In The Matter Of:

Jack Rogers, et al. v.
University Mednet, Inc., et al.

Neil A. Crane, M.D.
December 22, 2000

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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
JACK ROGERS, et al.,
Plaintiffs,
JUDGE T.P. CURRAN
-vs- CASE NO. 390671
UNIVERSITY MEDNET,
INC., et al.,
Defendants.

Telephone deposition of NEIL A. CRANE, M.D., taken as it upon cross-examination before Aneta I. Fine, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the offices of Bonezzi, Switzer, Murphy & Polito, 1400 Leader Building, Cleveland, Ohio, at 10:30 a.m. on Friday, December 22,2000, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants in this cause.

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APPEARANCES:
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On behalf of the Defendants.

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(Thereupon, Defendant's Exhibits 1 and 2 were marked for purposes of identification.)

NEIL A. CRANE, M.D., of lawful age, called by the Defendants for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF NEIL A. CRANE, M.D.

BY MS. REINKER:

Q: Dr. Crane, have you done a telephone deposition before?

A: Yes.

Q: Okay. So you're familiar with the problems that occasionally arise. If I cut you off, I do not intend to do that, this is not a fancy speaker phone we're on here, it's just a regular telephone speaker phone so let me know if I have cut you off, okay?

A: Sure.

Q: Where are you now, sir?

A: I'm sitting in my office.

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Q: Is there anyone there with you just so we know who is attending this deposition.

A: No. My office alone.

MS. REINKER: And Kevin, are you alone *or* is anyone with you?

MR. ROBERTS: I'm with Myra.

MS. REINKER: Okay.

A: I mean outside my door is my medical technician and other people, but in the room I'm in I'm alone.

Q: That's fine. I just need to know who's present at the deposition.

A: All right.

Q: Okay. Doctor, you understand that this case is going to trial in January, I'm sorry, in February, February 5th and I'm going to be relying on the answers that you give today, so if you do not understand one of my questions be sure to ask me to clarify that, okay, before you try to answer.

A: Yes.

Q: All right. Would you please state your name, sir, for the record?

A: Neil A. Crane, M.D.

Q: And that's, N-E-A-L, for Neal?

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A: No. N-E-H-L.
Q: I'm sorry, okay. Your Social Security number, please?
A: It's 488-40-2501.
Q: Date of birth?
A: April 11th, 1939.
Q: And your current age?
A: 61.
Q: Are you still involved full-time in the practice of medicine?
A: Yes.
Q: Who is your current employer?
A: Myself.
Q: Do you have the name of a professional corporation?
A: No.
Q: Okay. So you are unincorporated?
A: Right.
Q: Is that the only employer you have?
A: Yes.
Q: So you are not employed by any medical center, medical school or professional practice group?
A: That's correct.
Q: What is your business address?
A: 5530 Wisconsin Avenue, Suite 800, Chevy Chase, Maryland.
Q: And on the sign on your door or in the lobby of your building, how does it identify you as in what field or practice of medicine?
A: It just says Neil A. Crane, M.D. I am in a share expense relationship so there are other doctors in the office, a group of pulmonary specialists.
Q: Are you the — well, you are an internist, correct?
A: I'm an internist with a subspecialty of infectious disease, but the door just says Neil
A: Crane, M.D.
Q: Okay. Do you practice —
A: And the door it says the other doctors' names, too.
Q: Okay. Are the other doctors, do they form a practice group and you're an independent or are they also all independents?
A: No. They're a group of pulmonary specialists. There's three of them,
Q: What is the professional corporation name for that group?
A: I think it's just their names. Drs. Putman, Lerner and Simon.
Q: Okay. But the three of them do have some sort of a corporation?
A: I think they're incorporated. I mean we just share the rent so I don't get into that.
Q: Okay. Have you ever been a member of a professional practice group?
A: Yes. I have a CV by the way and I can — I don't know if Mr. Roberts has a copy but I'd be happy to send you one. I worked for an HMO called Group Health Association for five years before I went into private practice. That would have been around 1972 to '77 and currently that's, since I left them they've been taken up by Kaiser so it's part of the Kaiser Permanente group.
Q: Okay. I do have a copy of your curriculum vitae. It's one page long. There does not appear to be any date on it as to the date this was prepared so I don't know if it's up-to-date or not.
Do you have a CV that is longer than one page?
A: No. It's at the bottom. It gives my faculty appointments. It's probably the most recent one.
Q: Right. It does say academic appointments and the bottom line is 1980 to the present?
A: Yes.
Q: You're an assistant professor of medicine at George Washington University?
A: Yes. And I'd like to qualify that. I'm on the part-time faculty for private doctors, unpaid volunteer. It's not the full-time faculty that I'm on.
Q: Okay. So I was just going to ask you, you receive no compensation from George Washington University for performing any services for them?
A: That's correct.
Q: Okay. Now, going — so the last time you were involved in a practice group would have been 1977?
A: Yes.
Q: And that was with the Group Health Association?
A. Yes.
Q: Now, do you practice in the field of internal medicine or infectious diseases or family medicine, what exactly do you do as a practitioner?
A: I do internal medicine and infectious diseases, about half and half.
Q: What are your current office hours?
A: It's 9 to 5, but I'm usually just in the office in the mornings and in the hospitals in the afternoons. Basically, my internal medicine is

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90 percent in the office, 10 percent in the hospital, and my infectious disease is the reverse of that.

Q: Okay. Are you scheduled to see patients every morning of the week beginning at 9 a.m.?

A: Yes.

Q: And when do your office hours conclude?

A: Well, it's flexible but I try to get out of here by let's say 1:00, because then I have patients in the hospital to see.

Q: On the average, how many patients do you see in the office each week? What's your patient load?

A: 1 see about maybe six, six, seven a day, five days a week.

Q: So it's roughly 30 patients a week?

A: Yes.

Q: And then in the afternoons how many patients on the average do you see at the hospitals?

A: I'd say one or two new consults and then follow-up visits, four or five, but it varies, of course.

Q: Now, this week, this is Friday, the Friday before Christmas of course, how many patients have you seen in the hospital this week?

A: This week has been slower. I've seen about four

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patients. That's all, in the hospital.

Q: And would you see them every day or did you —

A: Everyday.

Q: So essentially this week you could have gone home I suspect fairly early in the afternoon?

A: Well, except a consult takes an hour, up to an hour and a half, and then follow-up — by the way, I also work on weekends in terms of the hospital, they have to be seen on the weekends, too.

Q: Okay. So in the weekends of course you would not have office hours?

A: Right.

Q: But you would do hospital rounds?

A: Right.

Q: So as of right now, today, how many patients are under your care in the, in some hospital or another?

A: Four.

Q: Okay. And you so are you going to be seeing those four patients over the weekend?

A: Yes. Unless they're discharged. But then there may be new consults over the weekend, too, so you can't predict.

Q: Can you just very briefly, the four patients who

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are now in the hospital, what are you seeing them for, what condition?

A: There's, let's see, diabetic foot infection, a pneumonia, fever of unknown origin in a cancer patient with pleural effusion, and I think urosepsis.

Q: Okay. The diabetic foot infection, was that one of your patients or is that —

A: No. All these are consults. They're all other doctors' patients.

Q: So this is not a patient, a diabetic you were caring for who happened to get a foot infection?

A: Right. I have seen those but the majority — I see a lot of that, diabetic foot infections because I work with podiatrists. Almost all of them are consults for other doctors.

Q: What do you mean you work with podiatrists?

A: Podiatrists who treat the foot infection surgically and I treat it medically.

Q: Are you affiliated with any podiatric group?

A: No. I'm a solo practitioner but I get consults from other doctors including podiatrists.

Q: But it sounded as though there's a particular podiatry group you were working with somehow. That's not the case?

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A: No. But there's one podiatrist that I do most of my work with, he's sort of a super specialist and he treats very complicated foot infections and he gets referrals from other podiatrists.

Q: So this patient with a diabetic foot infection, was this patient first being cared for by the podiatrist for the foot infection?

A: Yes.

Q: And then they brought you into the case?

A: Yes. This is very common. If it's bad enough for the patient to be hospitalized then I'm brought in. If it's not bad enough to be hospitalized I usually don't see those patients.

Q: I presume that a diabetic with a foot infection could turn into a necrotizing fascitis?

A: Can, but that's rare.

Q: Okay. Have you ever seen that, a diabetic with a foot infection that turned into necrotizing fascitis of the foot?

A: Yes.

Q: How many times?

A: I've been in practice, we're talking about 30 years of practice so I'd say 15, 20 times maybe.

Q: Okay. Can you give me any percentage, how often will a diabetic foot infection turn into a

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necrotizing fascitis. You said it's rare?
A: One percent or less.
Q: Okay.
A Depends on, you know, basically it depends on neglect. Mainly on the part of the patient, you know, if they're neglecting it, if they have no feeling into their foot and they procrastinate and they don't see a doctor and they present with it. That's the most common situation.
Q: Okay. What hospitals do you have privileges at?
A: You said you have my CV there.
Q: I do but —
A: Six hospitals on there.
Q: Okay.
A. The one that I go to mostly is Suburban Hospital in Bethesda.
MS. REINKER: Kevin, do you have a copy of the CV?
MR. ROBERTS: CV?
MS. REINKER: Yes.
MR. ROBERTS: I didn't pull it out. You have it, right?
MS. REINKER: Yes, I have it.
MR. ROBERTS: I think you have one from somebody other than me.

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MS. REINKER: I don't know where I got this.
Q: Well, doctor, the hospitals that are listed on this CV are George Washington University, Washington Hospital Center, Sibley Memorial Hospital, Suburban, Holy Cross and Shady Grove Adventist?
A: Yes. And that's still true.
Q: Okay. Those hospitals are still all in existence?
A: Oh, yes.
Q: And those are still their current names?
A: That's still their current names and I'm still on their admitting privileges to all six of those. I've had hospitals in the past that are no longer in existence but they're not on the CV.
Q: Right. When was this CV created; do you have any idea?
A: That one you have has probably been created maybe ten years ago because nothing's changed.
Q: Okay. You have no publications in your field, I gather?
A: I've published but they're out of date and they're basic science articles. I took them off my CV. They're not clinical.

