Group B Strep or Klebsiella came from.
A. With precision, no.

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Q. Could have come through his skin?
A. Yes.
Q. By washing with water that was not sterile.
A. No, that's not quite good enough.
We have to cover the difference between colonization and infection. Your skin right now, if we cultured it, my skin, I'll stop using you as an example of bacteria, if I cultured my skin I'll grow something. If I culture my nose, my throat, my rear end, I'll grow something. That's normal. That's colonization. I'm not ill, you're not ill, it is colonization.
At some point the organism starts invading, causing tissue damage, causing infection, quotation marks, and once we have infection, now you have a process that can then cause invasion, extension into other adjacent structures.
Those structures can go sideways, if you will, or they can go deep and that's what we would suggest meaning invasion, because the microbes produce substances which destroy your skin and your body, the so-called flesh-eating bacteria is producing enzymes that are actually turning your tissues into soup because they are enzymes. So you need that as well.
Q. What's the most likely scenario for Jack Rogers, came through his wound, his third-degree necrosis?

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A. I think that would be the most likely, yes.
Q. And obviously the Neosporin didn't prevent that, did it?
A. No.
Q. Neosporin doesn't really treat an infection, does it?
A. Yes.
Q. What kinds of infections?
A. Soft tissue infection, skin infection, ulcers, sores, we all know that.
Q. Neosporin?
A. Yes. I would be surprised to find somebody that's never used it in their life.
Q. Is it useful against Group B Strep?
A. Can be.
Q. Which ways can it not be, how effective can it be?
A. I wouldn't use it to treat a bacteremia, I wouldn't use it to treat an abscess. If you have it on your skin and you put this on, it can help treat a variety of infections.
Q. What about Klebsiella?
A. Should be effective.
Q. Why is it the Neosporin didn't work here?
A. Because the infection extended beyond the

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ability of the Neosporin to treat it, or the Neosporin cleaned everything up and the Klebsiella came in there afterwards because there's other bacteria in nature that won't be sensitive.
Q. Have you ever worked on ruptured popliteal cysts?
A. Have I done what?
Q. Have you orthopedically managed a ruptured popliteal cyst?
A. Yes.
Q. When did you do that?
A. Inpatient medicine.
Q. As an infectious disease expert?
A. As an internist.
Q. When in your career was that?
A. Many times.
Q. So you still practice as an internist?
A. Yes, I am an internist.
Q. And an infectious disease specialist?
A. Right.
Q. So you're still doing both.
A. Like you, you're a lawyer, you're an attorney, you do medical mal, but you could do corporate, you could do trusts and wills, but you're all lawyers but your subspecialty would be med mal, mine is infectious

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disease.
Q. Okay. Let's say within the last 10 years, about how many times do you think you've managed a ruptured popliteal cyst?
A. At least once a year.
Q. Have you ever managed a popliteal cyst before it ruptured as well?
A. No.
Q. Have you ever seen one on somebody's knee before it ruptured, bulging out?
A. You know, probably. But I'm trying to conjure up the patient. It's not unusual.
Q. Does there come a point in the rupture of a popliteal cyst when you would turn that over to an orthopedic specialist?
A. You know, to be honest, I've never seen one that I had to turn over.
Q. They all resolved?
A. M-hm.
Q. Under your care?
A. Given time.
Q. And so you've seen about one a year?
A. Probably, that would be about right.
Q. Typically in a certain kind of patient, older patient, younger patient, somebody who --

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A. I'm only seeing like one a year, so I wouldn't try and draw big conclusions from that.
MS. REINKER: YOU were nodding your head no. I don't think the court reporter got that.
I think the question was if he ever saw a particular age range and I *think* he was nodding his head no.
MR. ROBERTS: That's fine.
BY MR. ROBERTS:
Q. Have your patients who have had these had a particular cause?
A. Not usually. Some have had so-called degenerative arthritis, some it just happens.
Q. The people for whom it just happens, is it a traumatic injury?
A. Oh, yes.
Q. Excruciatingly painful?
A. Yes.
Q. When it ruptures?
A. Yes.
Q. Like screaming out in pain and agony?
A. Like getting admitted to the hospital because everybody is convinced they have deep venous thrombosis of their leg.

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Q. Have you read Jack Rogers' deposition?
A. Yes.
Q. He describes himself getting up and thinking he had a little muscle stiffness in his knee walking out to his truck, coming back and continuing to work.
Is that consistent with the kind of traumatic pain your patients have described?
A. M-hm.
Q. With a ruptured popliteal cyst.
A. Yes.
Q. He wasn't screaming out in agony, was he?
A. He was very soon.
Q. I guess my question is, is it instantaneous agony or hours and hours later?
A. No, no, no, no. I see what you're getting at, I get what you mean.
Virtually all the patients recognize an event after which pain and calf swelling becomes prominent to a point where they can't take it. That's when they seek care. Pain is also the reason they seek care, because they can't take it. That can evolve over a day, it can evolve in a shorter period. This cyst is an irritant, the material.
Q. Is there anything about the ruptured popliteal cyst that was the probable diagnosis here that was

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atypical of a ruptured popliteal cyst?
A. It's a little bit atypical in that it was more focal is the right word maybe.
Q. Focal where?
A. In the calf.
Q. He is describing pain and tenderness in his outer calf.
A. His description wasn't always consistent. What I took away from the description is there was lateral, upper, and there were times when he described posterior.
Q. I'm looking at Dr. Wellman's notes on October 12th, the first doctor who saw him for this. He says tenderness in the upper, outer calf. Pain is in the same area.
Upper, outer calf is not the true popliteal , is it?
A. It is part of it. Forms a boundary.
Q. But the typical rupture would be more towards the inner part of the knee, right?
A. What do you mean by inner?
Q. Towards the inside of your knee.
A. Into the knee --
Q. Looking at your --
A. That's the popliteal area.

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Q. The back of your leg over to the left.
A. The medial side.
Q. M-hm.
A. I've heard that.
Q. Isn't it more the medial side than the anterior side?
A. That's what they say, but that's not what I've seen.
Q. How often do your patients resolve just with rest and anti-inflammatories?
A. They all have.
Q. Have you ever had a patient who had not resolved after 12 days of rest, anti-inflammatories and ice, heat?
A. I don't know.
Q. He is describing a situation where the pain is continuously increasing, right?
A. Correct.
Q. And the swelling is continuing and the redness is continuing?
A. True.
Q. That's not consistent with the normal resolution of a popliteal cyst that's ruptured, is it?
A. Early on it's totally consistent.
Q. Comes a point where it is not consistent, right?

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A. Couple weeks in, yes, I would start being concerned it was something else.
Q. And in fact Dr. Posch sent him for an MRI, right?
A. True.
Q. To see what was going on.
A. Well, he sent him for an MRI.
Q. Now, he sent him for an MRI on October 21st and he reports the pain as having started October 9th, so now by the 21st we are 12 days later.
A. True.
Q. All right?
And would yon expect an orthopedic specialist who is convinced it is a ruptured popliteal cyst nonetheless to send him for an MRIwhich is a very expensive test?
A. Yes.
Q. Why?
A. He is getting towards the long side.
Q. So --
A. He is getting towards the extreme of a common problem.
Q. So why would the MRI be useful?
A. You have to ask him.
Q. You're not testifying in the area of orthopedics

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here?
A. I'm testifying that I think the management of this man was appropriate. There was nothing that I saw that said an MRI was not the thing to do. If he had concerns about the diagnosis, if he had concerns about other knee pathology, by all means, he needed to get that; if he had concerns about whether there was hematoma there, by all means, fine.
Q. Or infection perhaps?
A. Or infection perhaps.
Q. An MRI actually showed possibility of infection.
A. We are not quoting the report, though, are we?
Q. I can quote the report.
A. That would be fine. I'll stand by the report.
Q. I'm handing you the October 23rd MRI report. When Dr. Posch sent him for the MRI on October 23rd his impression was probable ruptured popliteal cyst, correct?
A. True.
Q. Now, after the MRI was done the impression is three different impressions. The first one includes four possibilities, right?
A. Yes.
Q. One of which is infe[illegible]
A. Yes.

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Q. And didn't the patient's family and the patient report increasing pain on the 23rd when the medications increased?
A. I know he had pain throughout this that was worsening.
Q. Is it your understanding the fact that he reported excruciating pain on the 23rd --
A. We have to look at the notes.
Q. Let's say that the family did and they wanted the doctor to read the MRI immediately, is that your understanding of the facts?
MS. REWKER: Objection.
A. You know, I don't know that I've seen that, at least in the records I have, that that's the fact. I mean I'm not going to say you're not telling me the truth. I don't know that I've seen that.
Q. Do you know who Betty Bellamy is?
A. No.
Q. She is Jack Rogers' sister.
A. Okay.
Q. Have you ever been told what her testimony is?
A. I know she has some pictures.
Q. Have you seen those?
A. I've seen the pictures.
Q. In color?

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A. They are in color.
Q. We will get t[illegible] later.
Do you have any understanding what [illegible] t to Dr. Posch's office on the 23rd?
A. No.
Q. Or what she told the UH radiology department?
A. No.
Q. If I told you that she told them that she wants to know when the MRI would be read and they told her it would be read and you can go see the doctor sometime next week, and she said I think my brother is dying, and that kind of information is reported to Dr. Posch, and he also had the MRI here, that he would have some duty to see the patient that day or have him sent to an emergency room?
MS. REINKER: Objection.
A. That's a big convoluted --
MS. REINKER: Also a lot of facts not in evidence and that won't be in evidence.
MR. ROBERTS: That's an if. They will be in evidence.
A. [illegible] to [illegible] seen that day, I would expect the patient to call the physician and be seen.

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What you're telling me, I'm not going to dispute that because I haven't seen any of those records to that effect, but it is too convoluted.

If Ms. Bellamy actually says my brother is dying, I don't believe I would need to tell her to seek medical care. I would give her credit for saying my brother is dying, I would take him to the emergency department for crying out loud, or if she thought Dr. Posch needed to see him and he is the managing physician, I would call Dr. Posch.

Q. Let's say she did that and asked him what to do and said we will go to the emergency room or come and see you, whatever you want us to do, and he told her I've seen the MRI, doesn't show any changes, come see me Monday.

Would that be appropriate?

