IN THE COURT OF COMMON PLEAS
LUCAS COUNTY, OHIO

THOMAS G. BALDWIN, :
Plaintiff, :
-vs- : Case No. CI96-2365
MARK E. REARDON, M.D., et al., : JUDGE LANZINGER
Defendants. :

- - -

Telephone deposition of DONALD E. FRY, M.D., Witness herein, called by the Defendants for Cross-Examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Jodi S. Jefferies, a Notary Public in and for the State of Ohio, pursuant to agreement and stipulations of Counsel as hereinafter set forth at the offices of Jacobson, Maynard, Tuschman & Kalur Co., L.P.A.m 1600 Summit Center, 333 N. Summit Street, Toledo, Ohio, on Thursday, September 4, 1997, at 11:50 o'clock a.m.

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APPEARANCES:

On behalf of the Plaintiff:

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By: DONNA TAYLOR-KOLIS
(via telephone)

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By: JOHN F. BODIE, JR.

- - -

DONALD E. FRY, M.D.

Having been first duly sworn, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. BODIE:

Q Dr. Fry, my name is John Bodie. Along with Steve Skiver in our office, I represent the defendants in the matter, Dr. Reardon, the estate now of Dr. Sogocio and Dr. True. You have been identified as an expert for the plaintiffs to testify against them rendering criticisms of yours of the care rendered by these physicians. Are you aware of that?

A Yes, I am.

Q Okay. Doctor, I'm going to be asking you some questions regarding your review and your opinions and the basis for your opinions in this case. We are doing this by telephone and if you don't understand my question or I don't come through clearly, please ask me to rephrase it. Okay?

A Okay.

Q If you respond to my question I'll assume that you understand it and are responding completely to the best of your ability to that question; is that fair?

A That's fair.

Q If at any time you need to take a break just let me know. Okay?

A That will be fine.

MR. BODIE: And, Donna, I'll just, since your there with Dr. Fry I'll just assume and take your word that there is no non-verbal coaching that I am not able to see since I am not present there.

MS. KOLIS: You have my word on that.

MR. BODIE: Thanks,

Donna.

MS. KOLIS: You're welcome.

BY MR. BODIE:

Q Doctor, could you please state your name, business address and social security number for the record, please.

A Donald Edmund, E-d-m-u-n-d, Fry, F-r-y. And my place of business is the University of New Mexico, School of Medicine and my social security number is 273-42-7448.

Q Thank you. Doctor, as we had discussed off the record, the previous attorney in the matter had provided me a 32 page document which was identified as your curriculum vitae and as we discussed there is a more recent updated one that you have identified that contains approximately 38 pages; is that correct?

A That is correct.

Q And, Doctor, could you provide, before Donna leaves New Mexico there, and I understand it's beautiful out there today, if you could provide her a copy of that curriculum vitae I think we could dispense with going over the background information and academic information that is contained on that

document.
A That will be fine, sir.
Q Good enough. The other thing is, as I have reviewed the documents that I had been previously provided I see that there are a number of publications, abstracts, book chapters, that you have written in the area of general surgery, is that a fair description?
A Yes, sir, it is.
Q Are there any articles, abstracts, book chapters, that you have written that you believe are pertinent to this case?
A Well, I think that much of the published material that I have listed on my curriculum vitae dealing with the issue of peritonitis, both experimental and clinical peritonitis as well as how peritonitis relates to the formation of abscess. So in that sense a very significant portion of my curriculum vitae would be addressed to the issues associated with a perforated appendix and its sequela and in that sense I think it bears very directly on the issues in this case.
Q You mean in general terms of the pathophysiology descriptions of peritonitis?

A That is correct.
Q Okay. In relationship to specific actions of physician diagnosis and treatment of a person with peritonitis or intra-abdominal abscesses, is there any of the articles, publications, et cetera, that are listed here, are there any that specifically address those particular issues?
A Relative to the treatment of appendicitis and abscesses, there are numerous of those that do and perhaps it would be appropriate for me to mark or asterisk the copy of the curriculum vitae that I will send with Ms. Kolis to you rather than to painstakingly go through each publication.
Q You read my mind, Doctor.
A Okay.
Q I don't want you to painstakingly go through each title. Just put check marks by the ones that address those issues.
A That will be fine.
Q I appreciate that. Doctor, I understand that also, you have also over the course of your career reviewed and testified in a number of medical/legal matters such as the one that we are sitting here today; is that correct?

A That is correct.
Q Okay. As far as breaking it down between plaintiff cases and defense cases, could you give me some percentages?
A It's about 60 percent defense cases and about 40 percent plaintiff cases.
Q Okay. Doctor, have you reviewed a case that involves specifically allegations of failure to timely diagnosis and treat appendicitis, obviously other than this one?
A Yes, I am almost certain that I have. I am actually a defense expert in a perforated appendix case here in the City of Albuquerque at the present time. I am trying to remember whether I have been a plaintiff expert before in perforated appendix and right off of the top of my head I cannot remember such.
Q Okay.
A But that is just on pondering the cases right here at the present time. So I am a defense expert in one such case relating to perforated appendix here in Albuquerque at the present time but I don't recollect of any others.
Q What is the name of that case?

A The name of the case is Jeo, J-e-o, that's a last name, that's a native American last name, Jeo versus Coon, C-o-o-n. The defense counsel is a good friend of mine named Gregory Chass, C-h-a-s-s and plaintiff attorney is another good friend of mine, Steven Durkovich.
Q Have you given a deposition in that case?
A Indeed, I have.
Q Okay. Tell me a little bit about what that case involves.
A It involves a perforated appendix in an elderly patient who presented with highly atypical physical findings and the patient ended up dying as a consequence of a perforated appendix.
Q And you are the defense expert in this case?
A That is correct.
Q Okay. And based upon the atypical presentation, I'm just kind of guessing here, I guess based upon the atypical presentation it was your opinion that the doctor did not deviate from standard of care in his evaluation and/or diagnosis of that patient?
A That is correct. The substance in that case is dramatically different from this one. In that the

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physical findings were atypical and that selective aggressive diagnostic modalities failed to document appendix or abscess and I'm taking the position that it would have been reasonable for even the best trained physician to have missed the diagnosis in that case.

Q Now, when you say atypical presentation for appendicitis or abscess what is, what do you mean by atypical? Or I guess more specifically, what was the presentation in that case that made it atypical?

A The absence of localized right lower quadrant pain, the absence of rebound tenderness, the fact that the patient was ambulatory and able to eat and drink during the period of evaluation. Those are, I think, distinguishing features that separate a patient with, who has an acute perforation of an appendix from someone who does not have appendicitis at all.

Q Those are atypical presentations or atypical symptoms that would lead a reasonable physician away from the diagnosis or away from the suspicion of appendicitis?

A I would agree with that.

Q Okay. Getting back to this case. What have you been provided to review?

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A I have reviewed an extensive number of records here. I have the records from the Westech Medical Center where this patient was originally evaluated. I have office records from Drs. Sternfeld and Husted. I have some specific records from Flower Memorial Hospital that are dated relative to the operations that the patient subsequently had. I have Bedford Medical Center's records from Dr. True. I have emergency room service records from May of 1986 relative to the patient Thomas Baldwin.

Q Hey, Doctor, I'm going to interrupt you here because I think we're looking at the same things. I am looking at in front of me what are four bound copies that say Binder Tech down in the left bottom corner.

A That is correct.

Q Okay. And these were provided to me by a Mr. Albrechta or Theado sometime ago by way of the medical records in this case that they have maintained.

A That is correct.

Q I assume these are the same records and, excuse me, I'm talking about three bounds ones because I'm flipping through the fourth here and it appears my fourth one is an identical copy of my first one.

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A That is correct. And then I have received a few additional records other than the ones that have already been indicated.

Q Okay. What are those?

A And this relates to care following the two operations that this patient had there at the Flower Hospital. That is to say these are records relating to care after the patient has moved to Nebraska.

Q Okay. So these are Nebraska records?

A These are Nebraska records from Fox Butte, B-u-t-t-e, Hospital and records of Dr. Forney, F-o-r-n-e-y and of a Dr. Elston, E-l-s-t-o-n. And I believe that is -- no. And then there are some records interestingly enough of a Dr. Mary Baldwin, B-a-l-d-u-i-n, that are also from Nebraska, I believe as well.

Q Could you give me just a, since I don't have those subsequent records could you give me just a brief synopsis or dissertation of what the treatment involved in those four entities was?

A Yes. The majority of the subsequent care and management of this patient have related to the issue of diarrhea and its management. The patient has had subsequent to his move to Nebraska an episode of

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documented clostridium difficile which was successfully treated with Vancomycin. And then the patient has then had some additional assessment and evaluation for persistence of diarrhea in the, even in the face of the resolution of the acute infection. So the patient appears to be, from this record, having some sustained problems of continued diarrhea.