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Q: Okay. So you have never published in any of the peer review medical journals?
A: I've published in Lancet and in proceedings in National Academy of Sciences and in a textbook, but again the most recent is 1970 and they're on molecular biology so they're not relevant.
Q: So none of your publications had to do with the management of infectious diseases?
A: Right.
Q: I understand that you have reviewed quite a number of medical malpractice cases over the years?
A: *Yes.*
Q: Can you give me an estimate as to how many?
A: Yes. I started reviewing cases around **1978,** and it was only defense cases and then after about five years I did my first plaintiff's case and then that gradually increased, and I'd say for at least maybe the last ten years I review maybe three or four cases a month for both defense and plaintiff.
Q: That hasn't changed any in the past few years?
A: No. That's the maximum I can handle.
Q: Is four a month?
A: Yes.

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Q: You would agree you have reviewed hundreds of cases over the years?
A: *Yes.*
Q: In fact, it might be close to a thousand cases?
A: I never thought about that but I think I reviewed like 30 or *40* a year. Still **less** than a thousand but it's getting there.
Q: Okay. You have received cases in the past from referral services, correct?
A: Yes.
Q: Saponaro is one of the services you received cases from?
A: Right. That's how I got my first plaintiff's case is from them.
Q: I don't know if they're still in operation but if they are, are you still getting cases from them?
A: I think they are because I do get cases but rarely, maybe once every six months or so.
Q: **Are** you still on their list then?
A: I assume so, yes.
Q: Have you been on the list for any other referral sources?
A: **Yes.** Forensic Medical Advisory Service which is in Rockville, Maryland. It's near where I practice.

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Q: Okay. Do you know who owns Forensic Medical Advisory Services?
A: I think Steven Greenfield.
Q: Okay.
A: I know he runs it. I don't know, I assume he owns it.
Q: How many cases do you get from them on a monthly basis?
A: Probably get one case every two months, something like that.
Q: Any other services that you have reviewed cases for?
A: No. I had a few from Technical Advisory Service for Attorneys but they've stopped sending cases about three, four years ago.
Q: That's what **we** call TASA?
A: Yes.
Q: Do you know why they stopped sending you cases three or four years ago?
A: It might have been my office because it was too much of a problem with them. And plus it wasn't very many to begin with.
Q: Any other sources —
A: They required, I think they required prepayment and often they would send me a case that hadn't

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been paid for and, you know, it's just too much of a hassle.
Q: So did you terminate your relationship with them because of financial issues?
A: Yes, and also because they weren't sending very many anyway. It may be the man who sent them to me retired because he, he was in his 70's. So I don't really know, you know, why they stopped sending cases.
Q: Are there any other services that you have received cases from?
A: No. That's it.
Q: Did you receive this case through any one of those services?
A: No.
Q: What are the other sources whereby you acquire cases?
A: Well, on the defense side I get cases from attorneys and from insurance companies and on the plaintiffs' side I get cases from those two services plus directly from attorneys.
Q: Do you advertise in any journals?
A: No.
Q: Have you ever done that?
A: No.

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Q: In any kind of legal literature?
A: **No.**
Q: Have you ever spoken at any kind of seminars or set up a booth at any kind of organizational meeting?
A: No.
Q: Okay. It's my understanding that most of the cases that you review outside of your local area are plaintiffs' cases?
A: Yes. I've gotten defense cases outside of the area but most of them are plaintiff.
Q: What percent outside of your own geographical area are plaintiffs' cases?
A: It would be 90, 95 percent.
Q: When is the last time you got a defense case outside of your own geographic area?
A: In the past year there's been a firm in Ohio that sent me a couple of cases.
Q: Which firm?
A: I think they're called Eastman & Smith, is my thought.
Q: Do you know where they're located in Ohio?
A: Toledo.
Q: Okay. Are you testifying for any, in any cases for Eastman & Smith in Ohio for the defense?

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A: You know, there's a case, there's probably a case that I reviewed a few months ago because I don't know what you mean. What do you mean by the present?
Q: Have you agreed to serve as an expert for a defendant in either one of those cases in Toledo?
A: Yes. There were two cases that I just said from Toledo that I've reviewed that I'm going to help them with.
Q: Okay. So you reviewed two cases for them and you're going to be testifying for the defendant in both of those cases?
A: Sure, if it goes to trial. I mean, that's the trouble, most of these cases I review never get to trial.
Q: How did you happen to get involved in this case?
A: I don't know. I've done many cases in Ohio and Mr. Roberts probably got my name from somebody.
Q: Did you know him before this case?
A: I think this is the fist case he sent me. I can't be 100 percent sure but it's either the fist or the second. I haven't done a lot of work with Mr. Roberts.
Q: Are there any lawyers in Ohio with whom you have done a lot of work?

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A: Yes. I've done a lot of cases with the Nurenberg Plevin firm in Cleveland.
Q: Okay. Any other firms?
A: Let's see.
Q: Can you give me an idea, before you answer that, how many cases have you looked at for the Nurenberg Plevin firm?
A: I really don't keep records of that but I would say 20, 30 cases over the years.
Q: Any other, any other **firms** in Ohio you've done a lot of work with?
A: I'm trying to think. There was Leonard Davis and Julian Cohn but I think they're both gone. They were in Cleveland.
Q: Right.
A: Let's see. There have been others but I don't remember the names now.
Q: Can you give me any idea how many times you have come to Ohio to testify in court?
A: I would guess three or four times.
Q: And how many cases arising out of Ohio have you given depositions in?
A: I would guess maybe five times that many because I do, I do more depositions than I do trials.
Q: So 15 to 20 depositions in Ohio?

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A: I would guess so, yes.
Q: Okay. And any estimate how many cases you have reviewed other, in addition to the 20 or 30 from the Nurenberg firm, how many cases in addition to that that arose in Ohio have you looked at?
A: You know, I don't keep records of all this but I guess *40* cases maybe, and for plaintiffs' cases I turn down 80 percent of them.
Q: Okay.
A: So if you work the math, I've reviewed a lot more cases than I've given depositions and trials.
Q: So as an estimate you have reviewed roughly 60 to 70 cases arising in Ohio over the years?
A: That's a guess. That's probably in that range.
Q: What is your fee schedule?
A: I would say or less. Go ahead.
Q: What is your fee schedule?
A: I charge $250 an hour with a maximum of a thousand. I never charge beyond four hours in reviewing a fiie.
Q: No matter how voluminous the records are you just cut it off at four hours?
A: Right. I've always done that.
Q: So do you just stop reviewing at four hours?
A: Stop charging. I review till I'm finished. I just stop charging because I take a long time in going through it because I don't like to look at the records twice, I like to take notes and go through it slowly.
Q: I'm just puzzled, if you're spending so much time reviewing those cases and you're only charging a thousand dollars, how do you compensate for that?
A. I just feel like if I charged for 20 hours they wouldn't, they wouldn't want to pay it. And I enjoy doing this. It's educational and so on so that's the way I do it.
Q: How much do you charge for deposition time?
A: I charge $250 an hour, usually with a minimum of a thousand because I have to schedule out the time. Sometimes I cut that down if it's real brief.
Q: And how about when you come to Ohio to testify, how much do you charge for that?
A: It's always $250 an hour for the time it takes me away from my practice.
Q: So if you come to Ohio and have to spend the night do you bill $250 an hour for the entire time?
A: No. Just for the work hours. It's usually a maximum of $2000.

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Q: Have you yourself ever been sued for malpractice?
A: Yes. That's how I started reviewing cases. I was sued in the 70's and a representative from Hartford Insurance liked the way I analyzed my case and asked me if I would like to start reviewing cases for them.
Q: So your only —
A: The only time I've been sued.
Q: And what was that about?
A: It's when I was at Group Health and I was acting as an internist a man had, was having chest discomfort, a man in his 60's which was worse with lying down and better with sitting up and I thought it sounded like a hiatal hernia type discomfort and he did have a hiatal hernia, he got better with treatment but then several months later he had a massive heart attack and died and the allegation was missing the diagnosis of coronary artery disease.
Q: How did you arrive at the conclusion that he had a hiatal hernia and that that was the cause of his pain?
A: The character of the pain. As I said, it was worse with lying down, it was better with sitting up. It was relieved by antacids and it was not

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exertional.
Q: So you put all that picture together and you made a clinical judgment this is hiatal hernia pain?
A: Right, and then I got a upper GI. And he had a hiatal hernia and I treated him with antacids and he got better.
Q: Okay. Was that case, it was actually filed in court?
A: Yes.
Q: Is that the only time you've ever been sued?
A: Yes.
Q: Did that go to trial?
A: No. My side settled and there was some nonmedical reasons it settled and the Group Health Association side of it, I don't know what happened with that. I don't think that went to court.
Q: How many medical malpractice cases, files do you currently have open that you're involved in at one stage another?
A: I don't know. Could be 10 or 20. I don't — because, you know, you can review a case and give a positive opinion to the lawyer and then never hear from it again.
Q: Don't you keep any billing ledger cards or

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records of that?
A: Usually we bill as I go along, they pay it, and then we don't know if the case is still open after that. I discard the file after a certain period of time if I don't hear from them.
Q: So I gather you don't bill a maximum of $1,000 on each case, there may be additional work involved that you would bill for?
A: That's right. And there may not even be a thousand. I said a thousand was maximum then charts would be less than that.
Q: When is the next time you're scheduled to testify in trial?
A: I don't think I'm scheduled right now for any trial.
Q: Okay. You know this one's coming up in February?
A: I'll have to check on that. I wrote a note to myself when you said that to check, because I'm going to have to talk to Mr. Roberts about that.
Q: So you don't have any others that you can think of that are, you're currently scheduled to testify in?
A: Right.
Q: How many depositions have you given this year?
A: I average around two a month.