MS. REINKER: objection.

No such facts in evidence.

A. I don't know. I don't know. I can't accept the premise without any of the records to any of that effect because that's first of all --

Q. A hypothetical question.

A. Not just hypothetical, you start off by asking me if this was interpreted as a possibility of infection, which it isn't. If there are records that

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Q. Even Dr. Posch.

A. No.

Q. Who was there.

A. He wrote was he was thinking and I accept that. And I can defend this based on what he had at the time that this was all taking place.

Q. If his sworn testimony adds to what you see in his records you would ignore that sworn testimony?

A. I didn't say I would ignore it. I just chose not to read it to form my own opinion.

Q. How does that differ from ignoring it? If you chose not to read it, that's called ignoring.

A. If you ask me a question about his sworn testimony that I have to comment on about the legitimacy or the truth or voracity or any of that, then I have to look at it and comment on it. If you ask me to base my opinion on this eschar, I don't need it because the record has to speak for itself.

Q. The medical record.

A. True.

Q. It has been my experience that doctors don't write down everything that you tell them.

A. Okay.

Q. Have you ever seen that?

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say that, I'm happy to look at them and say the records say you should have done X.

Q. Well, this impression was reported to Dr. Posch, correct?

MS. REINKER: Objection.

A. He is aware of the findings. How it got to him, I don't know.

Q. You've read his deposition?

A. No.

Q. Any reason why not?

A. Because the records have to speak for themself.

Q. Did anybody ask you not to read his deposition?

A. No, I chose not to.

Q. Why not?

A. Because when I review a case the records have to speak for themself. The only thing that occurred at the time that this was going on is what they wrote in their records. What people say two years later is all bias.

Maybe he has a vivid recollection, that's fine, maybe the patient has a vivid recollection, maybe all their family took notes, but the only thing that usually is written at that time is the record. And if I can't base my opinion on that record, I don't want to hear what he thinks.

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A.

Q. Patients give you a family history and you look at the page and you see one-fifth of it written down.

A. I wouldn't dispute that.

Q. We all know doctors don't write down everything you tell them, right?

A. True.

Q. If the doctor recalls specifically a description of a wound on a certain day and testifies under oath that's how it looked, I'm still at a loss as to why you would ignore that. It is his sworn testimony.

A. I didn't say I would ignore the appearance of a wound. In this case he documented the appearance of a wound. We would both agree that two years from now if I asked you to tell me what tie I was wearing, maybe you have that kind of memory, good for you, but I bet you won't, and if you didn't write it down you wouldn't remember. You might say, well, let's see, I kind of vaguely remember because we were arguing and you had a dark tie on.

Q. If Dr. Posch described this wound then on October 21st under oath as weeping and open, would that affect your testimony in this case, your opinions?

A. No.

Q. Why not?

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A. Because there's a description in the record and there's a description of a burn.
Q. I take it from your report that you think he had no duty to perform any cultures on October 21st?
A. True.
Q. That's your opinion.
A. Yes.
Q. And does that opinion differ whether he says it was a weeping and open wound or not?
A. Well, it's a burn. All burns are going to weep somewhat. Burns by their nature weep because you have exposed tissues. That doesn't surprise me.
Q. So basically it's your opinion he can have a third-degree necrosis about the size of a quarter; is that right? Is that your understanding how big it was, 2.0 by 2.5 centimeters?
A. Yes, and that's fair enough, fine.
Q. An inch by an inch.
A. A quarter is fine.
Q. And surrounded by a 4.0 by 8.0 centimeter area of second-degree necrosis.
MS. REINKER: Objection.
BY MR. ROBERTS:
Q. Right?
MS. REINKER: Not

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second-degree necrosis.
MR. ROBERTS: second-degree what?
MS. REINKER: I thought you were mistaken when you used the word -- I thought they talk about a reddened area, I think. MR. ROBERTS: That was in his deposition.
MS. REINKER I don't think so.
BY MR. ROBERTS:
Q. Doctor, let me hand you the October 21, 1998 notes from Dr. Posch.
A. Oh, good, okay. I have the same.
Q. All right. Why don't you read page 39, please, of Dr. Posch's deposition. You can read the whole thing, but I'll ask you about --
A. Out loud?
Q. No, just read it to yourself.
A. Okay.
Q. That's his description of what he saw on October 21st, okay?
A. In the deposition.
Q. That's his sworn testimony?
A. True.

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Q. Does that affect your opinion at all in this case?
A. No.
Q. Why not?
A. Because he has a burn.
Q. Okay.
A. He is not describing infection here.
Q. refer
A. Open skin. If we look at a burn that extends beyond the first degree which is sunburn, and you have exposed underlying soft tissues, they weep, which means fluid comes out of them because there is fluid in them. That's what causes burn patients to lose so much volume and go into shock. They are expected to weep or you don't have that degree of burn.
Sunburn, for instance, we all know sunburn doesn't weep, just gets red and painful, first degree. You burn your hand on the stove and you end up with a little open area. We all know you put a Band-Aid on, it's wet, the tissue juices come out. That's weeping, that's a burn.
Q. Okay.
A. That doesn't me.
Q. A third-degree burn?
A. Third degree is full tissue, *so* now you have an

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area that's deeper than that and frequently implies -- we use the term necrosis, but it is tissue death.
Q. Okay. And necrotic tissue cannot regenerate itself, right?
A. True.
Q. And necrotic tissue cannot resist infection.
A. True.
Q. And now he has a third-degree necrosis down to his fascia?
A. We don't know that.
Q. What's between --
A. It can go down into the -- you're talking about -- okay.
We are talking about layers of the skin below which is the subcutaneous tissues like fat and then there's fascia. So when we talk about burns, we are talking about skin.
Q. Have you ever seen any pictures of his legs?
A. No.
Q. He is a pretty skinny guy; does that matter?
A. We all have fat in our legs. I don't care how skinny you are.
Q. I'm not saying he has zero percent body fat, we have somebody who is diabetic, right?
A. Right.

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Q. He has coronary artery bypass surgery.
A. True.
Q. Doesn't that compromise the circulation somewhat?
A. To the skin?
Q. Doesn't he have coronary artery disease?
A. Yes.
Q. In the lower extremities, does that indicate some less than desirable c ul c
A. There is an association, but I don't know that he has any problem with the circulation in his legs.
Q. And he has some trauma to the back of his knee if he has this ruptured popliteal cyst on the 21st.
A. Could.
Q. He has an area of palpable fluctuance?
A. On the 21st?
Q. That's described there.
A. Right.
Q. He has third-degree necrosis, full thickness through his skin.
A. True.
Q. That cannot resist infection.
A. True.
Q. Skin is colonized.
A. True.

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Q. You don t think you need any treatment b than Neosporin and gauze?
A. True.
Q. No follow-up care?
A. He carc.
Q. For his wounds?
A. Yes, he was being seen regularly.
Q. How often was he going to be seen after the 21st?
A. He was going to come back to see him after the MRI result.
Q. Okay. Were there any special precautions given him, a diabetic with an open wound like that as to what to do or what to look for?
A. He is given topical Neosporin to dress the area.
Q. Is this w y u d for y p t
A. If there's no extension or infection I would use a topical and I would dress it.
Q. Have you ever had this situation, somebody has a third-degree burn about the size of a quarter?
A. About the size of a quarter, I've seen all kinds of burns. We have a burn center here.
Q. I know
A. Okay.
Q. What do you do when a patient comes in with a

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third-degree burn the size of a quarter, do you send them home?
A. Yes.
Q. With Neosporin?
A. Yes.
Q. Do you debride the wound?
A. Depends.
Q. Depends on what?
A. Age, how it looks, how it is progressing.
Q. If it has progressed from the 15th to the 21st, six days, from an area of redness to an area that has a black area the size of a quarter surrounded by 3.2 inches of red that's weakening, would you that?
Q. Depending on what?
A. Well, let's look at how this is going to heal. It is going to heal by retraction. That area is going to go like this (indicating). At some point it either stops or falls off, and then the skin on the outside heals in.
Now, every burn doesn't get debrided. You might dress it, you're going to watch it, follow it, and if it doesn't fall off or it doesn't continue to retract and get smaller, you may have to debride it off in order to facilitate healing. It is not going to be your first move to start debriding.
Q. What' the largest third-degree b that you personally have not ide
A. Well, I personally don't debride.
Q. Or recommend debridement b a surgeon.
A. Ask me the question again.
Q. ou've seen a lot of ti t with third-degree burns?
A. Yes.
Q. Do you work in the burn unit here, too?
A. Yes.
Q. Some people with third-degree burns need to be hospitalized, right?
A. Oh, yes.
Q. At what point do they need to be hospitalize
A. Depends on the host, their age, whether they have disease, who can take care of them at home and the extent of the burn.
You have 25 percent of your body burned, you probably need to be in because you are going to need to be grafted.
Q. 25 percent of your body surface?
A. Yes.
Q. If you stick your whole forearm in a barbecue grill?

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A. I haven't seen that one.
Q. My sister did it.
A. She stuck it in the grill?
Q. She tell.
A. She would need to be in because she has hand involvement.
Q. You don't think Jack Rogers should have been admitted?
A. When he came in, yes.
Q. On the 21st.
A. No.
Q. Shouldn't have been debrided?
A. No.
Q. Why not?
A. There's no evidence that he needed to be debrided.
Q. How much bigger would his hole have to be, third-degree hole?
A. He has a little hole -- it is not a hole, it is an eschar, a little round, hard, blackened area that's pared. Just like you would imagine when they say it's hard, that's exactly what it is, and it does this (indicating), it retracts, and at some point it stops retracting and either it comes off because the skin grows in and it just dries up and falls off, or it sits

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there and it doesn't heal and then they take it off, but that's the smallest amount they have to take off, because the less they take off the less area to re-epithelialize, and it is only the third degree that's likely to need the graft.
Q. You said it depends in part on the age of the patient.
A. M-hm.
Q. Jack Rogers was in his late 50s.
A. Younger every day.
Q. Also depends on his health.
A. Yes.
Q. The fact he has diabetes, is that something you would consider of whether you should admit or debride a patient, is that one of the factors you consider?
A. Yes.
Q. And all other things being cool, are you more likely to debride somebody who is diabetic than somebody who is not?
A. No.
Q. Are they less likely to heal?
A. Yes.
Q. To re-epithelialize?
A. Yes.
Q. Would the fact that he had coronary artery

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disease be a factor you would take into consideration in determining whether to debride this wound?
A. No.
Q. Why not?
A. It is irrelevant.
Q. Why?
A. It has no bearing on healing, debridement, infection, antibiotics, et cetera.
Q. I think you said it also depended on what kind of home care they are getting, whether you would admit them or not.
A. M-hm.
Q. Do you know what home care instructions he was given here.
A. Not really.
Q. What do you instr our paticnts to do for third-degree burns if they go home?
A. First of all, I would send them to the burn unit so they would take care of them, that would be my instructions.
Q. So you don't fully manage third-degree burns as a general rule?
A. No.
Alone you mean by fully manage?
Q. M-hm.

