

1 IN THE COURT OF COMMON PLEAS
2 LUCAS COUNTY, OHIO
3 THOMAS G. BALDWIN, :
4 Plaintiff, :
5 -vs- : Case No. CI96-2365
6 MARK E. REARDON, M.D., et al., : JUDGE LANZINGER
7 Defendants. :
8 - - -
9 Telephone deposition of DONALD E.
10 FRY, M.D., Witness herein, called by the
11 Defendants for Cross-Examination under the
12 Ohio Rules of Civil Procedure, taken before
13 me, the undersigned, Jodi S. Jefferies, a
14 Notary Public in and for the State of Ohio,
15 pursuant to agreement and stipulations of
16 Counsel as hereinafter set forth at the
17 offices of Jacobson, Maynard, Tuschman &
18 Kalur Co., L.P.A. 1600 Summit Center, 333 N.
19 Summit Street, Toledo, Ohio, on Thursday,
20 September 4, 1997, at 11:50 o'clock a.m.
21
22 CLASSIC REPORTING SERVICE
23 2210 National City Bank Building
24 405 Madison Avenue
Toledo, Ohio 43604
(419) 243-1919
- - -

2
1 APPEARANCES:
2 On behalf of the Plaintiff:
3 DONNA TAYLOR-KOLIS CO., L.P.A.
4 1015 Euclid Avenue
5 34d Floor
6 Cleveland, Ohio 44115
7 By: DONNA TAYLOR-KOLIS
(via telephone)
8 On behalf of the Defendants:
9 JACOBSON, MAYNARD, TUSCHMAN & KALUR
10 CO., L.P.A.
11 1600 Summit Center
12 333 N. Summit Street
13 Toledo, Ohio 43604-2619
14 (419) 249-7373
15 By: JOHN F. BODIE, JR.
16 - - -
17 DONALD E. FRY, M.D.
18 Having been first duly sworn, was examined and
19 testified as follows:
20 CROSS-EXAMINATION
21 BY MR. BODIE:
22 Q Dr. Fry, my name is John Bodie. Along with
23 Steve Skiver in our office, I represent the defendants
24 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.

3
1 Q Okay. Doctor, I'm going to be asking you
2 some questions regarding your review and your opinions
3 and the basis for your opinions in this case. We are
4 doing this by telephone and if you don't understand my
5 question or I don't come through clearly, please ask
6 me to rephrase it. Okay?
7 A Okay.
8 Q If you respond to my question I'll assume
9 that you understand it and are responding completely
10 to the best of your ability to that question; is that
11 fair?
12 A That's fair.
13 Q If at any time you need to take a break just
14 let me know. Okay?
15 A That will be fine.
16 MR. BODIE: And, Donna,
17 I'll just, since your there with Dr. Fry
18 I'll just assume and take your word that
19 there is no non-verbal coaching that I
20 am not able to see since I am not
21 present there.
22 MS. KOLIS: You have my
23 word on that.
24 MR. BODIE: Thanks,

4
1 Donna.
2 MS. KOLIS: You're
3 welcome.
4 BY MR. BODIE:
5 Q Doctor, could you please state your name,
6 business address and social security number for the
7 record, please.
8 A Donald Edmund, E-d-m-u-n-d, Fry, F-r-y. And
9 my place of business is the University of New Mexico,
10 School of Medicine and my social security number is
11 273-42-7448.
12 Q Thank you. Doctor, as we had discussed off
13 the record, the previous attorney in the matter had
14 provided me a 32 page document which was identified as
15 your curriculum vitae and as we discussed there is a
16 more recent updated one that you have identified that
17 contains approximately 38 pages; is that correct?
18 A That is correct.
19 Q And, Doctor, could you provide, before Donna
20 leaves New Mexico there, and I understand it's
21 beautiful out there today, if you could provide her a
22 copy of that curriculum vitae I think we could
23 dispense with going over the background information
24 and academic information that is contained on that

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5

1 document.

2 A That will be fine, sir.

3 Q Good enough. The other thing is, as I have
4 reviewed the documents that I had been previously
5 provided I see that there are a number of
6 publications, abstracts, book chapters, that you have
7 written in the area of general surgery, is that a fair
8 description?

9 A Yes, sir, it is.

10 Q Are there any articles, abstracts, book
11 chapters, that you have written that you believe are
12 pertinent to this case?