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Q: And that's been true in the year 2000 as well?
A: Yes.
Q: When was the last time you testified in trial?
A. A couple weeks ago in a defense case here in the District of Columbia.
Q: What was the issue in that case?
A: It was a woman who went to Howard, she went to a clinic and this is, this was over ten years ago, for a GYN problem, the culture grew gonorrhea and she wasn't informed of the results although she was treated with antibiotics for something else, they suspected a urinary tract infection, and then ten years later she developed extensive, she was explored for extensive pelvic adhesions and the claim was because you didn't treat the gonorrhea she developed all these adhesions.
Q: I presume you testified that they did, in fact, treat the gonorrhea?
A: I testified for the defense because she was given antibiotics and she had eight negative gonorrhea cultures after that so I said there's no, there's no linkage.
Q: Have you ever, well, testified before in a case involving necrotizing fascitis?
A: I'm trying to think. I think I have had other

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cases but I can't remember specifics.
Q: Do you recall if there were any defense cases involving necrotizing fascitis?
A: I don't recall, no.
Q: How many times have you testified in court in the year 2000?
A: Probably twice but I don't remember the one before.
Q: Okay. When was the last time you testified in Ohio?
A: It must be sometime in the last couple years but I don't really remember now.
Q: You have no recall of when the last time you testified in Ohio might have been?
A: Right.
Q: Have you been in Ohio recently?
A: I'm trying to think. Yes, I think I was in Cleveland in the last few months but I really don't remember the details now.
Q: You have no recall of being in Cleveland and testifying in a trial in the last few months?
A: I recall being in Cleveland but I don't recall the details of the trial. I probably could, if I was told a few words about the case I probably would recall it.

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Q: Well —
A: You know, when I prepare for a deposition like this I just have the case, this case in my mind right now.
Q: So you think you've only testified in court twice this year, is that right?
A In 2000 I think I've testified twice, maybe three times.
Q: Okay.
A: But I don't recall the details on the cases at this point.
Q: I can see from your curriculum vitae that you have not done a residency in orthopedics, is that correct?
A: Yes.
Q: Do you currently have any ongoing research projects in which you're involved?
A: No.
Q: Now, the academic positions, do you currently hold one or two academic positions?
A: One.
Q: What do you have to do to maintain that academic position?
A: Nothing. I thought in the past I did rounds with interns and residents to discuss their cases, and

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then more recently I did, taught sophomore students how to take histories and physicals, but for the past three, four years I haven't been doing anything.
Q: Okay. So this is not the type of clinical position or rather academic position where you need to publish and you need to do research in order to maintain the position?
A: That's full-time faculty. Part-time faculty it's basically people with admitting privileges who are on call for filling in gaps.
Q: So is it, which hospital entitles you to this title, your academic title?
A: George Washington University.
Q: So basically any physician who has admitting privileges at GW can get this academic title?
A: I think so, yes.
Q: Which of the six hospitals where you have privileges do you primarily see patients?
A: I said earlier Suburban.
Q: Okay. What percent do you see at Suburban?
A: In the past year I would say 90 percent. My practice has changed over the years.
Q: Okay.
A: You know, it used to be a lot more at other

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hospitals but I've been mainly narrowing down to Suburban just for convenience and time factors. Also I've gotten very active there in terms of committees and so on.
Q: Where is Suburban located?
A: In Bethesda, Maryland.
Q: And what's the size of that institution?
A: I think it's got something like 300 beds and it's a major trauma center with a helicopter landing site. That's about it.
Q: Do they have any — is it a teaching institution?
A: No.
Q: So they have no residency programs there?
A: Not that I'm aware of. There may be some surgical residents but we used to have — we're right across the street from the National Institutes of Health. We used to have NIH fellows coming over for infectious disease but not recently.
Q: When is the last time they had any infectious disease fellows there?
A: In the past year, about a year ago.
Q: Do you know why that stopped?
A: Yes. They just didn't have the time, they just were too busy at the NIH. They've wanted to get

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some more practical experience with ordinary infectious disease because they don't see it at the NIH but it didn't work out because of the time factor.
Q: You said 90 percent of your patients are at Suburban. Where are the other ten percent?
A: I go to Sibley, Shady Grove and Holy Cross. I basically stopped going to GW and Washington Hospital Center.
Q: Okay. When was the last time you had a patient at GW?
A: Years ago. I've stopped going there because for two reasons, both of those two have infectious disease departments, so, you know, for me to go there and do a consult doesn't make sense in terms of time; and secondly, just the location, it's just too far away from my office and my home.
Q: Can you tell me how many years it's been roughly since you had a patient at GW?
A: 10, maybe 15 years.
Q: I'm curious that you still can maintain the academic title if you haven't seen patients there for 15 years.
A: I can maintain, I can maintain my privileges at

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all the hospitals as long as you pay your dues.
Q: Okay. You said you started reviewing cases in 1978. What got you started doing case reviews in '78?
A: I told you before, I was sued myself and the insurance agent liked my case plus I was leaving Group Health at the time plus I had extra time to do it.
Q: Did you do any case reviewing in the, oh, late 60's, early 70's?
A: No.
Q: Did you do any case reviewing when you were a resident?
A: No. I started in 1978.
Q: Okay. And so of any kind, did you do any case reviewing when you were a research fellow?
A: No.
Q: You were still in training when you were a research fellow?
A: Yes.
Q: I gather that you would have not felt qualified to review a case when you were still a fellow?
A: Probably but I never even knew such a thing existed so —
Q: I mean you probably would have been qualified or

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would not have been qualified?
A: I would say not, Board-certified yet.
Q: So you feel in order to be qualified to serve as an expert a physician ought to be Board-certified?
A: Not necessarily. He should at least be fully trained and I wasn't fully trained when I was a fellow.
Q: Okay. Do you subscribe to any of the literature in orthopedics?
A: No.
Q: Have you ever attended any continuing education seminars in orthopedics?
A: Well, we have Grand Rounds every week and there will be times when an orthopedist will talk but never a organized seminar, no.
Q: Have you ever managed on your own the care of a patient with a ruptured popliteal cyst?
A: No.
Q: Okay.
A: I'm only called in as a consultant when infection is suspected.
Q: Right. Have you ever been called in a case in which a patient had a ruptured popliteal cyst which was being managed by an orthopedist and

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your consultation was requested?
A: Yes.
Q: Okay. How many times?
A: Not too often. I think, in fact, I would only be called if infection is present or suspected.
Q: Correct. And I'm trying to find out if that's ever occurred in your practice, where the patient had an underlying condition of a ruptured popliteal cyst but your consult was requested for some other reason or —
A: Right. Or suspected ruptured popliteal cyst, rule out infection, that's the type of thing I would see.
Q: Do you recall the last time you saw a patient like that?
A: Sometime in the last couple years. I don't remember specifically, no.
Q: So I gather with regard to the management of ruptured popliteal cyst, the orthopedic condition, that is something that does not fall within your expertise?
A: That's right, if there's no infection or suspected infection it's not something I would deal with.
Q: Okay. And so the symptoms, the management, the

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treatment of a patient with a noninfected ruptured popliteal cyst, that is something that you would not deal with?
A: Right. Unless it's my own patient, you know, if I were the primary care doctor but then I would get an orthopedic consult.
Q: And the orthopedist would take over the management of the ruptured popliteal cyst part of the case?
A: Right.
Q: So I gather then that you are not familiar with the standards of care for an orthopedist managing a patient with a ruptured popliteal cyst?
A: Right.
Q: I have marked here as Exhibit 1 the curriculum vitae that we have been talking about, just so the record's clear on that, okay.
A: Yes.
Q: And Exhibit 2, we have marked as a copy of your report which is dated June 29th, 2000.
Do you have your report there with you, sir? Are you looking?
A: No. I said yes.
Q: Sometimes it cuts out. We didn't hear your answer.

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A: Okay. I'm sorry.
Q: What all do you have there in front of you?
A: I have notes that I took from the records, and they're numbered pages one through seven. Actually, one through six are notes from records. Seven is my comment sheet which is actually more up-to-date than my report, so I'd like to, I'd like to read that to you sometime.
Q: The comments sheet?
A: Yes.
Q: I would like to read it but I also would like you to send copies of all seven pages or fax them to Mr. Roberts and he will then send them on to me.
A: Fine. I then have notes that I took in deposition, that I lettered pages A through C. I lettered them so I could keep them separate from the notes, from records.
So I have pages one through six, notes from records, page seven is my comment sheet, and then A, B and C are notes that I took from deposition. And then I photostated a couple things that I wanted to keep. One is the infectious disease consult by Dr. Hutt on October 27th, 1998; the discharge summary from the October 26 to November 16th, '98 hospitalization which is a handwritten

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discharge summary, one page; and the face sheet which gives the final diagnoses from that admission. It's called diagnosis and procedure list.
Q: Why did you —
A: And the patient transfer form. Those are the things I photostated.
Q: Okay. And those are all really from the Lake West chart?
A: Yes. The Lake Hospital admission. Dr. Hutt's consult, the discharge summary, the list of final diagnoses and the transfer form.
Q: Why did you select those pages?
A: I basically always do that. I always keep a copy of discharge summaries and if there's something I especially want to keep rather than just take notes on, I just photostat it.
Q: Okay. There's nothing particular in those documents that you wanted to emphasize or use in your testimony today?
A: No. Well, one is infectious disease consult I usually photostat because I'm most interested in that and I always photostat discharge summaries, and the discharge summary didn't really have a list of final diagnoses so that's why I