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A. No, I would not.
Q. Would you expect an orthopedic specialist to fully manage a third-degree burn?
A. It would be okay.
Q. Why?
A. Because he is trained --
Q. In the treatment of burn injuries?
A. Yes. They have to do general surgery before they are accepted into orthopedics.
Q. What kinds of surgeons are in the burn unit?
A. General surgeons.
Q. Is that who you turn your third-degree patients over to?
A. Yes.
Q. As a general rule you in your practice don't give home care instructions for patients with third-degree burns, you turn them over to the burn unit.
A. Right.
Q. And you don't know what home care instructions were given here?
A. I am I sure could find out, but do I have it in the back of my head, no, other than --
Q. Do you have any notes or anything?
A. I know he was given Neosporin.

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Q. Go ahead, look at whatever you want and see --
A. **Continue topical care -- talking about the burn now?**
Q. Yes, on the 21st.
A. **Do you want me to read from it?**
Q. You don't have to.
A. **Okay.**
Q. Just tell me what you learned after you read through it. Read your notes, whatever you want to read.
A. **It says -- I'll tell you what he says, continue the topical care to the burn, redressed with Neosporin and gauze, elevate the leg, rest, and then he has Lorecet. So that's what he is telling him to do for the burn care.**
Q. By the way, is it your understanding that the pain medications were continuously increased up until the 26th?
A. **Yes.**
Q. By the end of the day on the 23rd he was taking Lorecet every three to four hours, right?
A. **That's my understanding.**
Q. I can show you the chart.
A. **That's okay.**
Q. Would you describe Lorecet as a pretty serious

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pain medication?
A. **It's a pain medication.**
Q. So is aspirin. Is it stronger than aspirin?
A. **Yes.**
Q. Is it stronger than Codeine?
A. **Maybe a little.**
Q. Was it equivalent to Vicodin?
A. **That's not unreasonable.**
Q. And is three to four hours as necessary a typical prescription for Lorecet or is that for a patient that is very painful, in a lot of pain?
A. **You know, everybody experiences pain differently. That dose is acceptable, somebody perceives they have severe pain, that dose is okay.**
Q. You say okay, what do you mean?
A. **I could put the same problem in your leg and your perception of pain will be different than your partner's, and that's just the way pain is.**
If somebody has pain, you adjust their medication to deal with their pain and some take more pain medications than others and the deal is you give them doses up to where you're giving them overdoses, and this would not be considered overdose.
Q. Do you think that Dr. Posch should have included in his differential diagnosis on the 21st the

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possibility that what's going on in Jack Rogers' leg was infection?
A. **I think he did.**
Q. You think he did on the 21st?
A. **Let me be sure it was the 21st.**
Yes, because he stuck a needle in there.
Q. Let's look at his chart on the 21st.
Do you see the word infection there anywhere?
A. **What does that have to do with my opinion?**
Q. I thought you were relying just on the words and the record.
A. **I do, his actions.**
Q. Is the word infection --
A. **His actions tell you he was concerned about infection.**
Q. Is that the only reason to aspirate his leg?
A. **Yes.**
Q. And what did he find?
A. **Blood.**
Q. He wasn't trying to remove extra fluid?
A. **You can ask him that one. When I see a person describe fluctuance, what he described, swelling, he is looking at this, he is saying this man has pain, there's swelling, there's fluctuance, he preps it and sticks a needle in there.**

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Now, you could say what is he doing that for. He is doing that because he is thinking to himself this is getting to be on the long side of this problem, could there be infection there, so he stuck a needle in there and he did not get infection. He didn't get pus. He got blood.
Then maybe he starts thinking, you know, there's blood in here, maybe there's more pathology in the knee than I recognize, I'm going to do an MRI to define the anatomy because Mr. Rogers is not turning around after 12 days. His actions tell you he was concerned about infection.
Q. All right. And on the 23rd there's an MRI report which includes the possibility that this area of abnormal single intensity could be from infection.
A. **True.**
Q. Don't you think he should have taken any further action --
A. **But he did, he already had, he already stuck a needle in it. He did not say, geez, I think that's infection, go get an MRI and I'll check you in three days. He said I'm putting a needle in that area right now, and he did, and he got blood.**
And then he goes down the list, I don't find infection here, why is this man on the long side of

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this process.
Q. Okay. Well, would you agree that his impression contains his differential diagnosis?
A. Not necessarily.
Q. Is there somewhere else here that contains his differential diagnosis?
A. He may have not reported it at all.
Q. Isn't it typical for a doctor to Write down a differential conclusion so that down the road they can recreate what they are thinking a week or two down the road? You see dozens and dozens of patients at an HMO.
A. Not always.
Q. Is that good medical practice not to record your differential diagnosis?
A. It's an accepted medical practice.
Q. What do you do?
A. It varies.
Q. I would assume you write down your differential diagnosis, all the things you are thinking this could be
A. No.
Q. No?
as you go your career your ability to gcncrate a differential diagnosis gets longer and longer and longer and longer. You don't

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write all those things down. You document what you see, what you're doing, what you need to do next and, you know what, as you gain more experience you know what you were thinking when you look back at that.
And I look back at that and I see a practice that says to me I know why he is doing that.
Q. Even though you don't see it written in the records?
A. I'm in this world, you're not. You say that doesn't mean anything to me, he didn't write down he is thinking infection. We are not sticking needles in the back of people's calves unless we are thinking infection. I know what he is doing, I've been there, I understand it.
Q. Have you done that for ruptured popliteal cysts?
A. No, I have never seen this happen.
Q. Okay. Go ahead, I'm sorry, I didn't mean to cut you off.
A. I forgot what I was going to say.
Q. Fair enough.
A. Sorry.
Q. So you're coming up With some thoughts by Dr. Posch that aren't recorded here and you haven't read his deposition, but --
A. I didn't say thoughts. I said his actions.

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Q. You say you know what he s th g.
A. His actions speak for what hc was thinking. You don't have to acccpt that and I understand that.
Q. So it is your opinion that his actions indicate he thought there was infection or he considered it?
MS. REINKER: Objection.
A. He considered it.
Q. As of October 21st.
A. Yes.
Q. You are saying he ruled it out because of his aspiration and because he only got blood?
A. True.
Q. Why does that rule out infection?
A. Because it was blood.
Q. Tell me medically why that means there's no infection.
A. All right. I'll tell you, blood is an extremely good medium for bacteria to grow. Bacteria loves blood. If you go to a microbiology lab and you ask them, show me your most common culture media, we call it auger, it is called blood auger, has blood in it, and that's what bacteria grow on.
You put blood in your body anywhere and you put bacteria in it, it can grow. And bacteria multiples quickly. Depending on the organism they can double in

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20 minutes. So they can grow very quickly if you have blood there.
Blood that gets infected turns into pus very quickly. And the description of infected blood is very different than the description of hematoma or blood in the tissue, it is obvious. It was obvious to Mr. Rogers.
Q. Mr. Rogers?
A. Yes. When he came in that day it was obvious he knew something bad was wrong with his leg.
MS. REINKER: You mean on the 26th?
BY MR. ROBERTS:
Q. Which day?
A. When hc came in on the 26th with thc drainage that was brown.
Q. Like a volcano in his leg.
A. That's the point. You put bacteria in there, they are not going to sit in there for a week and just sort of smolder along. Thcy are going to say this is great, this is a great place for us to live. And they multiply fast and then they --
Q. So on the 21st Dr. Posch aspirates and he finds blood.
A. Okay.

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Q. Right?
A. True.
Q. Does that mean this area of palpable fluctuance is blood as opposed to pus?
A. I would be worried that it is blood. It is blood. He didn't get pus out of there.
Q. Why do you say you would be worried if it was blood?
A. Because I wouldn't go sticking around in there much more. I would say he has blood back there and that explains why he has some of these symptoms that are nagging along. Why does he have blood back there, is there other pathology in the knee other than the cyst. I understand that.
Q. Okay. But I was asking you why the aspiration ruled out infection, because he found blood instead of pus?
A. True.
Q. Blood has not become infected.
A. True.
Q. It could be quickly because you say blood --
A. It could happen.
Q. What other pathology do you think he was thinking about then?
A. I don't know.

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Q. What would you be thinking about?
A. I wasn't there.
Q. I know, but you've been telling me what you think he was doing based on your experience.
A. I think it was not unusual for him to get the MRI at that point because he is seeing, first of all, he has a ruptured cyst; secondly, he sticks the needle in the area and there's blood there; third, he has this burn overlying the top if it. It's a mess.
Q. Where is the blood from?
A. That's the question. Does this cyst lead to all this inflammatory milieu and he bleeds and that's why he is having all this pain on top of this cyst. And in addition he has this burn that's, I'm sure, not comfortable. And he is trying to sort out what's going on here.
He samples this to see if there's infection there, he needs to know it, and then he takes the next step of saying, okay, we will image this to see if there's other pathology.
Is there a big hematoma there, is there the cyst there, is there something else there that I'm not even thinking about, does he have other knee pathology. I understand that.
Do I know exactly every possible thing in his

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mind, no, but I don't need to. I understand the process.
Q. Okay. Let me ask you a dumb question.
A. I'm sure it isn't.
Q. If somebody has a ruptured popliteal cyst, what comes out, synovial fluid?
A. Yes.
Q. It is clear?
A. Yes.
Q. Like water on the knee?
A. Sort of, yes, it's pretty clear.
Q. If the palpable is from synovial fluid wouldn't you expect him to aspirate clear fluid?
A. Sure.
Q. But he has blood instead.
A. Yes.
Q. So there's some pathology going on in his knee, the blood is coming from somewhere?
A. Yes, fine.
Q. Did you ever consider that this was an infection all along?
A. Oh, yeah.
Q. Going back to October 8th or 9th?
A. I wouldn't have considered that, no.
Q. Betty drew some pictures which have little black

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spots in the middle of the wound going all the way back to even the 13th.
Any explanation for what she was seeing?
A. If I had to guess why she has drawn a black spot, I'm thinking that's the necrosis, eschar.
Q. All the way back to the first use of the heating pad?
A. You know, I'll be honest with you, I've sort of like seen this almost like (indicating), the dates I haven't focused on, is that what you're asking me?
Q. You can look at them, go ahead.
A. That's good. This is the 13th, right?
Q. Yes, this is the first one.
A. Okay.
Q. Just for the record, I handed you drawings by Betty Bellamy dated 10-13 through 10-26, each of these has a little black spot and my question was, do you know what would explain the spots that she says she saw all the way from the 13th through the very end?
MS. REINKER: Objection.
A. No.
Q. No?
You are saying before you thought it might be an eschar?
A. Possibly.