Q And the sustained problems of continued diarrhea are as a result of the enterocolitis?

A It would appear from my medical judgment that the sustained problems of diarrhea in all likelihood are sequela of, from right hemicolectomy and the loss of the ileocecal bowel. So even though the enterocolitis was successfully treated it appears that the patient is continuing to have significant diarrhea symptoms with no infectious agent identified and could, would appear clearly related to sequela from having a right hemicolectomy.

Q Doctor, what are some of the sequela of patients who have experienced clostridium difficile as a result of, was that viral or bacterial enterocolitis?

A Yes, clostridium difficile is a bacterium.

Q So this was a bacterial --

A Yes, it was a bacterial enterocolitis that was commonly a consequence of patients having preceding systemic antibiotic therapy and since clostridium difficile is resistant to many of the antibiotics that might commonly be employed in the treatment of any, of a number of infections or problems the patient ends up with overgrowth of clostridium difficile in the intestinal tract, particularly the colon, and clostridium difficile produces an enterotoxin and that enterotoxin causes inflammation of the lining, cells of the colon and that results then in the patient having a thoroughly acute syndrome of diarrhea, severe cramps, abdominal pain, perhaps even gastrointestinal loss of blood from the severity of the enterocolitis. It's generally necessary to use oral antibiotics for the treatment of that condition, either Metronidazole or Vancomycin and in this case the patient was treated with Vancomycin. And the clostridium difficile enterotoxin disappeared given the documentation of clearance of the infection but he continues to have frequent daily stools. So the acute infection part of this patient's picture resolved with treatment but he still has the problems of frequent bowel movements which reasonably relate to

the rapid motility that one experiences after the ileocecal bowel of the intestinal tract has been removed.

Q Do patients who have had their bowel removed always have frequent bowel movements?

A Actually, they do not and it is variable from one patient to another.

Q So is it rare for patients to have frequent bowel movements as a result of removal of the ileocecal bowel?

A I wouldn't say that. I wouldn't say it was rare but I think having bowel movements to the magnitude of six or more stools a day, as are reported in Mr. Baldwin's record, would be certainly on the high side of what one would see. But I think that patients that have ileocecal bowels removed will not uncommonly have more frequent bowel movements than individuals who have their intestinal tract completely in tact.

Q What percentage of patients who have had their, in your experience, Doctor, what percentage of patients who have had their cecal bowel removed go on to experience frequency of bowel movements?

A Probably all have a slight increase in

frequency, meaning instead of a single bowel movement a day it would be common for them to have two or three. It would be my estimate that probably less than 20 percent would experience frequency on the magnitude of what is being described for Mr. Baldwin in the most recent records that I have reviewed.

Q Would it be less than 10 percent perhaps?

A Oh, it might be. I would say 10 or 20 percent is a reasonable number.

Q Of the patients who have experienced a problem with bacterial enterocolitis is one of the sequela of that frequency of bowel movements?

A No. Once the disease has been microbiologically cured the patient should return to bowel habits that would have been characteristic of their pre-infection state.

Q Is there an entity known as chronic enterocolitis?

A There is chronic ulcerative colitis and then there is sort of the chronic irritable bowel syndrome. There is no real evidence that this patient had those kinds of symptoms prior to his operation in the fall of 1992. There is certainly no histological evidence or other evidence to support a diagnosis of

ulcerative colitis so it's always reasonable to entertain potential other diagnoses. But I would say at that point the weight of the evidence would support the conclusion this his frequent bowel movements reflect rapid gastrointestinal transit from removal of his right colon and other segments of his small intestine.

Q Has the entity of chronic irritable bowel syndrome, have studies been performed on Mr. Baldwin to rule out that problem?

A If they have I certainly don't see them. And very commonly chronic, chronic spastic colitis and so forth, irritable bowel and so forth, almost is a diagnosis of exclusion. There is not much in the way of a definitive diagnosis that one could do in terms of a specific study to identify those entities.

Q Is there an incident of patients who have appendicitis or who have had appendicitis that also have other bowel problems, be it diverticulitis or colitis?

A I would say that the presence or absence of appendicitis would not be a variable that would increase or diminish with the likelihood of having an intercurrent secondary chronic disease. So it would

be my opinion that patients with or without appendicitis have the same probability of developing diverticular disease or irritable bowel syndrome. So I would not say the presence or absence of appendicitis either increases nor diminishes from the likelihood of either of those entities.

Q Okay. Have you seen those two entities frequently co-exist?

A Diverticulitis co-existing with appendicitis.

Q A patient that has had appendicitis and had surgical treatment for a ruptured appendicitis, that those patients have also been treated for other bowel problems?

A Well, I mean, given the fact that probably 50 percent of people with a normal life expectancy develop diverticulitis it would certainly imply that 50 percent of patients that have had appendectomies will probably have diverticular disease at some point in their subsequent life. So, yes, I have certainly seen patients that have previously had an appendectomy that develop diverticular disease but I, I would caution that there is no evidence to support, in my judgment, a causal relationship between appendectomy and the subsequent development of either irritable

bowel syndrome or diverticular disease.

Q Doctor, are there other diseases or conditions of the bowel that can cause increased bowel movements?

A Oh, yes, there is certainly a wealth of different things that can cause chronic diarrhea over time. There is various parasitic infections; GR diseases is a notable one, in that regard. Patients getting amoebic infections, particularly if they have traveled to South America or to Central America. There is regional enteritis as a disease entity that can cause a chronic diarrhea. There are other bacterial pathogens that we have not talked about that could be associated with drinking contaminated water, usually in places outside of the United States, that can cause diarrhea. And so frequent bowel movements and, and diarrhea can be the consequence of fundamental intestinal diseases. It can be the consequence of infectious pathogens where there is bacterial or parasitic disease and it can be the consequence of the shortened gut, such as we see here with Mr. Baldwin, or it can be the reduction in the total amount of colonic length that is present. Since the primary physiological function of the human colon

is actually water absorption and so it makes sense that a 50 percent reduction, or a 40 percent reduction of the total colon that's available might very well result in more frequent stools simply because more water is being delivered to the distal part of the colon.

Q Mr. Baldwin does not have short gut syndrome, does he, Doctor?

A No, he certainly does not. He does not have short gut syndrome. But short gut syndrome really specifically is referring to patients who have problems in maintaining nutritional support. On the other hand, patients that have their intestinal tract shortened do have more rapid motility rates and so they very well may have more frequent bowel movements. But clearly, Mr. Baldwin has no evidence of, at this point of short bowel syndrome.

Q And no evidence of, to your knowledge, of problems with malnutrition, malabsorption, et cetera?

A That is my understanding at this point, yes, sir.

Q Doctor, would you agree that eating and drinking habits of the patient can also effect the frequency and consistency of bowel movements in the

patient, as well?

A No question that that's true.

Q Okay. Doctor, we were talking about the things that you had reviewed before we went down this path. Have you reviewed any radiological studies?

A I have not reviewed the films myself. I have only reviewed the report.

Q Do you believe that it is necessary for you to review those studies themselves to render your opinions regarding the care and treatment in this case that you would plan on rendering at the time of trial?

A I can see no particular diagnostic value that would be derived from directly reviewing the films.

Q Okay. And I guess in that regard would you agree that it would be appropriate for the physicians that are named as defendants in the case to rely on the expertise of the radiologist in interpreting those studies?

A Generally I would agree with that, yes, sir.

Q Okay. The depositions in this case, have you reviewed any depositions?

A I have reviewed no depositions.

Q Okay. I will tell you that the depositions of my clients, Dr. True and Dr. Reardon, as well as

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Mr. Baldwin have been taken. Doctor, I understand you were out in this neck of the woods for a while practicing?
A Well, I not only was practicing in that neck of the woods, I actually have been raised in that neck of the woods so I know the northeastern, north central parts of Ohio pretty well.
Q Did you know Dr. Sogocio?
A I did not.
Q Okay. Dr. Sogocio, I don't know if Donna had explained to you Dr. Sogocio's deposition was not taken because shortly before the filing of this lawsuit he was diagnosed with essentially an inoperable brain tumor and died before, became incompetent and died prior to his deposition could be taken in this case. So all we have to go with Dr. Sogocio is what is in the records. Okay?
A Okay.
Q Doctor, I would ask that if it is your intent -- well, let me back up. Have you been told anything by Ms. Kolis, or Mrs. Kolis, regarding the testimony of the defendants in the case?
A I have not been told anything about the contents of the depositions whatsoever.