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photostated that.
Q: Okay. I was asking you what all you have in front of you today. Do you have everything in front of you that you have reviewed in this case?
A: Yes, and my notes.
Q: You've described the notes that you have there with you, what other documents do you have there?
A: That's it.
Q: Okay. What about the complete copies of the medical records, do you have those?
A: No, I don't. I returned them. Usually — I didn't know this was going to be a phone deposition. I usually have the attorney, expect the attorney to bring them back. I don't need to look at the records again when I prepare for a deposition.
Q: Do you have any records in your custody whether they're with you in the deposition today, whether they're back in your office or at home?
A: No.
Q: You have nothing?
A: Right.
Q: The things you just told me about, the notes that you've written and the pages that you've copied from the chart, are those the only documents you

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currently have in your possession in this case?
A: Yes. And my report.
Q: Have you prepared any other reports other than the one from June 29th of 2000?
A: No.
Q: Have you communicated in any other way with Mr. Roberts, like e-mail or anything like that?
A: We've had phone conversations. When I reviewed the records I called him and when I reviewed the depositions I called him, just to tell him how my opinion is the same or different, you know, with the latest review.
Q: But there's nothing that created a document or something that we could have printed out like an e-mail?
A: Right.
Q: When is the last time you looked at the records?
A: I reviewed the records May 25th, 1999 because I wrote that date down, and then I reviewed more recent records December 11th of this year and December 19th of this year, this month, and then looked — so those are the last records I looked at. But the original records I didn't look at again because I took notes on them. And I can tell you when I reviewed the depositions.

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Q: And what is currently your opinion on Dr. Wellman?
A: Well, it looks to me if you — that he did give proper advice as to how to use the heating pad.
Q: Okay.
A: And doctor — looks **like** the patient followed that advice. And as far as not checking him for peripheral neuropathy, you know, I still stand by that but it looks like to me from reading the patient's deposition he doesn't have any significant peripheral neuropathy.
Q: Okay.
A: I really don't have any criticism of Dr. Wellman.
Q: Okay. Now, how about Dr. Kakish, do you have any criticism of Dr. Kakish?
A: My opinions on Dr. Kakish and Dr. Posch haven't changed and but my comment sheet I think goes, if I could read that to you when we get to it, maybe in a little more detail in the report.
Q: Do you have any additional materials that you have asked to review or you intend to look at before you testify?
A: No. I try to, when I **see** a deposition scheduled I try to make sure that I've got everything I need.

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Q: So you're not intending to review anything more before trial?
A: Right. The only thing I notice that I haven't **seen,** I don't know if the wife's been deposed.
Q: She's —
A: I haven't seen that.
Q: She's deceased.
A: Oh, the wife is?
Q: Yes. She died in, last June.
A: Okay.
Q: Did you ever speak with Mr. Rogers?
A: No.
Q: Do you intend to examine him before trial?
A: No.
Q: Were you ever given any statements or documents that Mr. Rogers prepared or someone prepared on his behalf?
A: No. I just have his deposition.
Q: Okay. Now, will you be testifying at trial that the care of Dr. Kakish fell below recognized standards?
A: Yes, but I'm just — in a couple of ways. It's all on my comment sheet.
Q: Okay. I gather you will not be testifying at trial that Dr. Wellman's care fell below

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standards?
A: Right.
Q: Will you be testifying at trial that the care of Dr. Posch fell below standards?
A: Yes. And I know I'm not a medical orthopedist but there's some medical side to the care that I'm critical of.
Q: Now, let's go back to Dr. Kakish. Can you tell me in what manner you believe Dr. Kakish's care fell below standards?
A: I only have one criticism of Dr. Kakish but this is sort of taking it out of context because — but the criticism is, let's **see,** on October 21st of '98 when Dr. Kakish saw him and knew that the patient was having a problem with his leg and he, his diabetes was out of control, was not to consider that this, this could be an infectious process going on because that's one of the causes of diabetes, to go out of control and there was no communication with Dr. Posch that I could, that I could **see.** Because I think what happened, think infection was being missed during this time. Primarily by Dr. Posch but this is just this one incident with Dr. Kakish.
Q: What kind of things can make a patient's blood

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sugar level elevate?
A: Well, you can not take your medicine, you could binge eat or you can have some other kind of stress such as an infection cause, that increases the requirement for insulin or the hypoglycemic agents.
Q: What kind of, what kind of stress other than infection can cause a change in the patient, an elevation in the patient's blood sugar?
A: Almost any inflammatory process. Trauma, those kind of things.
Q: So —
A: It could **be** a physical stress.
Q: Are you aware — I'm sorry, what was that about physical stress?
A: It has to be a physical stress. I'm not talking about mental stress.
Q: It's something that's stressing the body?
A: Right.
Q: ***Are*** you aware that on the, I'm sorry, the 21st of October, Dr. Kakish did not examine the patient's leg?
A: Yes.
Q: Okay. And that, you understand that to be appropriate since he assumed the orthopedist was

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Q: Okay. Now, the first time you reviewed records was in May of '99?
A: **Yes.**
Q: What did you review at that time?
A: I reviewed starting October 13th of '97 the office records of Dr. Kakish and then Dr. Wellman from October '97 through October of '98; and then Dr. Posch in October of '98; the MRI; and then Dr. Posch again October 26, '98; and then the Lake Hospital admission October 26 to November 16th of '98; and then the follow-up visit to Dr. Kakish November 19th of '98; Dr. Eisengart November 23rd of '98; and then that was the end of it until I got these more recent records this month.
Q: Okay. So in May of '99 before you prepared your report, you reviewed the records you just identified, some parts of the Mednet chart and the Lake West chart?
A: **Yes.** From October of '97 through November of '98.
Q: Now, you mention the MRI. Did you see the film or just the report back then?
A: The report. I don't read MRI's.
Q: When were these records returned then to

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somebody?
A: What I do is I review, I review the records, call the attorney, give them my opinion and then return them.
Q: So do you have any indication when in 1999 these records were returned?
A: No. But I can tell you it was probably June of '99.
Q: Now, you prepared your report in June of 2000?
A: Right.
Q: When you prepared — are you okay?
A: **Yes.**
Q: When you prepared the report in June of 2000, what were you relying on?
A: Mynotes.
Q: And then you later received some more, additional materials to review?
A: **Yes.**
Q: Now, the first batch, was that December 11th of this year?
A: Let's **see.** No. I reviewed depositions before that.
Q: Okay.
A: Want me to do this in order?
Q: Yes, I do. When is the next time you received

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something to review?
A: On November 7th of 2000 I reviewed Dr. Posch's deposition; on November 23rd of 2000 I reviewed Dr. Wellman's deposition; on December 19th of — excuse me, I skipped some. No. The next thing was December 11 of 2000 when I reviewed records of Dr. Paris and Dr. Eisengart, Dr. Bell, this is September through November of 2000, records, I reviewed those on December 11th.
Q: I'm sorry, what were the dates?
A: From September 26 to November 7th of 2000.
Q: Okay.
A: Let's see. The next thing I reviewed was December 19th where I got more outpatient records that actually came before those dates I just gave you. From January 11th of '99 to August 15 of 2000. Those are records of Dr. Kakish and Dr. Eisengart.
Q: Okay.
A: And I also reviewed on that same day Dr. Kakish's deposition, Jack Rogers, and Jack Rogers' deposition.
Q: Okay. Have you reviewed anything else in this case?
A: That's it. Last thing I did was December 19th.

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Q: Have you ever seen any of our expert reports?
A: I think **so,** yes. I think I saw **those** reports but I didn't keep them. I think I gave Mr. Roberts my comments on them, but I don't, I don't go by what other experts say so I didn't keep them.
Q: Do you recall what expert reports you saw? I'm *sorry,* if you answered we didn't hear it.
A: I'm thinking. No, I don't. I know it was an orthopedist and an infectious disease specialist but I don't remember their names.
Q: Now, you reviewed these different depositions. What happened to the depositions?
A: I returned those, too.
Q: So even the deposition that you got just last week, whatever, the outpatient records you received on December 19th, they've already been reviewed?
A: **Yes.** Because I don't need to look at them a second time. I take notes from them and then I study my notes.
Q: When you reviewed these subsequent depositions and records, did they in any way change the opinions you rendered in your report?
A: **Yes.** In some way. I think my opinion on Dr. Wellman has changed.

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caring for the leg?
A: Yes.
Q: Okay. I'm curious about your conclusion that Dr. Dr. Kakish's care fell below standards. What clue would Dr. Kakish have had that this patient might be infected?
A: The high blood sugar and knowing that the leg was, there was a problem with his leg.
Q: Well, wouldn't, I mean, an ongoing inflammatory process can cause an elevation in blood sugar, correct?
A: Yes, but usually, I mean it has to be pretty significant inflammation. Yes, it can, and that would be in the differential diagnosis.
Q: So wouldn't it be fair for Dr. Kakish to conclude that possibly an elevation of blood sugar could be due to the ongoing rupture of the popliteal cyst?
MR. ROBERTS: Objection.
A: Yes.
Q: I'm sorry, your answer was yes?
A Yes.
Q: Do you have any opinion as to whether Mr. Roberts was a compliant patient in the past prior to October 21 of '98 with regards to management of

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his blood sugars?
MR. ROBERTS: Rogers.
Q: Mr. Rogers?
A: I think he was relatively compliant. I don't know if he was perfect.
Q: Are you aware of any notations in the chart which indicate he was not a compliant patient?
A: No.
Q: Do you recall what instructions Dr. Kakish gave to Mr. Rogers on October 21?
A: Yes. I have here, let's see, that he's on Glucotrol. Instructions you asked me?
Q: Correct.
A: Call me with blood sugar report results over the next 24 to 36 hours, may need to start insulin.
Q: Okay. If you asked a patient to do that you would expect them to follow through, would you not?
A: Yes.
Q: Did Mr. Rogers follow through on that instruction?
A: Not that I'm aware of. I don't see any other notation from Dr. Kakish.
Q: Okay. So to your knowledge, Mr. Rogers did not follow through on Dr. Kakish's instruction to