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Q. You don't think that anymore?
A. You have to tell me when she drew these. These are dated 10-13-98.
Did she actually draw them on that date?
Q. She drew them a few months ago.
A. I would say the best explanation, if you ask my opinion --
Q. M-hm.
A. -- is her recollection is fuzzy. What I think she is trying to represent by that is an eschar, but when you start dating things and she is drawing these day by day by day, she may have a very good memory and good for her. I'm not -- but these are drawn late, this is where I start getting into the problem of what happens when we try to go back two years and recreate events.
Is it perfectly accurate, the only perfectly accurate -- I shouldn't use that term. The only record at the time is what was written down at that time. And her recollection may be very vivid about an area of eschar, but it may not be timed as nicely as we like to see by saying this picture is 10-13-98, because she drew it two years later. But I think --
Q. And the eschar is formed after what?
A. Well, eschar, if you burn skin to the point

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where it dies, it turns black and it's hard like leather. That would be a good -- if you put a piece of leather on your skin and felt it, that is what it feels like. It's hard and it is black because it has no -- it's dead. And that would be what I think she is trying to create there, I think, if you're asking me to guess.
Q. Let me ask you the big picture question.
You think what happened here, he suffered a burn from the heating pad?
A. Yes.
Q. It doesn't all come from an underlying infection.
A. Absolutely not.
Q. Why not?
A. It is too indolent.
Q. Too what?
A. Indolent, it is too slow. If it came from inside out, it would have happened just like it happened that day when he came in. He wakes up and boom, just blows open. That's what I would expect.
Q. So you think this happened in 24 hours on Monday morning.
A. And I think that's on the long side.
Q. In your opinion is there any reason to put him

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in the emergency room on Friday?
A. I don't have an opinion on that.
Q. How about Saturday?
A. I have no records to go by about whether he needed to be there or not. I clearly believe he needed to be in on the 26th. There's no question about that.
Q. We all agree with that.
A. Okay.
Q. Let's go back to what you believe Dr. Posch was thinking on the 21st and why he ordered the MRI.
When he got the MRI results and they gave him this mix set of impressions, what do you think he should have done then?
MS. REINKER: Talking about on Monday when he got the results?
MR. ROBERTS: You're assuming -- that's not in evidence, a disputed fact.
A. Let's say it's a disputed piece of evidence. He sees this man on the 21st. He was already thinking in his mind ruptured cyst. He has an area of fluctuance.
Q. Full of blood.
A. When he puts a needle in and then he pulls out blood.
MS. REINKER: Couple of

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drops. I'm sorry. You're misrepresenting this as being full of blood.
BY MR. ROBERTS:
Q. Are you saying you think it's -- I asked before if you thought the palpable fluctuance was from blood.
A. Yes.
Q. I think you said yes.
A. Yes.
Q. When I say full of blood am I misinterpreting? Obviously some other tissue.
A. Okay, full of blood, blood there, whatever. I forgot what I was supposed to say.
Q. You were talking about his mental state at the time, what he was thinking.
A. Fine. So he looks at this and says there's blood there, I think there's a cyst, now there's blood there. I send him for an MRI, the MRI report comes back with a differential diagnosis, this, this, this, this.
He looks at it and goes, well, I aspirated the thing and it wasn't pus. The description of this could be hematoma and cyst. Fine. This hasn't shown me anything new. There's no other pathology in the knee, all right, fine. He had some bleeding back there, he doesn't have anything on this image that he didn't

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already know.
Q. It also has infection, right?
A. He aspirated it on the 21st. He got blood and then from there he said now I need to go to MRI. He clearly didn't go to MRI on Monday when he look. at this and he sees brown pus. He didn't say go for another MRT.
Q. He had the MRIresults before he saw him on Monday; would you agree with that?
A. Okay, yes.
Q. Regardless when he got them, just for the moment when Dr. Posch saw the word infection on the MRI, couldn't he have thought -- shouldn't he have thought between the 21st and 23rd that blood could now become infected?
A. No.
Q. He does have an open wound, third-degree necrosis, right? It is not medically possible --
A. Go ahead.
Q. I'm asking too many questions at once.
MS. REINKER: what is the pending question?
BY MR. ROBERTS:
Q. Here is the question, between the 21st and 23rd could it be medically impossible for that blood at the

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back of his knee to become infected?
A. Impossible, no.
Q. In fact, he has diabetes, he has a third-degree necrosis right there, right?
A. True.
Q. That could be a source of infection of that blood between the 21st and 23rd, right?
A. True.
Q. And how is it that someone seeing the MRI on the 23rd who knows the whole clinical picture like Dr. Posch does could just rule out that that blood had become infected between the 21st and 23rd? Could they?
A. Yes. It could have not changed, the sizes could be small.
Q. With no other information --
A. You didn't tell me no other information. You said could he do it --
Q. Could he rule it out?
A. Yes. He could look at it and say it is small just like when I put my hands on it on the 21st.
Q. He would have to see the patient to do it.
A. They are not describing this thing in his calf as big as a watermelon, they're describing this little thing there. He thinks, I felt that area, I stuck a needle in, it's blood and here is this MRI report that

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docsn't tell me anything I don't know.
Q. This MRI is two days later.
A. Yes.
Q. Could have been infected?
A. Yes.
Q. How could he exclude the possibility of infection when it says infection and two days have passed between the time he has seen him and the morning of the 23rd?
A. As soon as it gets infected, it grows, gets big. He doesn't find something on the MRI that says this thing is now huge.
Q. He can't compare what he saw on the 21st to verbal words coming off an MRI report.
A. I don't know.
Q. Can he?
A. That's possible. He is sitting there looking at this thing. He knows in his mind just like you would know if you had your hands on it, you have a vision of the size of this and he gets this report. When I look at this report I thought this doesn't say a thing. The fascial planes aren't involved. There's some edema. Big deal.
This is not the MRI of a necrotizing fasciitis, period.

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Q. What is it? I didn't say it was, okay?
What is it about the October 23rd MRI that indicates to you the size of the area of palpable fluctuance?
A. It's my sense of what they are saying.
Q. You want to go by the records, what do the records say? What records there tell you what size this is?
A. Because they don't make a big deal out of the size, they don't say --
Q. Why should they?
A. I see what you're doing.
I'm not going to be able to answer this to your satisfaction. I can tell you what this says to me, this is a small, little thing. They didn't even measure it.
Q. Let me ask you this --
MS. REINKER: They didn't even what?
THE WITNESS: Measure it.
BY MR. ROBERTS:
Q. When it says, quote, abnormal fluid collect that is l s well as focal in the subcutaneous and deep issues of the e compartment of t knee, close 1 is tl the pi ss

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Q. Impression.
A. That's down here. They describe it up here.
Q. Let's look at the impression, number 1, I just read the sentence?
A. True, but then under here is where they actually give their description. Lobular, subcutaneous.
And listen, like I said, I can't answer to your satisfaction because I don't have a measurement, but they don't have a measurement because it is a teeny, little thing that they are not even that impressed with. They didn't even make a call.
If I showed you this --
Q. What do you mean they didn't even make a call?
A. They didn't.
Q. Who didn't call who?
A. I'm sorry, they didn't make a diagnosis, a call, you're out, you're safe, a call.
Q. All right.
A. Sorry.
They were so underwhelmed they didn't even make a diagnosis on this. They just said this could be infection, cyst, blood or trauma. Did they leave something out? They should have said this could also be cancer and then they would have covered all the bases.

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Q. You re speculating here, aren't you?
A. No. I'm trying to tell you when I look at that, that's what I see.
Q. Just throw it in the garbage, don't worry about it.
MS. REINKER: whoa, whoa, whoa, whoa.
BY MR. ROBERTS:
Q. Little thing, doesn't matter.
MS. REINKER: You're all speaking at the same time. Can we have a question and then an answer?
THE WITNESS: sorry.
MS. REINKER: Do you have a question?
MR. ROBERTS: I'm waiting for the end of the answer.
A. You asked me how do I get this notion of size, that's how this all started.
This is based on what I see in reports. When you're looking at pathology, that is significant. What I see here is a very sort of hazy insignificant report.
Q. He has an abnormal signal in the subcutaneous and deep fat in the posterior compartment of the knee, says infection, could be infected?

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A. They listed four things it could be.
Q. That's one of the four; is it not?
A. And they didn't pick one.
Yes, but they didn't pick one.
Q. Would you expect them to Dick one?
A. Yes.
Q. Why?
A. Because if there was real pathology they would say this is most consistent with X. They couldn't even say out of four things which was most likely.
Q. So are you saying Dr. Posch is saying in his opinion this is just an insignificant MRI finding, just a tiny, little thing?
A. I don't know what his opinion on that is.
Q. You don't know what he was thinking when he read this?
A. No.
Q. But you know what he was thinking on the 21st.
A. I know what I'm thinking. You're asking my opinions.
Q. Well, are you saying he is free to ignore this?
A. He didn't ignore this.
Q. Why do you say that?
A. Because the patient came in to see him in follow-up.