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Q Do you believe that it is necessary for you to render the opinions regarding the care of the defendants that you will be rendering at the time of trial?
A I believe that the best opinion is the one that is derived from the objective evidence in the medical records and so it would be my intention to address really only issues that are identified in the record and not rely on deposition testimony.
Q I appreciate that, Doctor. All I'm trying to do is find out what you're going to say at the time of trial so I'm not surprised then.
A And you won't be surprised.
Q Thank you. Also in that regard, Mr. Theado had provided me a copy of a report that you had issued in this case. Do you have that in front of you?
A I do, sir.
Q Okay. Are there any other versions of this report floating around that you had authorized?
A That is the only version.
Q Okay. Were you asked to amend this version by Mr. Theado?
A I was not.
Q Doctor, again, I guess I'm not going go

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through this, per se, and I'm sure we'll cover the nut of what is in here but I take it this report essentially sets forth your criticism of the case; is that fair?
A That's fair.
Q Okay. And we'll go into that a little more in detail because I represent different physicians and it really isn't broken down as to who these criticisms are directed to. Are you with me?
A I understand that.
Q I appreciate it. Do you believe that you -- let me back up. Did you do any literature search?
A No, sir, I did not.
Q Plan on doing one?
A No, sir, I don't.
Q Okay. Anything else that you have reviewed other than the medical records in this case?
A No, sir, I really have not.
Q Made any notes or anything?
A I guess I may have a scratch here or there or an underline here or there in the records but, no formal notes other than the report that I prepared for Theado that's dated October the 1st of 1993.
Q Thank you. I appreciate that. Have you made

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any assumption of facts in this case to reach or render your opinions?
A Well, I guess we always assume some things to be true. I'm assuming that the, the physical findings and the medical records to be true as presented to me. My assumption is that the facts in the record are accurate.
Q Okay. And when you say you assume that the facts in the record as they are reported are accurate that is by way of the physical findings, the exams and what the various physicians who saw this patients had at various times found at those various periods of time, you don't take issue with the validity of anyone's findings?
A No, I would accept the recorded, the recordings in the records to reflect the observations and the interpretations of the individuals who were evaluating the patient. I have no reason to believe that any of the information that's been recorded is in any way false.
Q Okay. And that includes the information generated and recorded by Drs. Reardon, Sogocio and Dr. True?
A I would agree with that.

Q Thank you. Why don't we jump right into it.
A Okay.
Q Why don't we just go chronologically here. What are you critical of with regards to the care rendered by Dr. Reardon?
A My primary criticism of Dr. Reardon's care would be very, very specific and to one very specific point and that is, is when this patient was presented with, admitted to the hospital on October the 27th of 1990 the patient was sent to Dr. Reardon with a diagnosis of rule out appendicitis. The patient was admitted by Dr. Reardon with a potential diagnosis of appendicitis. I would agree with Dr. Reardon in his decision to seek a surgical consult but my biggest criticism of Dr. Reardon is the fact that a 22 year old patient with no reason to have prostatitis was started on systemic antibiotics and that the initiation of systemic antibiotics in the patient where the potential diagnosis of appendicitis is at issue can clearly obscure the natural history of the disease and the clinical presentation that the patient will have subsequent to that point. And so I would make the very firm criticism that the initiation of Doxycycline backs the critical element in the

chronicity of the abscess that occurs in the patient and that the initiation and utilization of systemic antibiotics for a patient under evaluation for acute appendicitis is a departure from standard of care and materially contributes to the morbidity and problems that are sustained by this patient.
Q Doctor, before we go on to Dr. Sogocio I'd like to go to the medical records for that admission.
MS. KOLIS: August 27, turn to August 27th.
MR. BODIE: Yes.
MS. KOLIS: So the record is clean, you had said October.
MR. BODIE: Yes, I knew what he meant.
THE WITNESS: I'm sorry. Did I say October?
MS. KOLIS: Yes, you did say October. I love to testify. It's so fun.
BY MR. BODIE:
Q Are you with me so far?
A Yes, sir.
Q Okay. He was first seen by Dr. Reardon and

admitted on 8-27-90, correct?
A That is correct.
Q You were, by review of the records you were aware that he was, had been placed on antibiotics prior to that by the physician at Westech?
A I understand that he may have received Erythromycin prior to that point. I believe that is the drug that we had tried to identify in the emergency room records of August the 25th. But I understand from Dr. Reardon's notes that antibiotics had been given previously.
Q And you have no reason to dispute that?
A I tried to document that and that's been a source of some difficulty for me. But if I used my imagination I think I can interpret Erythromycin as being something that is being identified on the emergency room records of August, of August the 25th.
Q Right. I think it's in the Westech note. It looks like Erythromycin.
A I believe that's correct.
Q Would that play a roll in masking signs and symptoms of an abdominal septic process?
A Yes, it would be a source of concern to me.
Q Okay. Did you see in the diagnosis, the

admitting diagnosis, physical examination of Dr. Reardon that he had as his admitting diagnosis rule out gastroenteritis versus appendicitis masking by antibiotics?
A Yes.
Q Okay. Did you see that at that time he also stopped antibiotics?
A I believe that is correct.
Q Okay. Do you believe that was appropriate?
A I believe that was very appropriate.
Q And his admitting diagnosis, the decision to stop antibiotics and decision to bring in a surgical consult on 8-27, you do not take issue with?
A No, I believe those are appropriate strategies.
Q Okay. And you are not critical of him nor do you believe those actions demonstrate a departure from accepted standards of care?
A No. I would argue those are very well within the standard.
Q Okay. Your criticism, I guess, if you will, is that this patient was then started on Doxycycline?
A That is correct.
Q Do you know when he was started on

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Doxycycline?
A I believe on the, on the morning of the 29th I believe is when the order was written.
Q Okay. Doctor, how long would it take after you had stopped a patient on antibiotics to evaluate him for a non-masking of the signs and symptoms of appendicitis by antibiotics?
A Well, I think that that that's a tough question to answer but clearly the patient needs to be off the antibiotic for a period of time and if the patient still has symptoms that was potentially repable to acute appendicitis I believe they should remain off of antibiotics until a final decision has been reached and, in which case I can't give you a hard and fast answer to the question other than to say it was appropriate to take the patient off of the antibiotic and in my opinion it was inappropriate to re-initiate the antibiotic for a diagnosis that virtually would be unheard of in a 22 year old male.
Q Meaning mesentery adenitis or prostatitis?
A Prostatitis is my understanding from the records as to the justification for initiation of Doxycycline.
Q Okay. And where do you glean that

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information?
A It's from the orders when the Doxycycline was initiated and I believe that actually is, the discharge summary indicates that Doxycycline was initiated for prostatitis. And so I believe the record is fairly clear that that's the indication. Mesentery adenitis is generally a non-specific condition of the intestinal mesentery and is more commonly associated with little kids that have operations for appendicitis and would generally be thought to be viral in origin and not something that would be amenable to treatment with antibiotics.
Q Mesentery adenitis is not?
A Is not.
Q How is it treated?
A Leave it alone and it goes away.
Q Okay. What is prostatitis?
A Would be an infection of the prostate gland itself.
Q Can 22 year old gentlemen get it?
A They can get it but it would certainly be highly unusual.
Q What are the physical findings of prostatitis?

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A Pain and discomfort with voiding would be the patient's presenting symptoms. It would usually be associated with white blood cells and bacterial microorganisms in the urine and on physical examination would be identified with the diffuse severe tenderness of the prostate gland on rectal examination.
Q Doctor, I can't find the orders in my sheets here.
A Actually, the orders I think were not in my initial book.

MS. KOLIS: You know what, Chip, let me just say this, anything you think -- you can keep this on the records, I don't care. You have worked with me before and I always get complete hospital chart. So I gave him another set just making sure he had every single piece of paper from the hospital.

MR. BODIE: Okay. Well, Donna, I don't have a release so --

MS. KOLIS: If you don't have an order I can send you all the

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hospital records.

MR. BODIE: Okay.

MS. KOLIS: I assumed you had a complete set of records.

MR. BODIE: Unless I have a release I can't get them.

BY MR. BODIE:
Q The orders for Doxycycline, those were given on what day?
A That was started on the, the order was written on the morning of the 29th and the first dose was given at 1:00 o'clock p.m. on the 29th.
Q And that order was by whom?
A By Dr. Reardon.
Q Okay. Are you aware that that was after the evaluation of the general surgeon on the day before?
A I am aware of that.
Q And you are critical of his decision to administer, readminister an antibiotic to this, this patient on the 29th?
A Yes, sir, I am. And just so that, in keeping with the spirit of full disclosure so you don't have any surprises, you'll notice Dr. Reardon's note on the afternoon, 5:55 p.m., he basically provides a physical

examination again of right lower quadrant rebound, right lower quadrant tenderness with rebound so he's basically providing a physical examination consistent with all, the only indication necessary for doing an appendectomy and twelve hours later or so is writing orders for antibiotics. And so I would still contend that the initiation of antibiotics while the patient was still having symptomatology of acute appendicitis was a departure from standard of care.