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call him within 24, I think it was 24 to 48 hours to report his blood sugars?
A: I think that's, as far as I know, that's probably right.
Q: Okay. When you order a blood sugar on a patient how do you order it, what kind of blood sugar?
A: Well, there's — it depends. If you want, you can order stat blood sugar, you can do a finger stick, you could send it to the lab, or you could just order a routine blood sugar.
Q: What I'm looking for if you're interested in a diabetic, whether they're in control or not, wouldn't you generally order a fasting blood sugar?
A: You could either do fasting. What I prefer is sort of an afternoon blood sugar so you can see how the medicine's working because Glucotrol for example peaks at eight to ten hours, and I think an afternoon blood sugar gives you a better measure of the dose of Glucotrol rather than a fasting.
Q: Why not a morning blood sugar?
A: I know other people use fasting blood sugars, too. Another way of monitoring is with the glycohemoglobin which gives you an average over

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time.
Q: Would you order a morning blood sugar a couple of hours after breakfast?
A: If you're on a short-acting, you might, on a short-acting insulin. If I do that I'd still want an afternoon blood sugar, though.
Q: In this particular patient's case, do you think a blood sugar, a nonfasting blood sugar drawn a couple of hours after breakfast was a reliable test of his control?
A: It would not be a test of final control but certainly if you get 375 you're out of control no matter what time of the day it is.
Q: The medications, the instruction that Dr. Kakish gave to the patient, do you find that, that's an appropriate instruction, correct?
A: Yes. I think if it's just a matter of nothing else going on except his blood sugar is too high, certainly you would raise the dose of one of the drugs, you would tell him to make sure you suck to your diet and you repeat the blood sugar in a couple days.
Q: Okay. There's no other way that you feel that Dr. Kakish's care was inappropriate, correct?
A: No. I think that the rest of his actions were

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appropriate. I think on October 15th, just referring the patient to Dr. Posch was appropriate. October 21 we just talked about, and then he wasn't involved again. I mean except during that admission, which he was doing the medical side.

Q: And you don't find —

A: I don't have any criticism of the treatment on that admission anyway.

Q: Okay. And you feel it was appropriate for Dr. Kakish to rely on Dr. Posch's management of the underlying problem with the leg?

A: I think so. He's an internist, and so is Dr. Kakish, but I have an infectious disease subspecialty and he doesn't so I think I wouldn't rely just on an orthopedist but I think he has a right to.

Q: Okay. And I think you would agree that there are multiple other reasons in this case why Dr. Kakish might have thought Mr. Rogers' blood sugar was 375 on the morning of October 21 other than necessarily infection?

A: Yes. I think my only real criticism of him is not calling Dr. Posch and say what's going on because his blood sugar's high and infection can

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case a high blood sugar. That's really all. Make sure Dr. Posch is thinking infection.

Q: Now, you said you'll be testifying at trial that Dr. Posch's care fell below standards?

A: Yes.

Q: And you have a comment note, page seven of your notes which you have wanted to read to me?

A: Yes.

Q: When was that page prepared, page seven?

A: I just prepared that after I reviewed the final depositions, so the last thing I reviewed was December 19th.

Q: So this was prepared sometime within the past week?

A: Right. So I tried to update my opinions to take into account everything I knew at this point.

Q: Okay. Would you read that page for me, please.

A: Yes. I wrote down nine comments and they're in chronological order.

Number one, 10-8-98, Dr. Kakish, internal medicine. Routine visit, according to the patient's deposition, had pain in the right hip and knee. Diagnosis, degenerative arthritis. Also had pain in the left elbow, diagnosis, epicondylitis.

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Number two, 10-9-98. Parentheses, (per medical records, I just had per history here, and patient's deposition), close parentheses. Sitting cross-legged at work, cleaning furnace, developed pain in the right leg, which continued, and became worse the evening of October 11th. And that's according to the patient's deposition.

Number three, October 12th, '98. Dr. Wellman, internal medicine. Negative ultrasound for deep venous thrombosis. Had tenderness and swelling. Diagnosis, contusion. Treatment, elevation, heating pad, and parentheses, (low heat, 10 to 20 minutes, once an hour, according to the patient's deposition), close parentheses.

Number four, pain continued, got worse and swollen, that's patient's deposition. Wife called Dr. Kakish's office on October 15th, was told to come in. Dr. Kakish saw him and referred to Dr. Posch. No note by Dr. Kakish, according to his and the patient's depositions.

Number five, 10-15-98. Dr. Posch, orthopedic surgeon. The area was tender, erythematous and swollen, with increased swelling. Needed temperature, CBC, probable infection. In deposition patient claimed to use the heating pad

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correctly. He might have fallen asleep with it but he didn't remember.

Number six, 10-15 to 10-21. According to the patient's deposition, the area got worse, blister formed, more pain.

Number seven, 10-21, Dr. Posch. Area of necrosis thought to be a burn, had swelling, fluctuance and weeping according to Dr. Posch's deposition. Aspiration attempted, only a few drops of blood, no temperature, no CBC, thought to be a burn. Should have been admitted, rule out infection or treat as burn if not infected. Couldn't wait two days for a MRI, and then Dr. Kakish that day, high blood sugar, no communication with Dr. Posch, needed to rule out infection.

Number eight, 10-23. MRI showed possible infection; needed admitting.

Number nine, 10-26 to 11-16 admission. Deep infection, necrotizing fascitis, treated appropriately.

Q: Is that it?

A: Yes.

Q: Now, I would like you to list for me the testimony you will give at trial as to the manner

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in which Dr. Posch's care of this patient fell below standards.

A: Starting with October 15th, there was infection needed to be considered, patient's temperature should have been taken, blood count done and then go **from** there. I **think** he had an infection at that point.

Q: So you'll be testifying that he had an infection on October 15th?

A: Yes.

Q: Are you denying he had a burn?

A: Well, I don't know, but I think he probably didn't but he might of.

Q: You think he did not have a burn?

A: Yes.

Q: Okay. What's the basis for that opinion, that ne did not have a burn?

A: Well, Dr. Wellman and the patient both had low heat, 10 to 20 minutes, once an hour and that's not enough to give you a third degree burn. He might have had a first degree burn with a secondary infection. That's why I say, I just have to go with probabilities and possibilities. I didn't rule out a burn.

Q: If he did, in fact, have a burn, would YOU then

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agree that he probably did not have an infection?

A: No. I mean I think he had a secondary infection.

Q: What evidence is there, what is the basis for your opinion that this man had an infection on October 15th?

A: Well, he had tenderness, redness and swelling, he was getting worse and there was not enough data, you know. I'm saying that a temperature should have been taken, a blood count should have been done and I think he probably had a infection at that point in looking at the whole case but he might not have, it could have been prospectively, it could have been a ruptured cyst with a first degree burn from the heating pad.

Q: So this clinical picture on October 15th, it could have been an infection in your opinion?

A: Yes.

Q: And it could have been a ruptured popliteal cyst with a secondary burn from a heating pad?

A: Yes.

Q: And you don't know which it was?

A: Well, I don't know 100 percent, but if he really used the heating pad on low, I don't think he would get a burn from that.

Q: Well, I'd like you to tell me, you know, based on

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this clinical picture on October 15th, Dr. Posch diagnosed a ruptured popliteal cyst with a secondary burn from **a** heating pad. Can you tell me what is there in this clinical picture that leads you to believe that Dr. Posch was wrong about that?

A: I don't think you can look prospectively at the record and say he was wrong, all I can say is he needed to consider infection and take some steps to rule that out. In hindsight I think it was wrong.

Q: Okay. But putting yourself into the position Dr. Posch was in on October 15th, with his knowledge at that time, can you point me to any clinical symptoms or signs which indicated an infection, rather than a ruptured popliteal cyst with a burn?

A: Oh, no. I would just say that's part of the differential diagnosis.

Q: Okay. Are you aware of the patient admitted that day or Dr. Posch told the patient that day he believed he had burned his leg with a heating pad?

A: Yes. Let me just, before I say yes too quickly, let me look at my notes. We're talking about

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October 15th?

Q: Correct.

A: Dr. Posch recorded he applied heat at home which made his condition worse. Now, that doesn't mean there's a burn, it just means that heat made it worse so that's consistent with infection.

Q: And you don't have —

A: Prospectively you cannot say just looking at this note whether it's a burn or it's an infection.

Q: You do not have Dr. Posch's dictated note of October 15th, 1998 in front of you, sir, do you?

A: I just have the notes that I took from it.

Q: Are you aware in the dictated note Dr. Posch states that the patient attributes the redness of his leg to excessive application of the heating pad?

MR. **ROBERTS:** Objection.

A: But that's the patient's conclusion. That's not a doctor's conclusion.

Q: You stated I think that a temperature should have been taken that day?

A: Yes. First of all, you've got to consider infection and then once you do that then you take a temperature and you do a blood count.

Q: Those are the two things you think Dr. Posch

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should have done that day?
A: As a first step, yes. But the first step is to consider infection which he didn't do.
Q: If a temperature had been taken that day, do you have an opinion what the temperature would have been?
A: Well, again, that gets back to is there an infection present or not and I think he probably had a low grade fever and I think he had an elevated white count had those been done.
Q: What is the basis for your opinion that he would have had a low grade fever on October 15th?
A: Because I think he had an infection. Now, I know infections don't always cause a fever, and temperatures aren't always elevated at any given point in time. You have to have a *24* hour chart, you know, of temperatures to make sure a person doesn't have a fever.
Q: So taking a temperature that day would have not really told you anything then?
A: Only if it was elevated.
Q: And you don't know whether it would have been elevated or not?
A: No. If it was normal, then you have the patient keep a diary of their temperatures at home.