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Q. Okay. If he saw this on the afternoon of the 23rd -- or it was reported to him, you understand he could call in and get a radiology report over the phone?
MS. REINKER: Objection.
A. For Mednet?
Q. M-hm.
A. You're telling me that's what their practice is, fine, I accept that.
MS. REJNKER: objection.
If you don't know the practices in effect at the time at University Hospitals and Mednet, you can't testify.
If he doesn t know he doesn t know.
A. I did answer the question. I said I don't know the practice of Mednet. If you're telling me something that's accurate, I say okay.
Q. Let's say Dr. Posch had this reported to him, this MRI report on the 23rd.
A. Okay.
MS. REINKER Hypothetical question?
This is a hypothetical question, so it's clear.
MR. ROBERTS: At this point

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it's a hypothetical.
BY MR. ROBERTS:
Q. If he has this MRI report and he is told that the patient is in serious pain, wants more pain medication, that the patient's family wants to know if he should go to the emergency room or be admitted and he reads this, if he puts that whole clinical picture together and he knows that he has blood back on the 21st, he is diabetic and has a third-degree necrosis, don't you think he should have been seen that day?
MS. REINKER. Objection.
A. I don't know.
Q. Well, what factors would enter into your decision --
MS. REINKER: I'm objecting to all the misrepresentation of facts which will not be in evidence.
MR. ROBERTS: YOU can object to the whole deposition.
Q. Do you remember my question now?
MR. ROBERTS: Read it back because now we have been interfered with. Read it back, the whole thing.
THE NOTARY: Question: "If he has this MRI report and he is told

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that the patient is in serious pain, wants more pain medication, that the patient's family wants to know if he should go to the emergency room or be admitted and he reads this, if he puts that whole clinical picture together and he knows that he has blood back on the 21st, he is diabetic and has a third-degree necrosis, don't you think he should have been seen that day?"
MR. ROBERTS: I am giving you a standing objecting for every single word out of my mouth.
MS. REINKER: Kevin, I would ask that you not continue to misrepresent things. That's not appropriate.
MR. ROBERTS: YOU heard her testimony, that --
MS. REINKER: I heard her testify she had no conversation with Dr. Posch and doesn't know what he was told.
MR. ROBERTS: His office.
MS. REINKER That's a big difference.
MR. ROBERTS: I see. Called

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agency.
BY MR. ROBERTS:
Q. I think your answer was you don't know.
MS. REINKER: Objection.
A. But then you asked another question.
Q. Which is what factors would cause you to want to see him that day or have him admitted?
A. Okay. Let's say the family calls in, he is having drainage from the area that sounds like pus; let's say the family calls in and says he has a fever; let's say the family calls in and says, you know, this area that was already whatever size they perceived this to be has actually gotten bigger and now extended; let's say they call in and say, you know, he's getting dizzy when he sits or stands up, feels sweaty, those are things that I would say that's a change in his condition.
If you say it is pain, just pain, if it's pain, you can manage his pain as he has been doing by trying to adjust his pain medication to deal with his pain, so yes, all those things are factored in, but there are other factors that would say something has changed. That's what I'm not hearing in this exchange.
Q. At this point, and I say this point, as of the time of this MRI, after the MRI report, Dr. Posch still

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doesn't exactly know what's going on, does he?
A. I don't know.
Q. But I *think* as you've discussed before it isn't absolutely clear that he has a ruptured popliteal cyst [illegible] everything going on.
A. I think he has a ruptured popliteal cyst.
Q. Doesn't explain everything that's going on, right?
A. He has blood there. That may be related.
Q. He has blood.
A. He has a burn.
Q. He has blood, a burn, he has increasing pain, it is not resolving [illegible] after 12 days.
A. Okay.
Q. Right?
A. Fine. And the MRI doesn't give us any more information.
Q. Right, and the pain is increasing, so you can't necessarily attribute the pain increase to any one particular thing, can you?
A. Inadequate pain management, it could be.
Q. What do you mean by that?
A. He has never adequately managed him, never actually given him the right amount of drug to manage the pain with this patient, this popliteal cyst, this

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blood.
Q. He should get a larger dose or stronger medication?
A. That should be on consideration, yes.
Q. Also on consideration that something more serious is developing.
A. It's possible.
Q. If the pain medication managed him on Wednesday and Thursday, but now it is not on Friday --
A. I'm not of the impression that at any time in this course that there wasn't pain ongoing. I may have misread, but I didn't see any description that ever said, you know what, I was pain free today.
Q. I will agree with that, but by Friday he is complaining that the pain is much more, right?
MS. REINKER: Objection.
A. Okay.
Q. We will look at the chart, all right? Pain is increasing.
MS. REINKER: After MRI.
BY MR. ROBERTS:
Q. On the 23rd, a telephone contact records on the 23rd his pain is increasing.
A. True.
Q. Wants more pain medication?

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A. Right.
Q. So --
A. He ups the dose.
Q. I understand.
Now, can't you infer from that that things are getting worse by Friday?
A. It is not.
Q. The same dose is no longer working on Friday.
Why would he wait until Friday if it hurts like hell?
A. We have to ask Mr. Rogers that. What I'm trying to -- what I tried to say, when somebody called in and said there's something different, it is not just pain, it's all the other things I would expect to be happening with infection that's not being communicated. And not only not being communicated, but in Mr. Rogers' deposition, which I did read to see his perspective, there was nothing that I saw, that could be me, that suggested he was infected until that morning when this thing blew open and there was brown, nasty stuff. It was all about pain management, is my opinion. That's just how I looked at it.
Q. You're not saying that all the pain and swelling and stiffness and increasing pain and failure to resolve could not have been caused by an infection or

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infectious process?
A. Not this whole time, except this --
Q. Let's say the last week.
A. I don't accept it.
Q. You are saying no infection.
A. Not at all. I refuse to accept it.
Q. You refuse to?
A. Yes, it doesn't make any sense.
Q. That pain, increasing pain, increasing stiffness, continuous redness and everything was getting worse cannot be explained by infection?
A. No.
Q. Medically cannot?
A. No. It is all about a ruptured popliteal cyst. You are just describing the ruptured popliteal cyst syndrome. It mimics other pathology. He put a needle in it in his office and he got blood and nothing is changed other than pain. And he has stiffness in his knee which has been there since this started with his limited range of motion.
And then something changes, it's obvious to everyone. He didn't have any problem at all saying look how this changed. He brought the cup in. In fact, he had in his deposition almost like that little game because he knew it was different and not that he

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was playing a game, but it was clear to him.
Q. All right. His pain changed, didn't it, over the last week?
A. He had pain the whole time. Was it getting worse, I don't necessarily disagree with him that his perception was his pain is getting worse. I accept that. I don't have any problem with that.
Q. The swelling is getting worse, isn't it?
A. That's hard for me to say based on what's in those records.
Q. Stiffness is getting worse?
A. Stiffness is about the same as best I can tell.
Q. His ability to walk is getting worse?
A. He is having trouble walking all along.
Q. Now he can't even walk to the car or the bathroom?
A. On the 26th?
Q. No. On the 21st, he came in a wheelchair.
A. Okay, his knee is stiff.
Q. On the 15th he could walk in. He was given
[illegible].
A. Okay. He wasn't on crutches if he was walking in. I think probably there's pathology there that's starting to say there's range of motion problems here, he has a ruptured popliteal cyst, he is having pain, he

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comes in in a wheelchair because his range of motion is 45 to 90.

I hear what you're saying, but you're arguing pain equals infection. I can't accept that.

Q. I'm not just saying just pain, there's the whole picture.

A. Where is the fever?

Q. His p s g. : w orse, his pain is worse?

A.

Q. He never did get a fever, did :, en th gl he had necrotizing fascitis? He didn' present ith a fever even on the 26th?

A. You know what, I forgot to look at that in the record.

MR. ROBERTS: Pull out the admission note.

A. He actually does have fever in the hospital, it is on the 26th. His temp was 37.5 which is fever.

Q. Translates to what in Fahrenheit?

A. 38 is 100.3, so he is in the 99s.

Q. All right. What is 46.9, is that a fever?

A. No.

Q. I have the Lake Hospital medical surgical sheets for 10-26-97 at 1330 hours, says 36.9.

A. Okay. I have that one. That's one reading.

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That doesn't count. You can't just say one reading, that's it for the day.

That evening he is up to 37 and a half?

A. That's fever. You said he didn't have fever the whole hospitalization

Q. I didn't say that.

A. You said he didn't have it the whole time he had necrotizing fascitis.

Q. On presentation on the 26th in the morning.

A. You don't just get one temperature reading and say someone had no fever, I'm sorry, and every other reading after that that day was elevated.

Q. Okay. Let's go back to the last week before he got necrotizing fascitis. You're not saying any of the symptoms he had then are -- let me ask it this way, pain could be associated with infection, correct?

A. True.

Q. Swelling, too?

A. True.

Q. Stiffness, too?

A. No.

Q. If your leg swells up enough it gets pretty stiff, right, inability to flex your leg?

A. No, no, no, no, no, no, no, no.

Q. Doesn't happen?

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A. Well, stiffness where? Are we talking about a joint, are you talking about the ankle, what do you mean stiffness?

Q. Inability to flex your leg.

A. He had his leg flexed.

Q. I'm asking a theoretical question.

A. Okay, about what?

Q. Is that the kind of stiffness --

A. What infection is that supposed to be a sign of? You said these are signs of infection, you said stiffness, I said no, I don't accept that.

Q. The day he was diagnosed with necrotizing fascitis the doctor tried to bend his leg, did you read that testimony?

A. True.

Q. And he was in excruciating pain.

A. True.

Q. When he tried to bend his leg.

A. Right.

Q. Why would that be?

A. Any number of reasons, popliteal cyst, hematoma in the tissues, fluid in the knee.

Q. Also infection?

A. He is holding his knee flexed, that's the worst position to be in if he has infection in the joint.

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Q. Why?

A. You're going to be challenged with this, a joint --

Q. You can draw if you want.

A. No, I'm not drawing.

A joint has fluid in it, it's a three-dimensional structure. Think of a sphere. There are bones inside of it and those bones have cushions and there's fluid in there. When you bend a joint the pressure inside the joint skyrockets.

The joint will always be held in the neutral position because the neutral position allows the least amount of pressure which is most painful.

You're telling me somebody has their leg bent, it has nothing to do with joint pathology, other than the fact he has this syndrome of a ruptured popliteal cyst, and that is all part of it.