Q You believe what was the patient's condition on 8-29 at the time antibiotics were administered, ordered?

A The patient was still having abdominal pain and discomfort at that point but had been started, if my recollection is correct, had been started on a clear liquid diet.

Q Was the patient febrile?

A He was not febrile at that point.

Q Would you expect a patient that had been taken off antibiotics and was suffering from a perforated appendix to become febrile?

A Not necessarily at this point.

Q Why not?

A Because the duration of antimicrobial action

is must more sustained than simply withdrawal for a period of 24 hours or so. The antibiotic employed is Erythromycin which is notorious for having slow absorption characteristics. I would say with all reasonable confidence that the patient still would have, have circulating Erythromycin at the time so it is not surprising to me that there would be a potential absence of fever at this particular point.

Q Even if he is on antibiotics and febrile on the 27th?

A Oh, I think that you can have fever with antibiotics and you can have fever without antibiotics. And all I can say is trying to make sense out of fever curves in appendix cases is something that I think lawyers pay more attention to than surgeons that operate on the patients. It is just -- I'm not trying to be evil here. It is just very precarious to depend upon fever curves for making the diagnosis of appendicitis with or without antibiotics.

And so I think the antibiotics actually compound the judgment that needed to be made in the case and I think that the judgment by Dr. Reardon to take the patient off of Erythromycin was an

appropriate one but I would still argue there is an arythromyacin effect and that the patient still, if he perforated the appendix on the 27th might very well have an acute spiking fever at the time that's temporarily associated with the perforation even though he may have had some antibiotics on board. But the antibiotic would facilitate a rapid return to the normal temperature state.

Q What's the half life of Erythromycin?

A I'd have to look it up. It's been a while. I believe it's in the range of 23 hours half life but Erythromycin preparations have a distinct feature of being unofficially absorbed in which case one ends up with the sustained release of net, of Erythromycin in the gut. So that, as opposed to giving a parental or IV dose of Erythromycin which would be clear to a very predictable fashion, giving it by mouth not only results in a far more sustained release so the drug hangs around a lot longer than you would anticipate.

Q Would you expect reasonably it would hang around for two days?

A Two days would be a long time.

Q Doctor, you're aware he was stopped Erythromycin on the 27th?

A That is correct.

Q And he was observed in the hospital on the 27th, correct?

A That is correct.

Q And he was observed on the 28th, correct?

A That is correct.

Q And on both days he was not on antibiotics?

A He was not actively getting drugs at that time but he surely was symptomatic consistent with a patient having acute appendicitis.

Q Okay. What are the signs and symptoms of acute appendicitis?

A You really only need two. It's right lower quadrant pain with rebound tenderness and that defines the disease and defines in a 22 year old the indication for appendectomy.

Q Doctor, are there other disease entities that present with right lower quadrant pain with rebound other than acute appendicitis?

A That's correct, there are.

Q What are they?

A In a male patient, so if we can exclude -- if it's okay with you I would like to restrict the discussion to male patients to give a relevance to

this case.
Q Great.
A Since obviously female patients would bring in a whole sedentary of potential considerations. But in the male patient the diagnosis of an acute renal stem, patients having urinary tract infection, patients having initial onset of regional enteritis, patients having mechanical diverticulitis. One can see cecal or right sided diverticular disease of the colon that would present with right lower quadrant tenderness.
But the fact is that if you put all of the alternative diagnoses together they have a probability of less than 10 percent compared to a 22 year old patient with right lower quadrant pain and rebound having an appendicitis. So the overwhelming probability issues here favor a diagnosis of acute appendicitis as opposed to the alternatives.
Q Okay. Is it also consistent with the presentation of mesentery adenitis?
A Well, mesentery adenitis in a 22 year old is outside of my nickel of experience. I have never seen it in somebody 22 years old. Mesentery adenitis is a surgical diagnosis of having done an operation on a

child or an adolescent with the clinical diagnosis of appendicitis only to find out at the time of operation that the appendix is normal and that one has a whole array of lymph nodes that are identified in the mesentery. And for all practical purposes there is no way of establishing a diagnosis of mesentery adenitis in an adult. I know of no way to accurately do that short of an operation and removal of the appendix and actual observation of the mesentery.
Q Is right lower quadrant pain with rebound a sign and/or symptom of mesentery adenitis?
A Oh, it could be but you can't prove that without an operation.
Q Is it also a sign or symptom of prostatitis?
A Very unusual. I would say no. Absolutely not. Rebound tenderness implies that there is peritoneal inflammation and prostatitis would not be a disease entity that would cause the patient to have peritoneal inflammation.
Q Is a mildly enlarged and embodied prostate a sign and/or symptom of prostatitis?
A Well, it potentially could be.
Q Are you aware that there was a stool sample taken?

A Yes, I am.
Q You're aware that that was negative?
A That's not surprising.
Q Why not?
A That implies occult blood so I would guess that the overwhelming majority of patients with acute appendicitis would have no blood in their stool whatsoever.
Q You're aware that Dr. Segocio shortly after Dr. Reardon's exam noted no rebound?
A That's what he indicates.
Q Okay. Are you saying that that's incorrect or that --
A I'm saying that the weight of the evidence of the preceding examiners beginning back at Westech and running through Dr. Reardon's several examinations favor that there was rebound tenderness 30 minutes before Dr. Sogocio does his examination. Dr. Reardon identifies rebound tenderness so I guess we have disputed facts in the record.
Q The decision to take a patient to surgery is not that of the family practice doctor, that is the decision of the surgical consult, correct?
A I would agree with that.

Q Okay. So whether or not this patient was going to be explored for suspected appendicitis was not Dr. Reardon's decision but that of Dr. Sogocio?
A The decision to do the operation was the surgeons.
Q Okay. And the surgeon had seen the patient before -- well, let me ask you this. Do you, when do you believe this patient should have been taken to surgery? Let me rephrase that, please. When do you believe that standard of care in this case required that the patient be taken in for surgery?
A Since we have the separate individuals evaluating the patient on the 27th who identify right lower quadrant abdominal pain and rebound tenderness in a 22 year old male who has been ill with abdominal pain now for about 48 hours, I would argue that they should have gone to the operating room on the evening of the 27th.
Q Doctor, would you agree that you are on the more aggressive end of surgical exploration as opposed to other physicians?
A I probably am on the more aggressive side but I think that my opinion would be that there would be an overwhelming consensus in the surgical community

that right lower quadrant pain and right rebound tenderness in a 22 year old is all the indication that is necessary for proceeding with appendectomy.

Q But would you agree it would also have been within standard of care to evaluate the patient for a period of time off of antibiotics to see how his course progressed?

A I guess you could make that argument, if you wish. I would take the opposite position that the findings in a patient on antibiotics are likely to be more subtle and more difficult and I would make the argument that given a background of antibiotic treatment one probably needs to be more aggressive, not less aggressive in proceeding with an operation.

Q So are you critical of the emergency room physician for not getting a surgical consult?

A On which date?

Q The 27th?

A No. He basically sent the patient to the hospital to be admitted with the diagnosis of appendicitis so he provided effective transitioning of the care from his ambulatory setting to somebody who had the authority to admit and care for the patient.

Q What about Dr. Gallagher in the emergency

room at Flower Hospital, are you critical of him for not obtaining a surgical consult?

A No. I think that the standard of practice would be that the admitting physician is the accountable person for getting the consultation. The emergency physician is to provide initial screening and examination and then to provide a disposition. If the emergency physician had chosen to send the patient out without a disposition of the patient's care then I would be critical of the emergency physician but since the patient was being admitted under an admitting physician I believe there has been effective transition of the patient's care and responsibility to Dr. Reardon. And in that sense I am not critical of the emergency room physician.

Q And your only criticism of Dr. Reardon is for placing this patient on antibiotics on the 29th?

A I believe we have made that point, that the biggest, the biggest criticism that I have of Dr. Reardon is that particular issue. That is that he went ahead and initiated the antibiotic prior to the time that a differential diagnosis had been established and so the antibiotic issue remains my principal criticism of him.

Q How do you believe that placing the patient on antibiotics on the 29th when he was placed on it injured this patient?

A Because it further obscured the diagnosis from declaring itself. It would be my argument that had antibiotics not been initiated that Mr. Baldwin would have progressed to having more of the characteristic signs of perforation and the abscess would have been operated on sooner. It would have been less likely to have lost his colon and to have had many of the sequela that followed. So I think the unusual chronicity of abscess that's identified in the case materially relates to the initiation of anti-microbials on the 29th.