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Q: Do you have any opinion what the white count would have been that day?
A: I think the white count would have shown a mild elevation because I think, I think he did have an infection in hindsight.
Q: Where do you think he was infected on that day?
A: Where do I think he was infected?
Q: Yes. Where do you think it was?
A: This area of the leg where he had swelling, heat and tenderness and redness.
Q: So are you disputing the diagnosis of a ruptured popliteal cyst?
A: I think in hindsight, yes. I think prospectively, no, I think that should be considered.
Q: So now in hindsight it is your opinion that this man did not have a ruptured popliteal cyst?
A: I didn't see that ruptured popliteal cyst was ever proven, even at surgery.
Q: And, again, it's your opinion in hindsight that this patient never had a ruptured popliteal cyst?
A: I think that's probably true. Again, not 100 percent but within probabilities.
Q: If that's the case, when do you, since you believe he never had a ruptured popliteal cyst,

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when did he get this infection in his leg?
A: I think that he had some kind of trauma on October 9th and then after that infection set in and it was present on October 15th and possibly before that but 1can't be sure before that.
Q: So you believe he never, and just so I'm clear, you're going to testify at trial this man never had a ruptured popliteal cyst, but he had, the diagnosis should have been an infection in the leg?
A: At least considered. We have to distinguish prospective and retrospective. On October 15th infection should have been considered.
Q: Well, but I'm, it's my understanding that you're going to testify to, I presume to a reasonable degree of medical certainty that this man never did have a ruptured popliteal cyst?
A: I think again probably because I didn't see that a ruptured popliteal cyst was ever found once the leg was explored.
Q: And, again, do you know what the criteria are for diagnosing a ruptured popliteal cyst?
A: No. I'm just reading the operative report and the pathology report and I don't ***see*** any evidence of a ruptured popliteal cyst. I could be wrong

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about it, it could be that he did have it but I still think he had an infection.
Q: You think he had an infection on October 15th, whether or not he had a ruptured popliteal cyst?
A: Yes.
Q: What do you think a white — again, you think a white count would have shown an elevation on October 15th?
A: Yes.
Q: So you believe he already had systemic disease on October 15th?
A: No. I think the infection was localized to the leg but enough to elevate the white count.
Q: And, again, so I **can** be clear, what tissues in the leg do you think were infected, what planes of tissue?
A: Well, I don't think he had necrotizing fascitis on the 15th, but I think he had a cellulitis.
Q: Okay.
A: On the 15th.
Q: So in your opinion, he had cellulitis on October 15th?
A: Yes.
Q: And you think Dr. Posch missed that?
A: Yes,

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Q: How many times have you diagnosed cellulitis in an orthopedic patient that you were following?

A: Well, these are the kind of patients I see when they get a tenderness, a redness, swelling and the differential diagnosis would include cellulitis, a ruptured popliteal cyst, deep or phlebitis. That's a typical differential diagnosis for a situation like this.

Q: In what percent of cases of patients with cellulitis **is** the white count elevated?

A: If it's, if it's a significant cellulitis, I would say in most cases.

Q: What about, would you consider this a significant cellulitis on October 15th?

A: Yes. He had significant pain, he had significant area that was involved and it was going on for a while at this point.

Q: Can you tell me what a ruptured, what **is** a ruptured popliteal cyst?

A: First of all, popliteal cyst is a cyst of the synovium, from the knee joint. And then a — it ruptures. So fluid, synovial fluid leaks out into the tissues. That's about as far as I can go as an internist. An orthopedist can be probably more precise.

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Q: So I gather you would not particularly know the signs and symptoms of a ruptured popliteal cyst?

A: I do to a certain extent as an internist.

Q: What are they?

A: Swelling, pain, tenderness in the area near the knee joint, usually posterior. And down the calf.

Q: And, again, I think you said this before, but this picture Mr. Rogers presented with on October 15th could have been consistent with a ruptured popliteal cyst?

A: Yes.

Q: Okay. And, again, you don't know what the temperature would have been on October 15th?

A: No. I think I, again, you have to say more likely than not because no temperature was taken, that he would have had a low grade fever. Now, at that point in time, you know, it could have been normal but you have to have the patient monitor their temperature at home, make sure, because you've seen graphic charts in hospitals where the temperatures, even people with fevers will have normal temperatures at times and elevated temperatures at other times.

Q: And you think there would have been a low grade or mild elevation of the white count on October 15th?

A: I think low grade and, yes, because based on the patient's absence of systemic symptoms and signs, as far as I know.

Q: What's your estimate of what ***the*** white count would have been on October 15th?

A: Might be low grade, 12, 13,000, in that range.

Q: What other kinds of things can elevate a white count to the range of 12 to 13,000?

A: Well, you can have any kind of inflammatory process, that still would be consistent with a ruptured popliteal cyst.

Q: Okay. Anything else that Dr. Posch did or did not do on October 15th that you **feel** was below standard of care?

A: No. I think it primarily boils down to not considering infection in the differential diagnosis.

Q: But you agree that even if he had considered infection, and had done the white count and taken the temperature which you suggest that he should have done, he still could have ended up with a diagnosis of a ruptured popliteal cyst?

A: Yes. He could have wound up with the same

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differential diagnosis. It's possible that those tests would not have been helpful and you still haven't ruled out either one, ruptured cyst or infection. Then you would just follow the patient carefully.

Q: And, again, assuming he took the temperature, and let's just, assuming you're right, there was a low grade elevation, that could be consistent with a ruptured popliteal cyst?

A: Yes.

Q: And assuming he did the blood count, and assuming he got a low grade elevation of the white count, that would be consistent with a ruptured popliteal cyst?

A: Yes.

Q: So even if Dr. Posch had done the things you say he should have done on October 15th and gotten the abnormal findings you think he would have gotten, he still could have arrived at the diagnosis of a ruptured popliteal cyst?

A: Yes, except it still should have been a differential diagnosis.

Q: Okay.

A: And ruled out infection if those, if what you said is true. And what you would do then, you

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would have a choice between putting the patient on antibiotics empirically or just following him carefully.

Q: Well, Dr. Posch could have come to the reasonable clinical conclusion on October 15, even if he had done everything you say he should have done, that this patient had a ruptured popliteal cyst?

A: Yes, but without ruling out infection so then you would follow the patient carefully.

Q: Okay. But, again, you've never followed a patient with a ruptured popliteal cyst?

A: But I've followed patients with this differential diagnosis. If it's a known ruptured popliteal cyst then I would just give it over to the orthopedist.

Q: How would you conclude this was a known ruptured popliteal cyst?

A: That, I would have to defer to a orthopedist, how you actually prove it.

Q: You have no idea how an orthopedist would prove the word you used, a ruptured popliteal cyst?

A: I think with an MRI or with a ultrasound, not just clinically, because what the evidence here is possible ruptured popliteal cyst, possible infection.

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Q: After October 15 what is the next thing that you think that Dr. Posch did that fell below recognized standards?

A: Well, the first thing of course I just said, the absence of careful foilow-up, but then when he saw the patient on October 21st is my next criticism.

Q: What do you mean by careful follow-up, what do you think should have been done?

A: If infection is still a possibility and you haven't put the patient, and you haven't put the patient on antibiotics, even if you have, you should be following this patient sooner than six days later because you know infections can spread fairly rapidly.

Q: But again you say that would have been if Dr. Posch suspected an infection?

A If he hadn't ruled it out, if he considered it. Even if he put popliteal cyst as his first choice and infection as his second choice, you have to follow carefully.

Q: How would he have ruled out an infection? What should he have done to rule out infection on October 15?

A: Monitor his temperature, take his temperature,

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you monitor his temperature and do a CBC and then we just went through that, if those turned out not to be helpful, then you just follow the patient carefully.

Q: What do you mean by follow the patient carefully?

A: See him the next day or in two days.

Q: You're saying that's what an orthopedic surgeon should do?

A: That's what a doctor should do, yes, a differential diagnosis that includes infection.

Q: Now, doctor, I'm getting very confused here because I think you told me that everything this man presented with on October 15th was consistent with a popliteal cyst?

A: Yes, and everything is consistent with infection also.

Q: But Dr. Posch had every right to conclude this man had a ruptured popliteal cyst on October 15th, didn't he?

A: I think if a working — if the temperature were normal and the white count were normal or only slightly elevated, that's satisfactory to make that your working diagnosis but you still haven't ruled out infection.

Q: And, again, since you have not diagnosed or

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treated a patient with a ruptured popliteal cyst, you would rely on an orthopedic surgeon to render those opinions?

MR. ROBERTS: Objection.

A: Just on the popliteal cyst side of the equation, yes.

Q: Now, when is the next thing again that you feel Dr. Posch did that fell below standards?

A: Besides not following him carefully, the next thing is October 21st.

Q: Okay. And what is it that Dr. Posch should have done on October 21st that he did or did not do?

A: Well, he shouldn't have sent the patient home. This is a patient now who's got necrosis, an open wound, necrotic tissue, and that kind of person needs to be admitted. I mean this is infection, still hasn't been ruled out and even if there's no infection, if you send a patient home with a open necrotic wound it's going to get infected.

Q: Now, when you say open necrotic wound, what are you talking about?

A: He had four, just what he said in his note, four by eight centimeters area which he called a burn, with central 2 by 2.5 centimeter area of third degree necrosis.

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Q: Okay. What does that mean to you, the third degree necrosis area?
A: Means it's dead skin.
Q: Okay. Does not necessarily mean infected?
A: Right.
Q: Okay. Now, again, what are you referring to when you say an open wound?
A: Well, that's what I mean by the 2 by 2.5 centimeter area of third degree necrosis.
Q: So you thought the necrotic area was open?
A: Well, it's dead skin. I mean I think that's considered, in other words, there's no live skin there.
Q: Do you recall how Dr. Posch described that area in his deposition?
A: Yes. That's the next thing I was going to look at. He says — this is around page 39.
Q: Uh-huh.
A: This is around page 39.
Q: Right. Correct.
A: There was full thickness area, black, dead skin in the center of the erythematous area. It was weeping and open.
Q: Okay. Now, what is it your understanding —
A: I'm not finished.