So I say fine, that's not surprising to me that he is having that trouble from the ruptured popliteal cyst. Is that a sign of infection, I can't accept that.

Q. On the 26th?

A. On any day that you tell me he has his leg flexed, a sign of infection.

Q. You're saying he tried to bend his leg,

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Dr. Posch tried to bend Jack Rogers' leg on the 26th and the fact that he is in excruciating pain and almost jumped out of his wheelchair cannot be attributed to infection?

A. Anything is possible.

Q. I'm not asking you what's possible.

A. All right. Here is why I don't accept this, 17 days ago this happened, his leg has been flexed that whole time. He has contractures now.

Q. Why do you say it has been flexed for 17 days?

A. The description of his knee shows a range of motion that was limited. He couldn't extend his leg from the beginning when the records described this. You contract, and then you start trying to do this after all that time, and it is going to be painful.

Does he have infection on the 26th, yes, he reeks of infection.

Q. Massive infection from halfway up the thigh down --

A. That is necrotizing fascitis, just whammo.

Q. And that wouldn't make it painful when you try to flex that leg?

A. Yes, there would be pain, and he has had pain like this the whole time, but it is not just pain that day, is it? It bursts forth with fluid, he swells up.

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Q. One thing at a time.

A. Fine.

MS. REWKER: Just slow down a bit.

BY MR. ROBERTS:

Q. His pain is increasing the whole last week before he is diagnosed with necrotizing fascitis?

MS. REINKER: objection, that's been answered repeatedly. Is that a question, is his pain increasing?

MR. ROBERTS: M-hm.

MS REINKER: t has en answered t dl

Q. So is it your opinion, octor, there's no sign of infection until he had drainage on Monday the 26th?

A. Yes.

Q. hen you say no , you mean no sign reported Dr. sch, or no sign as it must have i at the time?

A. I couldn't find anything in the records or in Mr. Rogers' deposition that I could say look right there, infection, until the 26th.

Q. All right. Let me ask you this, from the 21st, if Dr. Posch had decided to debride him, okay, he is a

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surgeon, he could decide to do that, right?

A. True.

Q. He wouldn't have to refer him to somebody else?

A. True.

Q. He could do it right there in his office?

A. Yes.

MS. REINKER: In his office?

THE WITNESS: Yes, yes.

BY MR. ROBERTS:

Q. Let say e de d s to do that, would that malpractice on the 21st based on what he saw and what know from the record?

A. No.

Q. Why not, why would that be appropriate?

A. Because he looked at it and said it needs to be debrided.

Q. If he had done a culture that day l th t bc malpractice?

A. No.

Q. Why not?

A. I can't think of an instance where doing a culture is malpractice.

Q. Okay. If he had admitted him for debridement and a deep wound culture and prescribed general antibiotics, would that have been malpractice?

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MS. REINKER: objection. I object to this whole line of questions.

A. He didn't need antibiotics.

Q. I'm saying if he did.

A. If the man developed anaphylaxis and died, I could be sitting here trying to defend it. You asked me a wide-open question. I'm giving you an example. Then I would say see, that's what you get, you gave him antibiotics he didn't need. He had a 1 in 24,000 chance he drops dead from anaphylaxis and now --

Q. Doctor, you're not saying when somebody is anaphylactic it is auto atically malpractice, are you?

I'm are.

Q. Did you e er see that hold up, th s i --

A. I have seen things hold up that are just about

Q. All right. Well, has been a patient for over 35 ears, you l th some hance of ving i an antibiotic he is allergic to and gets anaphylactic shock?

A.

Q. All t That's a it of l ti here isn't it?

A. You did ask me, though.

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Q. I'm not saying could something have happened, I'm saying would it have been malpractice to put him in the hospital, debride the wound, do deep tissue cultures and give him a general antibiotic?
MS. REINKER: Objection.
Do you mean the legal definition of malpractice, is that what you're asking?
BY MR. ROBERTS:
Q. Yes, would that have been below the standard of care for Dr. Posch?
MS. REINKER: I don't know that he knows the legal definition of malpractice
A. You have to deal with the outcome after action, not just an isolated action.
Q. What do you mean?
A. I can imagine an outcome where that would be malpractice, I have given you an antibiotic you didn't need. I didn't tell you, by the way, that your chance of dying from penicillin anaphylaxis is 1 in 24,000, whatever, and I can't make a case you had infection, so why did I give you that antibiotic.
Q. I want you to look at two drawings by Betty Bellamy, one on October 15th and the other October 21st, okay?

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Assuming those are accurate, okay, does the change in his condition of that wound from the 15th to the 21st in any way indicate infection?
A. I don't know from these two.
Q. I'm saying assuming --
A. Assuming what?
Q. -- they are an accurate depiction of what she saw on that day.
MS. REINKER: Objection.
A. You know, I don't know.
Q. Would it be reasonable to include infectious process in a doctor's differential diagnosis if he had seen those two different conditions six days apart?
MS. REINKER: Objection.
A. These pictures?
Q. No, if he had seen that condition, the change from the 15th to the 21st as depicted there, would it have been reasonable to include infection in a differential diagnosis?
MS. REINKER: objection.
We have no idea what these drawings depict. This is a non medical person drawing pictures.
MR. ROBERTS: Let him answer the question.

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MS. REINKER I'm objecting.
MR. ROBERTS: Please stop answering for your witness.
MS. REINKER: Bringing pictures this lady drew two months ago and trying to say they are medical representations--
BY MR. ROBERTS:
Q. Doctor, do you think I'm tricking you, you can't answer the question? Do you need your lawyer to help you answer the question?
A. You know, let's be honest, you are putting pictures in front of me that she drew from recollection and we do have records that describe the pathology and based on those descriptions we have actions by this physician.
And this is a nice try on her part, but it is two years later, I'm sorry. When you get right down to it, come on, she is drawing it as if she can tell the difference in her memory two years later 24 hours apart.
I don't want to throw darts at her, I've not met her, I'm sure she is a nice person. This is questionable.
Q. All right. So you think what she drew on the

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21st does not describe an area of third-degree necrosis surrounded by an area of second-degree burn?
A. I don't know what she drew on that day.
Q. I'm asking you to look at this and tell me if that looks like it?
A. I have seen artwork from my child come home from elementary school that could be a boat. I don't believe I have to accept this picture that she hand drew, this series of pictures two years later as any accurate depiction of anything and I'm not going to accept that even in the hypothetical.
Q. How would you draw what's described on the 21st?
A. I would try and draw it on the 21st if I was going to draw it. I wouldn't wait two years.
Q. I'm saying if you had to, how would you draw it?
A. I'm not a very good artist.
Q. All right. How did you get involved in this case?
A. I was called, I believe, by Ms. Reinker and I think after that I got this letter.
Q. Can I see the letter, please?
A. Yes.
Q. Thank you.
Have you ever talked to Dr. Lerner about this case?

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A. No.
Q. Do you know him?
A. Yes, I do.
Q. Do you know why he couldn't testify?
A. No, I don't.
Q. Did you ever look at any other cases for Susan Reinker?
A. The very first case I ever did.
Q. When was that?
MS. REINKER: Does he have to say what year?
MR. ROBERTS: Yes, aught 6.
MS. REINKER: I t quite.
MR. ROBERTS: It has taken on a new meaning, this is aught 1.
A. I'm thinking '88 or '89.
Q. All right. Have you ever been a PIE insured?
A. No.
Q. Did you ever go to the law offices of Jacobson, Maynard, Tuschman & Kalur?
A. I might have. Are they -- weren't they up --
Q. Up in the North Point Building, up on the lake.
A. Was I ever up there? It's possible.
Q. How many cases have you looked at for Susan Reinker over the years?

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A. I know this one and I know the first one and maybe one in between or two. I just --
Q. You ever look at any cases for members of the firm of Jacobson, Maynard?
A. Yes.
Q. How many?
A. It has been a while since they've been doing this.
Can you tell me what year they closed? That will give me an idea; do you know?
Q. '97, end of '97 I think. That's my recollection.
A. Probably in those years I was maybe seeing half a dozen cases a year. Maybe.
Q. But they asked you to review --
A. Yes, they would ask.
Q. Did you ever testify for any of the lawyers in their firm?
A. Yes, I'm sure I have.
Q. Do you remember the names of any of the other lawyers?
A. If you mentioned them I would recognize them.
Q. Pat Murphy, tall guy, red hair.
MS. REINKER: If you don't recall, Doctor, you don't recall.

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BY MR. ROBERTS:
Q. John Polito?
A. Yes, I know John.
Q. Bill Bonezzi?
A. Does he have white hair?
Q. M-hm.
THE WITNESS: Is that your firm?
MS. REINKER: M-hm.
A. I know Bonezzi. I didn't testify for him, but I know who he is.
Q. How about Mr. Switzer?
-- a
Q. M-hm.
A. No, I don't know him.
Q. You testified for Mr. Bonezzi and Mr. Polito?
A. Not Bonezzi per se. He was involved in a case representing someone else where I was a defense expert. That's how I recognize the name.
Q. How about Mr. Polito, do you recognize his name?
A. Yes, and I'm trying to remember. For some reason I think foot, there might be a podiatrist named Polito.
MS. REINKER: There is.
A. That's why.

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Q. Do you know Dr. Fosch?
Q. Do you know Dr. Wellman?
A. No.
Q. Are you going to testify for Dr. Wellman as well?
A. Yes.
Q. You ever prescribe r pads for your patients?
sure
Q. What do you do now, still prescribe electric heating pads for your patients?
A. If they need it.
Q. So it's a supposition.
A. I use it myself.
Q. Do you ever determine whether your patients have any nerve damage before prescribing a heating pad?
A. I don't know that I have.
Q. Obviously you know what diabetic neuropathy is.
A. Yes.
Q. It's very common in people who have diabetes.
A. Yes.
Q. Longstanding.
A. Yes.
Q. Had it 20 years.