Q And you believe that because he was placed on antibiotics on the 29th that that caused him to have approximately 28 month delay in diagnosis of this condition?

A I'm saying that the initiation of antibiotics materially changed the natural history of the perforated appendix as we would customarily know it. In fact, patient continues to have symptoms and reassessment at intervals over the subsequent two year period of time which does make this a somewhat

atypical presentation of appendiceal abscess and I would argue that this natural history of the disease has been significantly changed by the institution of antimicrobial therapy at this critical point in the patient's care.

Q How?

A Because it reduces the bacterial count in and about the abscess. It allows for the host to have a more effective localization of the abscess and it paves the way for the patient having a chronic problem rather than an acute problem. And in the absence of the antibiotic the patient would have become more acutely ill and would have had a surgical intervention at an earlier point in time.

Q What's to say he would not have become more acutely ill if he had not had an, if he had not demonstrated, because he did not demonstrate a progressively downhill course on the 27th and 28th?

A I'm not sure if I understand the question.

Q Would you agree with me that after he is taken off antibiotics on 8-27 and maintained off of then on 8-28 and for the first part of 8-29 his condition does not worsen?

A It does not appear to clinically deteriorate

during the interval.
Q And, in fact, he becomes hungry, correct?
A That is indicated in the records.
Q He is afebrile, correct?
A That is correct.
Q He does not appear to be toxic, correct?
A He is not toxic.
Q It is noted by others in the records that the abdomen is flat, correct?
A I would have expected that.
Q It is also noted in the record during that period of time that there is, he has gone from what is noted to be rebound to no rebound, correct?
A In 30 minutes, excuse me, no. I think that Dr. Sogocio says there's no rebound but all the, of the previous examiners have identified it as such and so all I can say is that I somehow don't think in 30 minutes things completely resolved.
Q What about on the 29th, is there any evidence of rebound on the 29th before they start him on antibiotics?
A Yes. I believe that we have the identification by Dr. Reardon that there has been no significant change which from his note would link back

to his observations late on the 28th. So my interpretation of that is that the patient is still having right lower quadrant pain and rebound but, in fact, he is taking some clear liquid at that point.
Q Do the nurses note any rebound on the 29th?
A I would not place any particular credibility on the nurses physical examination. The nurses are not the ones that end up making the decisions. So while I generally like to look at the nursing notes the nurses would not know necessarily whether they're supposed to identify rebound tenderness or not.
Q Doctor, when do you believe this patient perforated to a reasonable medical probability?
A I believe that he perforated subsequent to the 27th and the 28th. I can see no evidence that he perforated necessarily during the hospitalization so I would say that he was perforated in the immediate aftermath of his discharge.
Q So he perforated after the 30th?
A That would be my best estimate.
Q What do you base that on?
A The fact that he was able to resume some degree of oral intake and that he remains stable, in general. There would be in the absence of an

antibiotic some period of deterioration associated with a perforation so my judgment is that we can see no acute deterioration up until the time that he's placed on antibiotics. So my conclusion is that perforation has not occurred prior to that time.
Q So it is your opinion that he had not perforated prior to his discharge, his appendix had not perforated prior to 8-30-90?
A That's correct.
Q Doctor, in your report you say that within a reasonable medical probability he perforated his appendix on or about August 27th.
A Well, I was referring specifically to the admission and the events there. And I would say in fairness that with the antibiotic cover it is still reasonable that he would have perforated in the hospital but that the antibiotic cover would have masqueraded his signs and symptoms.
Q Doctor, would you agree that you had all these medical records back when you issued this report?
A Yes.
Q And you had reviewed these carefully when you issued this report?

A And that is why I said on or about.
Q So there is at least a three, four, five day curtain of window as to when this patient could have perforated, you would agree with that?
A I would agree with that.
Q Okay. So would you agree with the statement within reasonable medical probability he perforated his appendix on August 27?
A I think within reasonable probability I would doubt that it was on the 27th.
Q Well, Doctor, why didn't you put that in your report?
A Because with the patient having had Erythromycin I still left open the opportunity, the potential possibility that the 27th may well have been potentially the time of perforation, particularly given that the patient had his biggest fever identification at about that time. I do think this -- the reason I put on or about is I believe that the evidence of the patient being able to resume oral intake would be some evidence that would diminish the 27th being the specific date.
Q Why is that?
A Because generally speaking patients don't eat

and drink with perforated appendix acutely.
Q They don't get better, they don't improve when they perforate?
A They have a transient period of pain relief but they don't materially get better for more than just a few brief hours. I mean, this is nothing that they don't get better for two, three, four days.
Q So you don't see a patient who is getting better, getting hungry, before they perforate?
A Generally speaking if they are perforated I would not expect the patient to be eating and drinking 12 to 24 to 36 hours later.
Q What would you expect to see if they perforated?
A I would expect -- well, again, this gets to the issue of where the appendix is anatomically located and I believe we have pretty good evidence that this patient had a retro cecal appendix and so we get into the issue of the magnitude of the perforation and that's why I deliberately tried to not point a specific date. That's why I used the terms on or about specifically referring to the hospital admission and it's events. So all I can say is that in general, with a perforated appendix we would not anticipate

that a patient would be eating and drinking 6 to 12 hours after the event occurred.
Q Meaning after the perforation occurred?
A That is correct.
Q So if he's eating and drinking after the perforation occurs and generally looking better that would speak against a perforation at that time?
A In general that is correct, sir.
Q So if he continues to improve after he's discharged from the hospital that would speak against a perforation afterwards, correct?
A Well, the problem now becomes one of having the compounding antibiotic treatment.
Q Well, wasn't there the problem with the compounding antibiotic treatment before the hospitalization, too?
A I guess that's again why I said on or about the 27th. I'm not suggesting that the patient perforated before the 27th when he he was on the antibiotics.
Q So it could be the 25th he perforated when he was having that problem but it was masked by antibiotics on the 25th?
A Well, he didn't get started on the

antibiotics until the 25th and there is no evidence of the, of his presentation on the 25th to suggest that he even had appendicitis and so --
Q But, Doctor, let me interrupt you. You said the diagnosis of appendicitis can be made with right lower quadrant pain.
A And tenderness.
Q And isn't that what --
A And rebound tenderness. And the records of the 25th does not indicate that, that is not what the record of the 25th says. So the patient did not have classic signs and symptoms of appendicitis on the 25th. And so I probably would not have started the patient on Erythromycin on the 25th given that there were some abdominal complaints. But I think there is no reason to believe that this patient had clear evidence of appendicitis on the 25th and I think within reasonable medical probability the patient did not have a perforated appendix on the 25.
Q Why do you say that?
A Because he didn't have the signs and symptoms of rebound tenderness at that particular time.
Q What about the 26th?
A Well, I don't know what happened on the 26th.

He wasn't examined again until the 27th.
Q Couldn't antibiotics mask the rebound tenderness?
A He wasn't on antibiotics at the time he was examined on the 25th. It was in the wake of the visit of the 25th he was started on the drug.
Q So it would take some time for the antibiotic to begin to mask something?
A Clearly that would be true.
Q How long would it take for Doxycycline after it had been initiated to begin to mask something?
A Probably 12 hours.
Q So we have another 12 hours of Erythromycin going downhill before the Doxycycline is coming in?
A Essentially, yes.
Q So we have almost until the 30th, or late on the 29th to continue to monitor this patient to see whether this is, quote, being masked because the Doxycycline hasn't been up taken, so to speak?
A There was no indication for starting the antibiotic. I think I understand what you're saying. I think you're trying to be too exact with something that is not a very exact science.
Q And you're saying that the diagnosis of

appendicitis when a patient is getting hungry, eating, taking food, it can be difficult?
A I think it can be difficult. I think that I clearly believe that it can be difficult.
Q Would you also agree that although the opinion had been held that inflammation of the retro cecal appendix produces an atypical presentation that that is now known to be incorrect, that the findings are usually the same as an ordinary or anti-cecal appendicitis?
A I think that retro cecal appendix can cause an atypical presentation.
Q And anti-cecal appendicitis can present an atypical presentation, too? Any type of appendicitis can be atypical?
A I would agree with that.
Q And appendicitis signs and symptoms when they present can mimic, it's a great my mimicker, isn't it?
A Oh, I think that appendicitis can mimic other things and other things can mimic appendicitis. But that doesn't eliminate the strategy of operating on patients when the criteria have been fulfilled.
Q And the criteria, the standard of care, the criteria under the standard of care is what, Doctor?