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Q: I'm sorry.
A: Compatible with a blister that had gone on to necrosis.
Q: Okay. Now, what in that picture makes you think there's an infection?
A: Well, I think that this has progressed from October 15th, it's necrotic, it's weeping, and it also, it's certainly compatible with infection; it's also compatible with a third degree burn. Again, if he was using a heating pad on low I think that's very unlikely.
Q: It's compatible with a burn that is not infected, correct?
A: Yes. I can't rule out that this isn't an infection, but I think it probably is and if it isn't I think he should have been admitted and treated aggressively for a third degree burn.
Q: Okay. You said you cannot, do you mean you cannot rule in that this is an infection?
A: Right. Again, there's no temperature, there's no CBC which were part of my criticisms I just read to you, and I think with those, it would have been more likely it was an infection than not an infection, but either way I think this wasn't treated properly whether there was an infection or not.

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Q: So assuming that this area was not infected, what kind of treatment do you think should have been rendered?
A: Well, then it's a surgical decision to-debride it and wet to dry dressings and skin grafting, at least wait for it to granulate.
Q: So what you're saying is debride off the top level of tissue?
A: Debride all necrotic tissue.
Q: Okay.
A: And then, this is a surgical thing but I work, and I work with surgeons because I know there's a risk of infection here. You continue to debride until it's granulating nicely.
Q: Okay. Now, that's something a surgeon would do?
A: Yes.
Q: You would not do that?
A: Right. I would advise it but I don't do it.
Q: That would be the judgment call the surgeon would make, whether they want to surgically open up this area?
A Yes. I would, as an ID person I would advise it because it's going to get infected if you don't.
Q: How do you know that?

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A: You've got necrotic skin that's going to get infected. Dead skin has no resistance to infection.
Q: So you're saying every time there's dead skin it's going to get infected?
MR. ROBERTS: Object to form.
A: If it's not, if it's not treated properly, yes. I mean if you debride, if you do wet to dry dressings it's not going to get infected.
Q: So you're saying, but any person who's got an area of dead skin, they need to be admitted to a hospital, debrided and treated with dressing changes?
A: Yes. I mean I can think of exceptions to that, but if you have dead skin that's open, necrotic and weeping, it's going to get infected.
Q: What exceptions can you think to that?
A: I'm trying to think. If you have dry gangrene, let's say an ischemic toe, for example, we just sort of let that demarcate and fall off. It's not an open wound.
Q: Do you have any opinion what Mr. Rogers' temperature would have been if it would have been taken on October 21?
A: Again, it depends on timing, because as I said

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before, temperatures go up and down. But I think he did have a low grade fever. He said in his deposition he was having chills so I think he did have at least a low grade fever. Whether his temperature would have been elevated at that one point in time, I can't tell but I think he had a low grade fever. I think his white count would have been elevated.

Q: And that's all based on your knowledge in hindsight, correct?

A: I think that even just necrosis of skin can give you a mildly elevated white count even if it's notinfected.

Q: So what do you think was infected on October 21?

A: I think he had infection in his skin and subcutaneous tissue at this point. I don't think he had necrotizing fascitis.

Q: But he might have?

A: I doubt it. You know, this is one of the things I remember from your defense experts, that necrotizing fascitis spreads faster than — he would have been in a worse condition on October 26 if he had necrotizing fascitis on October 21st.

Q: Have you ever treated a patient —

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A: I'm not finished. I tend to agree with that.

Q: I'm sorry. So you doubt that he had necrotizing fascitis on the 21st but you think it's possible?

A: I think it's improbable. Anything's possible.

Q: Have you ever treated a case of necrotizing fascitis?

A: Sure, lots of them.

Q: Have you ever treated one in an extremity?

A: Yes. Lots of them. But only conjunctive with surgeons. It's primarily a surgical disease with the infectious disease specialist, you know, just advising on antibiotics.

Q: Do you know what the mortality rate is for necrotizing fascitis?

A: It's a very broad question because first of all there's two types. There's the polymicrobial and there's the group A strep; and secondly, it depends on how extensive it is when it's diagnosed. So the mortality can be anywhere from five percent to 90 percent.

Q: Okay. What about, Mr. Rogers had polymicrobial, correct?

A: Yes.

Q: What would be the mortality rate for a diabetic with polymicrobial necrotizing fascitis in his leg?

MR. ROBERTS: Objection.

A: With this at this extent?

Q: Yes.

A: I'd say maybe 10, 15 percent.

Q: Are you basing that on any studies?

A: Yes, there are studies of necrotizing fascitis but again you can't, it's very hard to get a homogenous group where they're all the same and then you see what's their mortality rate.

Q: Have you ever had a patient develop a necrotizing fascitis while they were under your care?

A: No, I don't think so. Usually they come in with it.

Q: Okay. Have you ever seen a patient who's referred to you by another physician where they had been under that physician's care for some problem or another and developed a necrotizing fascitis?

A: I don't recall. I might of. I just don't recall a case like that.

Q: But you said you did not interpret the MRI in this case?

A: No. I just, I just read the report. I don't interpret MRI's.

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Q: And would you agree the MRI report lists a number of potential diagnoses for the problem in Mr. Rogers' leg?

A: Yes.

Q: And one of them was a ruptured popliteal cyst?

A: Yes. And one of them was infection.

Q: But the findings on the MRI were consistent with a ruptured popliteal cyst?

A: Yes. And with infection. That's been my point all along.

Q: There are about four or five other things it was consistent with, correct?

A: Yes. The only way — that's what radiologists do. They just give you a list of things it could be and then it's up to the doctor to sort it out.

Q: And to make a clinical judgment as to what they think best fits the picture?

A: Yes.

Q: Is there anything else you feel was done inappropriately by Dr. Posch on October 21?

A: No.

Q: And that was failure to get a white count and failure to check the temperature, correct?

A: Yes. Again, it's the same thing as the 15th. The first thing is you have to consider infection

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and then you go from there.
Q: But I want you to again list for me everything you feel that Dr. Posch did or did not do on October 15th that you believe fell below the standard of care?
A: I think he should have taken his temperature, I think he should have done a CBC, and I think he should have admitted the patient to the hospital.
Q: And the admission diagnosis would have been what?
MR. ROBERTS: Objection.
A: A necrotizing —
MR. ROBERTS: Hello?
MS. REINKER: Yes.
MR. ROBERTS: You said the 15th.
MS. REINKER: I'm sorry, I meant the 21st.
MR. ROBERTS: All right.
THE WITNESS: I think she said the 21st, too.
MR. ROBERTS: She said the 15th.
A: The admitting diagnosis would be necrotic wound and then rule out infection, rule out ruptured popliteal cyst, rule out third degree burn.
Q: Anything else you feel Dr. Posch should have done on the 21st?

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A: No.
Q: Okay.
A: I think he, I think once you admit, then you do an MRI right away, you don't wait two days. Once you consider infection there's a whole sequence of things you do, not just temperature and CBC.
Q: And assuming the MRI would have been done on the 21st and Dr. Posch got the same report that he got, or the report that was dictated on the 23rd, again, that would have been consistent with a ruptured popliteal cyst?
A: Yes. And infection. Then you go in and debrid and you see-what's going on, surgically. And you get deep cultures, you start I.V. antibiotics.
Q: A doctor would do that for a diagnosis of a ruptured popliteal cyst?
A: No. For a necrotic wound.
Q: Okay. Is there any risk to the patient in going through all those surgical debridements that you're saying should have been done for this?
A: The risk is greater not doing it than doing it.
Q: Okay. Can you tell me any signs or symptoms that Mr. Rogers displayed on October 21 that were not consistent with a ruptured popliteal cyst and a secondary burn?

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MR. ROBERTS: Could you repeat that, please?
MS. REINKER: Could I have Miss Court Reporter read it back, please?

(Thereupon, the requested portion of the record was read by the Notary.)

A: I would have to defer on whether this is going on for 12 days because as I said before, I don't treat those.
As far as the third degree burn, I think it's consistent with a third degree burn that's not infected, but it has to be at least superficially infected. You've got dead tissue, it's going to be infected almost by definition, but it could be not a deep infection.
Q: Are you aware of what treatment had been administered for the burn?
A: You mean on October 21st?
Q: At any point in time prior to that.
A: Well, let's see. The first time he was seen for a suspected burn was October 15th and it really wasn't any treatment, just keep the leg elevated,

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avoid heat, and use Vicodin for pain, and then on October 21st, he says continue topical care. I think he was already using something topical. It says wife is dressing this with Neosporin in the beginning of the note. And then his plan was continue topical care, which means continue to redress it with Neosporin, keep the leg elevated, and then something for pain.
Q: Would a topical antibiotic ointment be an appropriate treatment for a burn?
A: No.
Q: It would not?
A: I think it has to be debrided.
Q: Regardless, every — you're saying every burn has to be debrided?
A. Necrotic tissue, you've got to debride it.
Q: So between the 15th and the 21st, prior to Dr. Posch's seeing the necrotic tissue, would the antibiotic ointment be playing any role?
A: Yes, I think it can help prevent infection if you've got intact skin it can help prevent infection, yes. I don't think Neosporin treats infection, I think it helps prevent infection.
Q: Do you have any opinion as to the cause of the necrotizing fascitis in this case?