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A. Wouldn't surprise me.
Q. Is it more common in people who have non insulin dependent diabetes?
A. I don't know if that's true.
Q. If someone does have diabetic neuropathy wouldn't they, all other things being equal, be more likely to be burned by an electric heating pad than somebody who has healthy, intact nerve sensation?
A. Not necessarily.
Q. I know not necessarily, but wouldn't a person who has nerve damage be less likely to detect burn damage than someone who doesn't have nerve problems?
A. True.
Q. That's just pretty obvious, right?
A. Yes.
Q. Have you ever had a patient burned with a heating pad?
A. No.
Q. Have you ever heard that reported by other doctors or in the literature?
A. I can't -- nothing jumps out at me.
Q. What instructions do you give your patients with respect to the use of a heating pad?
A. Depends on what they are using it for.
Q. Let's say they have an orthopedic injury to

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their knee. That's what you think they have.
A. And I'm going to use a heating pad at some point?
Q. I'm assuming you're prescribing a heating pad.
A. Okay. Well, you limit the amount of heat and you limit the time that it's on at any one given point in time.
Q. What limitation do you put on the heat?
A. Well, generally I like to use what they call moist heat so you put some other sort of wrap on there and you put the pad on there and you leave it for a prescribed amount of time that would be limited depending what you're doing. If you're putting it over a joint I certainly wouldn't have it on there much more than a half an hour.
Q. You say moist heat, what do you mean, a towel and hot water?
A. You take like -- in the patient's home you tell them get a wash cloth, face cloth, put it in the sink in hot water, wring it out, feel it so they know it is not scalding, you advise him not to have scalding water, you put it in the involved area and you might tell them to put some cellophane around it to hold the moisture in, then you put the heat around it and you leave it there for a period of time, then you take it

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all off.
Q. What setting on the heating pad do you tell me them to use?
A. I don't ever tell anybody to use anything more than low.
Q. And no more than half an hour?
A. That would be a pretty good rule.
Q. When you prescribe a heating pad, people don't have direct contact between the pad and their skin?
A. You know what a heating pad is like, they are usually large, they are not -- at least the ones I've seen are fairly big, so there may be.
Q. But generally you avoid that kind of contact.
A. You know, I don't know that I comment on that, other than the area that's of involvement is where I would focus on the moist part of it. I don't know that you can avoid it.
Q. If you think your patient has a contusion of the knee, do you prescribe ice or heat?
A. Early on you ice it to try and minimize the swelling. Later on people use heat to try and reabsorb all the fluids.
Q. And when you say early on, what do you mean?
A. I don't know. Let's say you slip, you know, on the way into work, hurt your knee, fall down, sprain

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something, land on your wrist, whatever. You want to try and ice it soon. The sooner the better. The longer it goes on the less likely it is to help.
At some point after that, a day, two days, you're not going to get much more benefit of the ice, the action has happened. Now you have swelling and all the tissue reaction. Now you might use heat just to try and get that to reabsorb. Sort of depends on what you're looking at, what happened.
Look at baseball, a good example, they come in from pitching, their elbow goes in the ice bucket for hours, then it comes out. The next day they are using heat to try and clean it up, same sort of idea.
Q. Do you have some understanding of the facts that gave rise to Jack Rogers having a burn from the heating pad?
A. My understanding is he slept on this or he fell asleep while it was on and got a burn.
Q. But that's never happened to your patients.
A. You know, I don't have any recollection of that. I can believe it.
Q. Do you know how someone would get a third-degree burn from a heating pad without realizing it and taking it off before it happened, if someone had normal nerve sensation?

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A. Depends how sound a sleeper they are.
Q. I mean if someone is sound asleep and you put a hot frying pan on their foot, they would still wake up?
A. A hot frying pan is a hot frying pan.
Q. They would wake up?
A. Thermal injury is a tricky thing.
It's the frog analogy in the frying pan. You put a frog in the frying pan and you gradually increase the heat he will just sit there as happy as can be until you fry him into a smoke; did you know that?
Q. Is this based on scientific experimentation: is this a medical [illegible]?
MS. REINKER: This is human person myth.
A. You take the frog --
Q. With people, too?
A. I have never done that. The notion is that gradually increasing heat you -- what's the word, a gradually increasing noxious stimuli becomes imperceptible until you reach a threshold of pain at which point the frying pan theory takes over. But if you put something that's extremely hot all of a sudden, yes, you would, it's like a shock.
Q. But if you turn the frying pan from 98.6 up to 190 over a couple hours you don't notice it until the

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damage is [illegible] typically, is that what you're saying?
A. If you went up gradually or you just left it on there in a fixed amount of heat, you burn it continuously, you may not be aware of it.
Q. So what you're saying, you don't have to be someone with abnormal nerve [illegible] to get a third-degree burn from a heating pad.
A. No.
Q. [illegible] And is this frying pan [illegible] the frog in it theory known to medical students is that something that everybody learns?
A. One of those things when you hear it one time can't forget it, can you?
Q. Where did you learn this?
A. I forgot, but it was so bizarre I couldn't forget it.
MR. R[illegible] Ho[illegible]
MS. [illegible]ER: I don[illegible] it has anything to do w[illegible]dicine. I think it's an [illegible]logy to human [illegible]
BY MR. ROBERTS
Q. I'm wondering if doctors all learn that before they go into practice.
A. I didn't learn this in medical school. You know what, I know where I heard this, I went to take a

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course in health care administration at a business school, that's where I heard it. That's the only thing I remembered that day. It was sad.
MS. REINKER: Do you have any more questions?
MR. ROBERTS: Yes, I'm almost done here.
BY MR. ROBERTS:
Q. Do you have any opinions as to whether Jack Rogers did or did not have diabetic neuropathy in October '98?
A. [illegible] any
did.
Q. You think you can rule it out?
A. Yes.
Q. Why?
A. Because he didn't have any symptoms.
Q. Who tested them?
A. He didn't volunteer any symptoms.
Q. Do all your patients volunteer symptoms of diabetic neuropathy?
A. Just about.
Q. For example?
A. Numbness, pain, trouble sleeping, shoes rubbing ulcers on their toes.

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Q. But that's when it is pretty far along, right? Doesn't it gradually increase over years?
A. It may be gradually progressing. In terms of extent, neuropathy is neuropathy, sensation is sensation.
Q. If Jack Rogers had not had a test for diabetic neuropathy for five years before October '98. could an inter[illegible] seeing him then be [illegible]dent that he did not have [illegible]abet[illegible]a[illegible]t[illegible] prescribing a heating pad?
A. It may have been irrelevant
Q. In what sense?
[illegible]
Diabetic neuropathy is the classic what they call
[illegible]
Q. Meaning what?
A. [illegible]
Q. How far up does it go?
A. [illegible] progressesc[illegible] can go up your [illegible] that's very advanced and those patients are not asymptotic by any stretch of the imagination.
Q. How far up can it go?
A. At its worst the patient has painful neuropathies of the entire extremity.

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Q. Up t. their p?
A. Yes, and weakness.
Q. Have you ever seen that?
A. Yes.
Q. You see it in diabetics quite a bit?
A. I have seen it.
Q. How many times have you seen it up to the knee?
A. Not veryoftcn.
Q. You're saying your patients who have it up to the knee have already reported some other symptoms?
A. Yes, that's very advanced.
Q. If a patient reported that they had gotten a third-degree burn on their knee with a heating pad and you knew they had diabetes for 20 years, would you possibly think that that's an indication that they do have diabetic neuropathy?
A. Depends on what happened. If somebody tells me they fell asleep, you say okay, you fell asleep; taking pain medications, drowsy, you fell asleep, okay, it's an accident. Wouldn't nccessarily prompt me to say you have neuropathy.
Would a test show neuropathy if he had it, yes, but the point is you won't have neuropathy up to your knees without symptoms.
Q. Let's go to the record, because you like to, on

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the 15th.
A. Fine.
Q. Are there any records there that Jack Rogers fell asleep with the heating pad on?
A. It says increased swelling after applying heat.
Q. Nothing about falling asleep.
A. Not there.
Q. So the record doesn't say he fell asleep. It is mentioned after he --
A. This piece of paper says nothing about falling asleep.
Q. So where does the falling asleep come from?
A. Well, how about I will give you one example. This is the infectious disease consultant note from the hospitalization at Lake West, October 26th to November 16th, and it's the dictated note of Dr. Hutt.
Q. Who never saw the patient when he was applying heat, who wasn't there.
A. All right, but am I saying where the record shows that he fell asleep?
Q. Okay.
A. It says follow-up visit on 10-21.
Q. Are your pages numbered?
A. A follow-up visit on 10-21-98 found that he had used a heating pad and fallen asleep and sustained a

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second- and third-degree burn of the right popliteal area.
Q. All right. That's Dr. Hutt who wasn't there writing weeks later, right? Much later.
A. This is Dr. Hutt providing infectious disease consultation on October 27th.
A. And he dated his note that day at twelve o'clock noon.
MR. ROBERTS: Let me take a break for one minute, okay? I think we are almost done.
(Thereupon, there was a brief recess.)
BY MR. ROBERTS:
Q. Doctor, we were talking about diabetic neuropathy. Doesn't it gradually increase to the point where you feel like you're wearing like a pair of pantyhose, kind of dull?
A. I never heard it described that way.
Q. Do you know Dr. John Conomy?
A. Why do I know that name?
Q. Neurologist?
A. He is on this case.
Q. Do you know him?
A. I couldn't pick him out of a crowd.

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Q. Do you recall reading his report in this case?
A. Yes. Something about him examining him and saying he has neuropathy.
Q. Do you disagree with his report?
A. Was it this year he examined him, 2001?
Q. M-hm.
A. I have no reason to disagree with that.
Q. Do you disagree with his conclusion he had neuropathy in October '98?
A. Yes.
Q. Why?
A. He has no basis for that.
Q. He can't extrapolate back in time?
A. The record has someone who saw him in 2000 that found he had normal sensation in his feet.
Q. With the monofilament test?
A. That's the one.
Q. Is that adequate to determine diabetic neuropathy?
A. If he has neuropathy to the point where he is numb at the knee, yes. By that time it is very far advanced.
Q. Do you remember Jack Rogers' testimony that he was given a pinprick test by Dr. Posch and he was asked did you feel that pinprick and he said, well, I saw him

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poking me, so of course I did.
Do you remember that testimony?
A. No.
Q. No?
A. No.
Q. Is that useful in your determining whether he had loss of nerve sensation in October of '98?
A. Maybe.
Q. How so?
A. I need to read the description, where was he poking him, is it his toes, is it his foot, is it his thigh.
Q. When someone says I knew they were poking me because I could see it, doesn't that imply if I didn't see it, I wasn't feeling it?
A. No.
Q. All right. The fact that he had a high sugar count on the 21st, isn't that possibly attributable to infection?
A. is
Q. Not anything.
A. You said possible, I'm answering it.
Q. You can't be your own mother.
A. that
Q You cannot be your own mother.