A For a 22 year old male it is right lower quadrant pain and rebound tenderness.
Q So every 22 year old male who presents with right lower quadrant pain and rebound tenderness should be operated on for appendicitis, is that your opinion?
A That's my opinion and that's what I teach my residents and students.
Q And that's what the standard of care requires?
A In my opinion, that is correct.
Q Doctor, in your opinion that's what standard of care requires?
A I don't think there is any question, yes, sir.
Q Okay. What is the incidence of false positives in operating on these patients?
A Well, I think it depends on how aggressive or how non-aggressive you are. But I think most of us would accept a 20 percent normal appendix rate for doing appendectomy.
Q So on two out of ten patients that you go in and operate that present with right lower quadrant pain and tenderness, only that 20 percent of those

patients are going have a normal healthy appendix?
A I would bet that that's probably true for males and for female patients. The normal appendectomy rate may be even somewhat higher because of the vast additional area of potential diagnoses. But for a patient like Thomas Baldwin I would certainly accept a 20 percent rate of normal appendectomy.
Q Okay. Finishing up with Dr. Reardon. In the follow-up evaluation and treatment you are not critical of his care then I take it?
A Well, we have the continued problems of the patient presenting with the same symptoms. I guess I'm not really as critical of Dr. Reardon as far as the chronic long term problems of not being able to sort out, making a decision to operate since making a decision to operate was really not his decision to make. So being critical, should he have had additional surgical consultation, yes. But when you get into the chronic state of things I would cut Dr. Reardon a little slack and say making the diagnosis when things smolder into a chronic situation are much more difficult. So my principal criticisms of Dr. Reardon again relate to, specifically to the issue of

the Doxycycline being started on the hospitalization on August the 29th.
Q Okay. And just so I can clear up your response, Doctor. Am I to understand that therefore, the evaluation and treatment and actions of Dr. Reardon in evaluating and treating Mr. Baldwin after August 29, 1990 were appropriate and within accepted standards of care in your opinion?
A I believe that he should have had additional surgical consultation but as I indicated before I believe that things get to be fairly atypical when one gets into the chronic state. Though I am not being critical, I think with the same conviction that I am about the issue of the antibiotic. I think the problems that Dr. Reardon may have experienced later in the patient's evaluation all go back to the initial decision of starting the antibiotics so I don't want to pile on additional criticisms when everything really has their genesis with the initial decision.
Q Okay.
A Do you understand what I'm saying?
Q I'm trying to Doctor. When you say -- but you confuse me when you say he should have gotten more surgical consultation because that to me sounds like

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an opinion that because he didn't do that that was below standard of care. So I just I want to understand whether you believe there were actions below standard of care after that or not. It's yes or no.

A Since you want it yes or no I would have to say, yes, that it was beneath the standard of care to not have additional surgical evaluations subsequently in the patient's care when he's continuing to have right lower quadrant pain and tenderness. But I think I have tried to indicate that that's, that those problems still relate back to the original decision. And that original decision relative to the antibiotics happens to be the issue that I am most critical of. But if you have a patient with continued right lower quadrant pain and continued tenderness and continued rebound and he's not getting better, the standard of care would be to get additional surgical consultation.

Q Doctor, are you critical then of the emergency room physician then at Flower Hospital that saw him with these signs and symptoms and did not admit him and did not get surgical consultations?

A The emergency physicians consulted back with the attending physician and so they are providing

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transition of care back to the primary attending of record. So I don't believe that they should be criticized if they conferred with the attending of record as has been done in this patient's care and they have reached a consensus opinion or they have consulted with the primary physician as to what his wishes are in the patient's management. I realize that's a little bit of a disjointed answer but the concern, the standard of care issue is the emergency room physician needs to map a plan of care for a patient that he sees with the primary physician who is responsible and once that transition of care has been made to the primary provider I believe the emergency physician does not have any additional responsibility.

Q What if the primary physician isn't contacted?

A It depends on whether then the emergency physicians provided follow-up care for the patient or not. Let's just take the specifics, you have got a patient who has been seen by their primary care physician for a year with right lower quadrant pain. Is the emergency physician when he sees the patient coming into the emergency room with right lower quadrant pain going to go ahead and independently

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order a surgical consultation or is he going to continue follow-up for the patient back with the primary physician? So I think that in a patient with a chronic abdominal pain condition the standard of care for the emergency physician is really to send the patient back to the primary physician for continued care.

Q So it is, you are of the opinion that when a patient presents to the emergency room and is evaluated by an emergency room physician and there is right lower quadrant pain and abdominal tenderness and vomiting and loss of appetite, it is not required by the standard of care of that the emergency room physician request a surgical consult and get the patient admitted? That is your opinion?

A My opinion is, and I will guarantee what the standard of care is on this, if an emergency physician gets a surgical consult in the current era it probably will be the last patient he'll see of the primary care physician who's involved. The standard of care is to consult with primary care physician as to what they are wishing to do.

Q Okay. So in this case with a 22 year old who presents to an emergency room with generalized

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abdominal pain, vomiting, rebound, loss of appetite, right lower quadrant tenderness, it's within standard of care to discharge that patient and instruct them to follow up with their family practice care giver? That is within standard of care in your opinion?

A That's not what I said. I would say that you need to consult with the primary care physician directly to make sure that you're not going to do something that hasn't already been covered by the primary care physician in his sustained care of the patient. So there is, there are multiple different scenarios and everything is getting mixed up. I'm again saying that the standard of care for patients that have been having this problem for a year is to confer back with the primary care physician. I think if you see, obviously, a patient that comes in with acute symptoms as you have described in the emergency department who does not have a primary care physician that you would then certainly be justified, indeed, it would be the standard to get a physician to either admit the patient or a surgical evaluation.

Q Doctor, you reviewed all of the emergency room records in the case, correct?

A There are a bunch of them.

Q Doctor, in your opinion did the emergency room physicians depart from accepted standards of care in their evaluation and treatment of this patient?
A I do not, I do not know all of the interaction between the emergency physicians and the primary care physician so I am trying to give everyone a reasonable consideration in the matter. And in a patient that's chronically been coming to the emergency room I am not critical of the emergency room physicians.
Q In this case you're aware this patient was seen by a gastroenterologist, correct?
A That is correct.
Q Are you critical of the gastroenterologist in evaluating and treating this patient?
A No, I am not.
Q A gastroenterologist, is he in a better or worse position than a family practice doctor in diagnosing and treating gastrocolonic problems in a patient?
A I would say relative to appendicitis there is probably very little difference between the two groups.
Q You do not take issue with Dr. Padda's

diagnosis at that time that the symptoms that the patient was having and history, et cetera, that he had in reaching his diagnosis that the symptoms were consistent with duodenitis and gastronitis?
A Characteristic of Mr. Baldwin's care after his discharge on August 30 is that he had episodic exacerbations of his pain followed by periods of quiescence. So the patient was referred to Dr. Padda during a period of time when the patient was actually not symptomatic relative to his right lower quadrant pain so basically I have no criticism of Dr. Padda since he did not really see the patient during an acute exacerbation.
Q The records that I have demonstrate that the patient was discharged from the hospital on 8-30-90 from Dr. Reardon and was seen a week later in his office and was back to normal, the abdomen was benign. Would you expect to see that in a patient who in your opinion perforated his appendix a week, less than a week before that?
A I would not expect to see it.
Q Doctor, in a patient that had perforated his appendix less than a week before that would you expect him to have problems, abdominal problems and abdominal

complaints earlier than ten months later?
A If he had not been on antibiotics, no, I would not expect that natural history.
Q There is no evidence that this patient was on antibiotics for ten months, is there?
A No. But the chronicity of the abscess has already been created by the period of antibiotics in and around the time of perforation. So I think this, the antibiotic created a natural history of the disease here that's going to be highly atypical during the following months of follow up.
Q Now, when you say highly atypical do you mean the waxing and waning course or what do you mean?
A Yes. I think that the waxing a waning kind of course here is not what one would customarily see with somebody who has a perforated appendix and abscess.
Q Okay. Would you expect a perforated appendix and abscess to, to lie quiescent for ten months?
A If there had been antibiotic treatment in or around the period of treatment it is very plausible.
Q Why is that?
A Because it was, because the scar tissue forms around the abscess because some of the microorganisms,

if not the majority of the microorganisms have been eliminated and as a result one ends up with a chronic cavity that really does not have acute invasive infection, and so you have these little intermittent flare ups that cause the patient to have to go back to the physician. But I do believe that it is reasonable to conclude that all of the episodic events that Mr. Baldwin had in that 26 month period of time were related to the presence of a chronic abscess.
Q What causes it to flare up? Is that when it's breaking out of its cavity and causing peritoneal problems?
A Not. Causing peritoneal signs, it causes peritoneal signs by virtue of probably some additional contamination leaking from the appendix into the colonic abscess cavity, transients and temporary flare ups of bacterial growth. But the flare ups, I think, very much relate to inflammation in and about the area of the abscess for whatever cause.
Q Why do they suddenly, when you have this inflammation why does it suddenly quiet down? Is that because they're placed on antibiotics again?
A Not necessarily. The host defense can sometimes be very effective in containing the locally