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A: Yes. I think he had an infection that just continued to progress and then it progressed down into the deeper tissues. He had a fairly aggressive organism even though we said it was polymicrobial. Group B strep was a predominant organism here and that's fairly aggressive.
Q: Where does group B strep come from?
A: Yes.
Q: Where did he get it?
A From himself. It's on the skin. It's in the intestinal tract.
Q: Do we know, do we, of those possible options, do you know how it got into the tissues of his leg?
A: Well, it had to ultimately from the skin, from his skin. I mean I don't think it got there through the bloodstream. That would be the other route of entry.
Q: Why don't you think it got there through the bloodstream?
A: There's no evidence. It's very unlikely. I can't say it's impossible, but he would have had to have a transient bacteremia, because he wasn't septic in the sense of having infection in his bloodstream, he wasn't sick enough for that.
Q: Okay.

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A: But he could have had a transient bacteremia, for some reason that got to his traumatized area, but just the probability, it went straight in through the skin. You have an open, necrotic wound. Either that or he had infection already present which I mentioned on October 15th and it just progressed and caused the necrosis.
Q: We've been talking throughout this deposition of these two symptomatic pictures, one of a ruptured popliteal cyst with a secondary burn, the other of what you believe was an underlying or an infectious process. And I think we've agreed on a number of points that the symptoms of these two conditions can be virtually identical?
A: Yes. I think he could have had no cyst at all and had an infectious process and no burn at all and had an infectious process that wound up not causing necrotizing infection.
Q: You think that's one possibility?
A: One possibility. The other is the scenario of a ruptured popliteal cyst with a burn from a heating pad and then a secondary infection.
Q: So you don't believe he was necessarily — let's go with the second scenario, okay. When there was, when the patient appeared in the office on

Page a?

October 21, he has a ruptured popliteal cyst and he's got a burn and he now has a necrotic area, okay?
A: Yes.
Q: You're with me so far?
A: Yes.
Q: Assuming that to be the picture on October 21, you're not saying he was infected on October 27 necessarily?
A: That's right. I said that I think he was but it's possible he wasn't and he just had a open necrotic wound there from a burn.
Q: Okay. So that's really now a third possibility of the scenario?
A: Yes.
Q: That he had a ruptured popliteal cyst, a secondary burn that was not infected on October 21, but you think some intervention should have been taken so it didn't get infected?
A: It had to be superficially infected. I mean you can't have necrotic skin that's not infected.
Q: Well, let's assume he was appropriately using the Neosporin ointment.
A: That's not going to work on necrotic skin. It will work on intact skin to keep it from getting

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infected but not necrotic skin.
Q: So you're really testlfying here that every time there's necrotic skin that means there's an infection?
A: At least superficially, yes and you got to debride that. The dead skin, there's no resistance to bacteria from dead skin so you've got to debride it.

(Thereupon, a discussion was had off the record.)

Q: Are there any other opinions that you believe you'll be rendering at trial that we have not already talked about?
A: Yes. I said on October 23rd he should have been admitted also.
Q: By whom?
A: By Dr. Posch.
Q: And how should Dr. Posch have arranged for that admission on October 23rd?
A: Well, that's when the MRI was done. The MRI showed among other things the possibility of infection. There was a phone call that says the pain's getting worse, and he should have been

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admitted. I mean he knew there was an open necrotic wound and now there's evidence there's something going on deep and he shouldn't have been allowed to stay home untreated for another three days.

Q: But you would agree that the MRI was also consistent with a ruptured popliteal cyst?

A: Yes.

Q: And you don't know what the symptomatic picture is of a ruptured popliteal cyst that's not infected?

A: Right. But infection hasn't been ruled out. If the pain's getting worse, he's got an open necrotic wound, and even if there's a ruptured popliteal cyst, I think he should have been admitted.

Q: Do you have any knowledge of Mr. Rogers' condition over the weekend from October 24th and 25th?

A: Only by the depositions.

Q: Okay.

A: Medical record.

Q: If you had a patient who was getting worse would you believe that patient had some obligation to seek out medical attention?

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A: Yes. I think if the patient's getting worse they should call the doctor or go to the emergency room.

Q: Are you in any way critical of Mr. Rogers for his actions in this case?

A: No. Because, you know, it depends on the level of trust that the patient has and the level of insight that they have.

Q: So you don't in any way fault him for any of his actions or inactions?

A: No. I'm not a patient standard of care **expert.**

Q: Okay. Do you think this man should have sought medical attention over that weekend?

A: Yes. I think it's, you always hope that a patient, if they're getting worse, will tell somebody or go to the emergency room, yes.

Q: If Mr. Rogers had gotten medical attention over that weekend, would you agree that perhaps the condition of his leg would not have reached the point it reached on Monday morning, October 26?

A: Yes. I think once infection spreads exponentially and each day it's getting worse and worse in a multiplier fashion.

Q: So if he had gone to the emergency room over that weekend, the outcome could have been different?

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A: I think more likely than not would have been.

Q: What do you think would have been different if he had gone to an emergency room over the weekend?

A: Well, assuming infection would have been diagnosed and treated there would have been much **less** damage because I said the damages are multiplying each day.

Q: Okay. Any other opinions you're going to be rendering at trial that we have not talked about?

A: No.

Q: Okay. If you want to take a moment to look through your notes because this is my one chance to find out before the trial what you're going to say.

A. No. My opinions are contained in that comment sheet that I read to you.

Q: Okay. Let me take one moment to look at my notes, doctor, and to make sure I'm finished.

A: Thanks.

Q: Can you think of any other cases you currently have open that are in Ohio?

A: No. That doesn't mean there aren't any, I just don't have it in my mind right now.

Q: Do you have any kind of a computer list or anything?

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A: No.

Q: Of the cases you have?

A No. It's just usually the attorney calls me and says, you know, we'd like to schedule a deposition or something.

Q: Can you think of any other cases you're currently involved in which involve necrotizing fascitis?

A: No.

MS. REINKER: That's it, doctor. Unless Kevin wants to tell me about any opinions that I've missed.

If you anticipate any area that we've not gone into that you intend to inquire about to save a re-deposition it might be nice if you mention that now or did we cover everything?

MR. ROBERTS: We talked about what he thought about the operative note showing no cyst. He already went into that.

MS. REINKER: Okay.

Q: Doctor, have you ever seen an operative note on a patient who had a ruptured popliteal cyst?

A: Yes.

MR. ROBERTS: I shouldn't have

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said that. Here we go again.
A: I don't recall, because, again, I wouldn't get involved unless there's an infection.
Q: Do you know whether popliteal cysts are routinely operated upon?
A: No. I think, again, I would defer to an orthopedist. I think sometimes they are, sometimes they're not.
Q: So you don't know —
A: It depends whether conservative treatment, you know, works or not.
Q: So you don't know what the operative report on a patient with a ruptured popliteal cyst would show?
A: No. I mean I can, I would think it would show that, you know, the membrane of the cyst. If it's just a surgery for a ruptured popliteal cyst and there's no infection issue, you would just see the pathologist, would just show the synovial membrane of the cyst.
Q: But in this particular case due to the advanced stage of the infection, all that tissue, that would have been disrupted, wouldn't it?
A: It's possible. That's where I would defer because it's possible that the cyst wasn't seen

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because there was so much infection.
Q: Right. Okay.
MS. REINKER: Kevin, anything else I should ask about?
MR. ROBERTS: Well, I think we're going to have to accept what fluctuance means at trial because that's in the note.
Do you want to get into that?
Q: Doctor, I realize you'll probably be asked other things to support the opinions you've rendered but I just want to make sure I've covered all the opinions you've rendered.
A: I can't imagine anything else that we haven't discussed.
MR. ROBERTS: I think that's it, Susan. I can't think of anything.
Q: Okay. Have you ever aspirated a patient's leg whom you thought had a ruptured popliteal cyst?
A: No. That's not something I would do.
Q: Okay,
MR. ROBERTS: I guess, Susan, the big picture, I mean he would testify that this infection and consequences of it were the result of, where he says in his

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opinion this was a proximate cause of extensive damages from the infection.
MS. REINKER: Yes.
MR. ROBERTS: Okay. So I don't know if you want to get into what damage this caused and that caused by the infection but obviously that's an area of discussion.
Q: Doctor, I gather you've never performed surgical debridement for necrotizing fascitis, have you?
A: That's correct. And as far as the damages, I would just go by, you know, what the patient said in these follow-up records, he just lost a lot of tissue.
Q: Do you consider this man fortunate to have kept his leg?
A: Yes.
Q: Okay. So I gather —
A: His life, too.
Q: Okay. So you are in no way critical of the care that was rendered after October ***26?***
A: That's right. I said that.
Q: Would you agree they did a good job by this fellow?
A: Yes.

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MS. REINKER: Okay. I have nothing further.
MR. ROBERTS: Okay.
MS. REINKER: Thank you. And I am going to request this written.
MR. ROBERTS: Yes. We'll make copies of the notes.
MS. REINKER: Yes. Correct. I want copies of everything you have there in front of you, okay.
Q: Doctor, I do have one more question.
Have you iooked up any medical literature to get ready for your testimony?
A: No. Let me ask you, you said everything. You want copies of for example Dr. Hutt's consult?
Q: Do you have any notes written on those?
A: No. I didn't write on them.
Q: Just your handwritten note pages?
A: Okay. Where I did make a copy of something it says **see** copy.
Q: Okay. You know, you've only got four pages that you copied from the charts. Isn't it just four pages?
A: It's in terms of sheets of paper, three, five. We can copy those.

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Q: Yes, just send everything.
A: Okay.
MS. REINKER: Okay. Thank you.

NEIL A. CRANE, M.D.

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CERTIFICATE

The State of Ohio,) SS
County of Cuyahoga)

I, Aneta I Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named NEILA CRANE, M D , was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth, that the deposition as above set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewrlting under my direction, that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence, that said deposrtion was taken at the aforementionedtime, date and place, pursuant to notice or stipulations of counsel, that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financialiy interested in this action

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A D 20 ___

Aneta I Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 28.2001

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