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A. What does that mean?
Q. You said anything is possible. I'm saying that it is not possible.
He had a blood sugar of 375 on October 21st, right?
A. Yes.
Q. And he reported that he was extremely thirsty.
A. True.
Q. Now, doesn't that indicate that his diabetes is out of control?
A. Yes.
Q. And isn' a high bl sugar and extreme thirst something that can be attributable to infection?
A. Oh, yes.
Q. Have you ever attributed high blood sugar to infection?
A. Yes.
Q. Why?
A. Under those circumstances what happens is you have stress hormones go up in your body and infection is a manifestation of stress. Stress hormones are adrenaline and steroids, we call cortisol. Both of those lead to glucose intolerance which means glucose levels go up, but that's under stress response.
You get stress response from things other than

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infection and you can have your glucose go up, too, but yes, I have seen that in infection.
Q. Do you have any opinion as to why his blood sugar was 375 on October 21st?
A. Only speculation.
Q. Does speculation include infection?
A. Not really.
Q. Sort of?
A. No.
Q. Not at all?
A. I don't believe he had infection.
Q. All right. How can you rule out that as a symptom of infection in this patient on that day?
A. Because he didn't have any signs or symptoms of infection.
Q. Tell me what you *think* was the scenario for the necrotizing fascitis, where did it come from, what was the precursor to it and what happened?
MS. REINKER objection.
I think this has all been answered
long ago.
A. a
developed inflammation in the poplitcal and calf area, I think he developed bleeding and then it was complicated by a burn. And the burn included a full

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thickness necrosis that at some point became infected and extended into the fascial plane and caused necrotizing fascitis, that's what I believe happened.
Q. Okay. Could that have been prevented?
A. No.
Q. Why not?
A. Because then if you carry that to the extreme, say okay, this could be prevented, you shouldn't have sat with your legs crossed, that's absurd.
Q. I'm not sure I understand your answer.
A. A ruptured popliteal cyst because of the way he was sitting when he was working.
Q. Let me ask you a better question.
Was it medically possible -- was it possible there would be medical intervention to prevent his necrotizing fascitis?
A. No.
Q. You saying if he had seen a doctor Sunday there no and symptoms and it couldn't have been prevented?
A. If he has necrotizing fascitis, he has it, it boom.
Q. You not saying necrotizing fascitis can never been detected and prevented, are you?
A. You can't detect it unless it's there, and it's

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there.
Q. You're not saying someone goes from a perfectly quiescent normal leg to a necrotizing fascitis immediately.
A. Yes.
Q. Within what, seconds?
A. It unfolds in front of your eyes in minutes to hours, and when the patient comes in it is not frequently recognized for what it is, but preventing it --
Q. Are you saying there's no infection and then the first infection is necrotizing fascitis?
A. Yes.
Q. No precursor infection.
A. I have seen that more times than I can remember.
Q. There's never a precursor infection?
A. True.
Q. Never never?
A. Not never never. We talked early about there's different mechanisms, how this starts. One is spontaneous, one is you have an open wound that at some point gets infected and extends into that plane, boom,
Q. But th are medically known ios where there's n underlying infection which progresses to

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necrotizing fascitis, right?
A. Extends to the fascial plane?
Q. M-hm.
A. I'm sure we could think of examples.
A. That's always happens; does it not?
A. Yes.
Q. In other words, necrotizing fascitis is often just a more serious extent or complication of a prior infection.
A. No.
Q. Never is? Are we talking definites here?
A. You said never. Now I'm saying no, it is not never, but it is not more often.
Q. Tell me how his skin broke down and he developed necrotizing fascitis, when did this happen, what was different say on Sunday than on Saturday or Friday?
A. He has a burn, it is full thickness, there's necrosis there that has a potential for becoming an infection. He has a hematoma in his calf.
At some point the colonization of those organisms becomes an infection that extends into that hematoma. You're now in fascial planes, that hematoma subrogates into an abscess and it takes off along those planes and that happens in hours.
Q. Why is it that it appeared to be working in days

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prior, the Neosporin on Thursday, Friday, Saturday, and all of a sudden now it doesn't work anymore, what happened?
A. When you meet the person that has the answer to that you let me know because we will be famous. When you can predict who is going to get an infection at any period of time, despite their risk factors, when it is actually going to snap just like that, you have something.
Q. I'm not asking you to put an exact time on it, but I'm just saying physiologically why is it that the Neosporin isn't working, what would happen?
A. Let's say you have this burn and this central eschar. You look at that burn, it is not all even, you have little nooks and crannies, you're putting this topical stuff on, maybe you missed a cranny and the organism is there. Maybe it was working for a while and like everything in nature the organisms that finally land there are resistant to your antibiotic because are it and
because sooner or later nature arises with a bacteria that's resistant. That's the problem we have in modern infectious disease, antibiotic resistance. You can

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pick up any journal, any newspaper, all they say is look at how the germs have escaped our ability to treat them because of this phenomenon.
Q. The strep being Klebsiella that he had were treated when he got in the hospital, right?
A. Yes.
Q. That's why he still has his leg?
A. Yes.
Q. So the germs he did have then were treatable.
A. Surgically.
Q. And through antibiotics.
A. He wouldn't have his leg except for surgery.
Q. You're not saying all the infectious agents were removed surgically, are you? He didn't need antibiotics?
A. There are people in the pre-antibiotic era who had necrotizing fascitis and survived based on surgery, and we all know --
Q. How much more extreme was the surgery than what happened to him?
A. Some of it is no more extreme. What the surgeon has to do is cut out the infected tissues, that's their job, that's why it is so extensive. That's why you see these pictures you go wow.
The first time a medical student sees the

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surgery on a necrotizing fascitis they probably drop because they are so floored by how extensive it is. The surgeon goes in there with the notion I'm operating for cure, I don't leave any unhealthy tissue behind and you have these massive debridements.

They are not thinking the antibiotics will mop up. They *go* in and say I'm operating for cure, I'm not leaving anything behind.

Q. How can they tell whether the fascia is infected or not between the muscles way up the leg?

A. Normally that is, as we said, a potential space, it is stuck together. The surgeon puts their finger in that space, and with necrotizing fascitis that space falls apart and you just put your finger in there, goes right up.

I have been there myself because I have been in the operating room with the surgeons. They follow their finger up and follow with the knife until the fascial plane reappears, looks glistening, healthy. They debride a little further and leave the wound open, go back in in another day or so and say did it extend.

Q. If he had been debrided on the 21st and carefully followed up, at that point he would not have developed necrotizing fascitis?

MS. REWKER: objection.

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A. I think he still could have developed necrotizing fascitis because he still would have had an open entry point.

Q. But if he is under close medical supervision, either in the hospital or he has visiting nurses seeing him regularly and he has wet to *dry* saline dressings and prophylactic antibiotics, is it more probable than not it would have been avoided?

A. No, and he wouldn't have had a prophylactic antibiotic and I have seen it develop under those very circumstances. He has an entry wound, it will always be colonized. Prophylactic antibiotics, there is no data, none, zilcho it is going prevent this.

Q. I'm not talking in absolutes, I'm talking probabilities.

A. It is not even probable.

Q. More probable n t that h wil not develop necrotizing fascitis.

A. True.

Q. Why bother?

A. He is talking about --

Q. Debridement, wet to *dry* saline dressings, number 2; number 3, close medical supervision; number 4, antibiotics, with those four things, as opposed to what happened here which is Neosporin, gauze and ace bandage, isn't it more probable that necrotizing fascitis would have been prevented with those four things than with what he did get?

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MS. REINKER objection.

It has been answered.

A. No.

Q. No?

A. No.

Q. All right. Why do you say no?

A. Okay, let's say you debride off that eschar, big deal. You still have an ulcer, you still have a wound. It is not like he is going to close that wound because you debrided it. It is an open entry point for germs, it will be colonized.

I don't care what antibiotic you have, whether it is oral or IV, he will colonize, and you asked so I'm going to tell you, he has entry points. We haven't changed the pathology, he still has a ruptured cyst, still has blood, still has an entry point, still has diabetes.

All you have done is select with your antibiotics what resistant bacteria will land there, and when it lands there, boom, boom, off it goes.

Q. He has been carefully monitored, that's part of the scenario, for signs of infection.

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A. There's no evidence here --

Q. Are you saying there's no sign of infection until you get infection?

A. There's no evidence that he wasn't monitored for signs of infection, there's no evidence here he has infection. In his own words he had no symptoms that suggested he had infection until Monday morning. I give him the benefit of the doubt, I read his deposition.

Q. Other than pain getting worse, stiffness getting worse, everything is getting worse.

A. We have been there.

Q. But --

A. I don't accept pain as a sign of infection.

Q. You want to say drainage.

A. Fever.

Q. Fever, drainage?

A. Fever, drainage, extending signs of cellulitis and redness, dizziness suggesting blood pressure problems. We didn't see those. He didn't admit to any of those.

MR. ROBERTS: That's all I have.

MS. REINKER: You have the right to review your deposition transcript

before your signature is put on it. I would suggest that you do, but we have a trial in a week, so can we agree that any corrections we can get to you before he testifies? We have no choice. It is going be seven days no matter what.

MR. ROBERTS: I would like them in at least two days before he testifies.

MS. REINKER: TWO days before, I doubt if he will have it two days before, we will do our best.

MR. ROBERTS: I don't want to find out there will be a change 10 minutes before he testifies.

MS. REINKER: I doubt there will be any changes of substance.

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(DEPOSITION CONCLUDED.)

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Richard J. Blinkhorn, Jr., M.D. Date

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State of Ohio,) SS: CERTIFICATE
County of Cuyahoga.)

I, Janet M. Hoffmaster, a Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, RICHARD J. BLINKHORN, JR., M.D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy, and afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this sworn statement was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 17th day of April 2001.

_____

Janet M. Hoffmaster, RPR and Notary Public in and for the State of Ohio.