developing infection. I mean, not everyone that had a perforated appendix before antibiotics died from it.
Q Sure.
A And it's simply because the host defense is sometimes very, very effective.
Q When you have a host defense would you, would you expect to see a rise in WBC?
A You may and you may not.
Q You may just not see anything, you just have these coming and going type of things?
A That is correct.
Q This course that the patient has in the post-ceding, if you will, few months, it appears significantly related to epigastric complaints. What do you account that toward?
A The epigastric complaints are of clearly a confounding variable in this patient and I think they are difficult to interpret. A patient that has abdominal complaints commonly have an array of, of symptoms that are not always easy to put into a given pattern. And so Dr. Padda thought that the patient did have some gastritis or duodenitis and I would have no reason to argue with the fact that they may be true. I can tell you that patients with abscesses do

develop gastritis and so it's not totally unreasonable to associate an episode of gastritis and epigastric discomfort as being sequela of the chronic abscess in the right lower quadrant.
Q Do patients who work hard or are under a lot of stress and go binge drinking also develop gastritis?
A Sure.
Q You don't discount that from being the cause in this case because that is reflected in the records, correct, Doctor?
A I suppose that whole intake could cause gastritis and Aspirin intake could cause gastritis and so there are certainly other, there are other things that would cause gastritis to be sure. And I would clarify for the record that I'm not saying within reasonable medical probability that this patient had gastritis as a consequence of his right lower quadrant abscess. I'm only saying that is a potential plausible explanation but certainly the other things that you have identified could account for a patient having gastritis.
Q I appreciate that clarification, Doctor. Doctor, you had indicated that Dr. Reardon should have

gotten a surgical consult. When did standard of care require that he get another surgical consult in the days preceding, or months, or visits preceding the August 30, 1990 discharge from Flower Memorial Hospital?
A The patient had this several -- I'm looking at my --
MS. KOLIS: You want us to go through them, the notes? Which way you want us to do it?
MR. BODIE: I want him to tell me when standard of care required him to get a surgical consult after this patient was discharged.
A I would, I am saying that if you have a patient that has, has an interval in August of '90 until July of, of '91 and he is now again having these clinical signs that that would have been a very appropriate time to have had a second surgical consult.
Q Doctor, can we take just a real quick break?
A Sure.
Q Okay. I just need about two minutes. I'm being dragged away by an associate here.

- - -
Whereupon, a break was taken at 1:30 and the deposition was resumed at 1:34 o'clock p.m.
- - -
Q We're back after a short break here and we're talking about when standard of care required to bring in a surgical consult after the discharge and you said in that July visit, July '91, correct?
A That is correct.
Q Okay. And what is it about the July '91 period of time that Dr. Reardon saw him in the office that indicates that a surgical consult was indicated?
A Well, the fact that the patient is now having right lower quadrant symptoms again and so you now have symptomatology that has gone across nearly eleven months time and it would be my opinion that it was appropriate to have an additional consultation in a patient that's having chronic and persisting right lower quadrant pain.
Q How about if it's just generalized abdominal pain or epigastric pain that continued, would it be appropriate to send that patient to a GI specialist?
A It might be. And I think if you're now changing your diagnosis and you're more concerned

about peptic ulcer disease rather than appendicitis, I think it's appropriate to consider a GI consult.
Q Okay. Isn't that, in fact, what was done in the case?
A I don't think I have been critical of the fact that they referred the patient to the GI specialist for an evaluation.
Q Okay. I'd like to go to Dr. True. How in your opinion did Dr. True depart from accepted standard of care in his evaluation and treatment of this patient?
A My criticism of Dr. True would basically relate to the fact that, that the patient should have had a surgical consultation when he evaluated him.
Q You mean when he first evaluated him?
A I think that, again, Dr. True falls under the same criticisms that would be leveled against Dr. Reardon, that during the follow-up care, during the follow-up care after the hospitalization and the episodic things, the episodic events that occur in the next 24 months, you have a patient that initially had right lower quadrant pain and rebound and he's now coming back with episodes of the same event and that it would be the standard of care to get a surgical

assessment of the patient during these reoccurring events and that was not done.
Q Okay. That was not done by the emergency room physicians either, correct?
A But again, the emergency room physicians are under a different mandate because they need to be interacting with the primary care physician that provide the sustained care for the individual. So I believe in reviewing these records that the emergency room physicians were in contact with the primary care physician and that they were coordinating the care of this patient with them so I am not critical of the emergency room physicians because I believe they were not the parties that were accountable for needing to get the surgical consultation when they were interacting with the primary care physician.
Q And if this patient doesn't have a primary care physician then would you be critical?
A Depending on physical findings, very much so. I think if, if I'm an emergency medicine physician and the patient comes in with nebulous history and has physical findings of right lower quadrant pain with rebound tenderness and no primary care physician, you can believe that I would entertain a surgical

consultation.
Q So it is your opinion that Dr. True, when he first saw the patient on February 18, 1992 with complaints of constipation fever and was reported by the patient to him that an upper GI and lower GI were negative, that it was a required under the standard of care of the family practice physician that he obtain a surgical consult?
A In a patient is sent again to Dr. True on August 3 of 1992 after once again being seen in the emergency room on July the 25th with, again, having the recurrent problems of right lower quadrant pain, it would be my opinion at that point when the patient is referred to Dr. True for continued follow-up that it would be appropriate that the patient end up having a surgical consult at that point.
Q Not before that point?
A Well, I'm trying to look and see what the findings were on the first time that --
MS. KOLIS: Do you have Dr. True's chart in your stack of records?
THE WITNESS: I have it somewhere.

MS. KOLIS: Okay.
A I don't have the findings in my notes of what was seen in the February visit to Dr. True. That's what I'm looking for at this point.
MS. KOLIS: Chip, I just handed him my notebook, okay?
MR. BODIE: Fine. You still there?
MS. KOLIS: Yes, we're still here.
Q It's in the notebook, tab number four, where it says Bedford Medical, parenthesis, Dr. True.
A Yes, I have got it right here and I'm actually also looking at the emergency room records of Dr. Reems. Dr. Reems saw the patient on February the 16th and noted at that time that the patient had tenderness in the right lower quadrant but that the abdomen was soft and that it was not rigid at that point. He did not identify rebound tenderness and at that point he refers the patient, we have a little problem between the dictated note and the -- let's see. We have, I'm pausing because we seem to have some disputed facts between what was written in the emergency room records and what is dictated.

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We have the situation where is it written in the note of February the 16th by Dr. Reems that he identifies rebound tenderness but his dictated note indicates that there is no rebound.
Q Isn't it the nurses note that identifies rebound tenderness?
A I stand corrected. You are right.
Q And you don't give much weight to the ability of the nurse to identify --
A I would not. That's correct. In any event, the patient is having recurrent right lower quadrant symptomatology and the patient is then sent back to Dr. True who knows that these events have now been going on for 18 months time.
Q How does he know that? This is the first time he has ever seen that patient.
A So he didn't get any of the records from the patient's previous visit, previous evaluation?
Q No.
A Then I think it's reasonable to say that if you're seeing a patient as a new patient that you really need to try to get the other records if you're going to be establishing a sustained relationship with the patient. But presumably there would have been a

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history, even though I don't see that indicated here. So in general, if you have a patient with a 28 month history of right lower quadrant pain it would be the standard of care for a primary physician to get a surgical consult.
Q What if it's mostly epigastric pain and all the pain goes away after he takes Tagamet or Zantac? Given that history and that presentation would that require surgical consult?
A Probably not. So the answer is no.
Q Okay. Are you of the opinion that as of February '92 or even August '92 there is already an abscess?
A I think there is no question that that is true.
Q Had it been operated on on February 18, 1992 what difference would it have made in the outcome?
A I think that's a reasonable argument. That is to say there is no way I can say within reasonable medical probability that an operation in February of '92 would have given a better result than the one in October of '92.
Q Is there any way -- do you believe that in January of 1992 that there was an abscess formed?

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A I believe that it was formed.
Q Do you believe that had surgical intervention been undertaken in January 1992 that it would have made any difference in the outcome in this case?
A I think it's unlikely.
Q That it would have made any difference?
A That is correct.
Q Okay. So even had Dr. True diagnosed an appendicitis, diagnosed appendicitis or an appendiceal mass, got in a surgical consult and the patient underwent surgery on February 18, 1992 when he was first seen by Dr. True, those actions would not, it would have been unlikely that those actions would have made any difference in the outcome?
A There is no way that I can say within medical, medical probability that it would have made a difference.
Q Let's go back to Dr. Sogocio. What is your criticism of Dr. Sogocio?
A That he evaluated a patient that had been previously examined by two physician and noted to have rebound tenderness and he made a single assessment and did not follow up, reexamine the patient in a consistent fashion and accordingly missed a diagnosis

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of appendicitis.
Q Any other criticism of Dr. Sogocio?
A Not really.
Q I sense some hedging there, Doctor, and I'm not saying that you're hedging but I just don't like the answer of not really because that means there are some but they aren't.
A I didn't mean to be sounding like I was hedging relative to what I'm going to say which I appreciate is something that an attorney always worries about. I am hedging because it is interesting to me that within 30 minutes the patient is identified as having another confirming examination of having rebound tenderness and then 30 minutes later the surgeon comes by and says there is no rebound and, and then never sees the patient again. And so my criticism is that when I'm evaluating somebody with a diagnosis of rule out appendicitis I believe that those hospitalized patients deserve sequential examinations to ensure that you're not seeing a changing pattern that would impact your decision.
Q You mean a worsening pattern?
A That is correct.
Q Okay. And that is what you would be looking

for as a surgeon when you would go back on the follow-up, be it the next day or two days or three days later, whatever, it would be to see if this patient is demonstrating a worsening in his condition?
A That is correct.
Q Okay. Because that is the course that you would expect to see in a patient with acute appendicitis moving on to progression of perforation of the appendix?
A That is correct. And furthermore, the surgeon's continued participation, I would expect would, would also give him, would have also provided some counsel and guidance to the primary care physician that antibiotics should be deferred for a little bit longer.
Q Like another day maybe?
A Or even longer than that. I mean, it is interesting that the diagnosis of prostatitis here, as I have indicated to you, is highly suspect. It would have been worthwhile to have Sogocio make an opinion about that and whether antibiotics should be started or whether the patient should have had some further sequential examinations.
Q Okay. Any other criticism as to Dr. Sogocio

in which you believe he departed from accepted standard of care?
A I really don't, I'm trying to make a determination here about whether there were, were any narcotics given between the interval of Dr. Reardon's exam and Dr. Sogocio's examination.
MR. BODIE: Donna, correct me if I'm wrong, I don't think there were.
MS. KOLIS: No.
A But obviously that is a potential issue that could be involved in physical examinations in relatively short period of time showing dramatically different findings.
Q Got it.
A And so that was the reason why we were, I was sort of doing this scrabble through the records. It does not appear, it does not appear that there was Demoral given in the interval of that afternoon of the 28th.
Q Right.
A So with that understanding I have no additional criticisms of Dr. Sogocio.
Q Okay. Let me just, I'm wrapping up here,

Doctor, and I just want to sum up a few things. Dr. Reardon's number one criticism is that he should not have put the patient on Doxycycline on the 29th?
A That is correct.
Q That that had masked or halted the progression of the patient's septic, if you will, course?
A It changed the natural history of the disease.
Q Changed the natural history of the disease and led to the development of the abscess and chronic condition which subsequently developed?
A That is correct.
Q Okay. That is the entirety of your criticism as to Dr. Reardon, meaning that is the entirety of your criticisms of Dr. Reardon in which he departed from accepted standard of care?
A That is the seminal event in Dr. Reardon's departure from the standard of care?
Q Okay. And Dr. Sogocio should have seen the patient again to identify a worsening of the patient's condition and instructed that antibiotics be deferred for a longer period of time to let the condition pronounce itself?

A That is correct.
Q And those, that is the entirety of your criticism as to Dr. Sogocio regarding departure from accepted standard of care?
MS. KOLIS: I think he's already testified, like in the first five minutes of the questions, that it was a deviation for him not to diagnosis appendicitis.
MR. BODIE: No, I appreciate that.
MS. KOLIS: I just wanted to make sure you got that.
MR. BODIE: No, no. And the Doctor can correct me if I'm wrong.
A No, I would agree with that.
Q And Dr. True, you are of the opinion that given the presentation should have brought in a surgical evaluation of this patient but yet even had he done that the abscess had already presented itself and it is unlikely that those actions would have made any difference in the outcome in this case; is that correct?
A That is correct.

Q Did the phone drop?
A No, no.
Q Okay. The surgical operation for appendicitis, there are risks and complications with that, correct?
A There is risks with anything, yes.
Q What are the risks of, of appendicitis surgery?
A Principal risk would be wound infection. You can have very rarely a, what we call a blown appendiceal stump. You could very, very rarely have injury to other loops of intestine in the process. But overwhelmingly the biggest risk would be a wound infection.
Q Okay. With respect to any bowel surgery, would you agree that illius is a risk of procedure?
A Well, illius is a risk of the procedure but illius is also a risk of the fundamental disease process as well.
Q Meaning the fundamental disease process of appendicitis?
A That's correct.
Q Would you agree that bowel obstruction is also a fundamental risk of the disease process?

A That is a risk with any form of perforation or peritonitis.
Q Of which you would include appendicitis?
A Yes, sir.
Q Would you agree that there is no significant difference in the risk of developing bowel obstruction with the removal of a normal appendix versus the removal of the perforated appendix?
A There is less of a risk of bowel obstruction in removing a normal appendix than there would be for one that is perforated.
Q How about the difference between an inflamed appendix versus a perforated appendix?
A I would say there is less risk with the inflamed appendix as opposed to the perforated appendix.
Q Would you agree that bleeding, infection, potential of a colostomy and damage to surrounding organs are also a risk of an appendiceal surgery?
A Colostomy is unlikely but there is always a risk. I believe I already did testify to the fact that injury to other loops of intestine is a risk with the operation so, yes, I would concur with that, that is a risk.

Q Doctor, we know what his surgical course was after the identification of the abscess or appendiceal mass, however you want to describe it, and we know the extent of the complication that occurred following that surgery.
A Yes.
Q The complication, that specific complication, meaning the bowel obstruction, can that occur in the absence of negligence?
A Certainly.
Q Okay. Can it just be a risk of the procedure that was performed in this case?
A That's correct.
Q Okay. When, if you can say, at what time had this surgery been undertaken that these events you believe would not have transpired? I guess I better phrase that better. Had surgery been undertaken earlier when would it have made a difference?
A In my opinion, during the hospitalization on August the 27th.
Q Of 1990?
A That is correct.
Q Okay. And had it taken place after that, meaning at anytime after that, can you say whether it

would have made any difference or not in the outcome in this case?
A I think you can say that earlier operation has a greater probability than the delayed operation, but a delayed operation beyond the point of the chronic abscess cavity formation probably would not have made a difference.
Q Do you have an opinion as to when the chronic abscess formed?
A Oh, I'm sure it was within the, the few months immediately following that August admission, so we're talking within two or three or four months as it developed during that period of time.
Q So by Novemberish of 1990?
A That would be a reasonable estimate.
Q Okay. So essentially after November '90, surgery after November '90 would not have made a difference in this case?
A Surgery after November of 1990 would have in all likelihood required the same operation as was performed in October of '92.
Q With the same percentage of risk of the same complications that developed in the case?
A I believe so.

Q Doctor, I think we have covered all your opinions as to departure of standard of care in the case. It sounds as if we have gone over a number of your opinions regarding what the actions of these individuals caused, as well. Does that jog with your recollection as well?
A I believe so.
Q Okay. And I think we have gone over the damage issue as well, you know, about what difference it would have made?
A Yes, sir.
Q And the period of time that it would have made any difference, correct?
A I agree.
Q Doctor, have we covered all the opinions that you plan to give at the time of trial regarding departure from accepted standards of care in this case?
A I believe we have.
Q Doctor, have we gone over all your opinions that you plan to give at trial in this case regarding how you believe those departures caused the injuries to Mr. Baldwin?
A I believe we have.

Q Doctor, have we also gone over all of the opinions that you have previously given to Ms. Kolis?
A Yes, sir, we have.
MR. BODIE: I have no other questions. Thank you.
THE WITNESS: Okay. Thank you.
- - -
Whereupon, the deposition was concluded at 2:04 o'clock p.m.
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DONALD E. FRY, M.D.

C E R T I F I C A T E

I, Jodi Jefferies, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, DONALD E. FRY, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to Stenotype in the presence of said witness, afterwards transcribed by the use of a computer under my supervision, and that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid, and that the reading and signing of the witness was not waived.

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

I do further certify that I am not a relative, counsel or attorney of either party.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio, on this _____ day of October, 1997.

My commission expires
April 3, 1999

Jodi S. Jefferies, aka
(Jodi S. Cozza)
Notary Public
In and for the State of Ohio

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