13 A Well, I think that much of the published
14 material that I have listed on my curriculum vitae
15 dealing with the issue of peritonitis, both
16 experimental and clinical peritonitis as well as how
17 peritonitis relates to the formation of abscess. So
18 in that sense a very significant portion of my
19 curriculum vitae would be addressed to the issues
20 associated with a perforated appendix and its sequelae
21 and in that sense I think it bears very directly on
22 the issues in this case.

23 Q You mean in general terms of the
24 pathophysiology descriptions of peritonitis?

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1 A That is correct.

2 Q Okay. As far as breaking it down between
3 plaintiff cases and defense cases, could you give me
4 some percentages?

5 A It's about 60 percent defense cases and about
6 40 percent plaintiff cases.

7 Q Okay. Doctor, have you reviewed a case that
8 involves specifically allegations of failure to timely
9 diagnosis and treat appendicitis, obviously other than
10 this one?

11 A Yes, I am almost certain that I have. I am
12 actually a defense expert in a perforated appendix
13 case here in the City of Albuquerque at the present
14 time. I am trying to remember whether I have been a
15 plaintiff expert before in perforated appendix and
16 right off of the top of my head I cannot remember
17 such.

18 Q Okay.

19 A But that is just on pondering the cases right
20 here at the present time. So I am a defense expert in
21 one such case relating to perforated appendix here in
22 Albuquerque at the present time but I don't recollect
23 of any others.

24 Q What is the name of that case?

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6

1 A That is correct.

2 Q Okay. In relationship to specific actions of
3 physician diagnosis and treatment of a person with
4 peritonitis or intra-abdominal abscesses, is there any
5 of the articles, publications, et cetera, that are
6 listed here, are there any that specifically address
7 those particular issues?

8 A Relative to the treatment of appendicitis and
9 abscesses, there are numerous of those that do and
10 perhaps it would be appropriate for me to mark or
11 asterisk the copy of the curriculum vitae that I will
12 send with Ms. Kolis to you rather than to
13 painstakingly go through each publication.

14 Q You read my mind, Doctor.

15 A Okay.

16 Q I don't want you to painstakingly go through
17 each title. Just put check marks by the ones that
18 address those issues.

19 A That will be fine.

20 Q I appreciate that. Doctor, I understand that
21 also, you have also over the course of your career
22 reviewed and testified in a number of medical/legal
23 matters such as the one that we are sitting here
24 today; is that correct?

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1 A The name of the case is Jeo, J-e-o, that's a
2 last name, that's a native American last name, Jeo
3 versus Coon, C-o-o-n. The defense counsel is a good
4 friend of mine named Gregory Chass, C-h-a-s-s and
5 plaintiff attorney is another good friend of mine,
6 Steven Durkovich.

7 Q Have you given a deposition in that case?

8 A Indeed, I have.

9 Q Okay. Tell me a little bit about what that
10 case involves.

11 A It involves a perforated appendix in an
12 elderly patient who presented with highly atypical
13 physical findings and the patient ended up dying as a
14 consequence of a perforated appendix.

15 Q And you are the defense expert in this case?

16 A That is correct.

17 Q Okay. And based upon the atypical
18 presentation, I'm just kind of guessing here, I guess
19 based upon the atypical presentation it was your
20 opinion that the doctor did not deviate from standard
21 of care in his evaluation and/or diagnosis of that
22 patient?

23 A That is correct. The substance in that case
24 is dramatically different from this one. In that the

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

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

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

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

22 A I would agree with that.

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

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

4 Q Okay. What are those?

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

9 Q Okay. So these are Nebraska records?

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

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

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

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

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

16 A That is correct.

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

20 A That is correct.

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

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

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

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

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

23 A Yes, clostridium difficile is a bacterium.

24 Q So this was a bacterial --

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

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1 the rapid motility that one experiences after the
 2 ileocecal bowel of the intestinal tract has been
 3 removed.
 4 Q Do patients who have had their bowel removed
 5 always have frequent bowel movements?
 6 A Actually, they do not and it is variable from
 7 one patient to another.
 8 Q So is it rare for patients to have frequent
 9 bowel movements as a result of removal of the
 10 ileocecal bowel?
 11 A I wouldn't say that. I wouldn't say it was
 12 rare but I think having bowel movements to the
 13 magnitude of six or more stools a day, as are reported
 14 in Mr. Baldwin's record, would be certainly on the
 15 high side of what one would see. But I think that
 16 patients that have ileocecal bowels removed will not
 17 uncommonly have more frequent bowel movements than
 18 individuals who have their intestinal tract completely
 19 intact.
 20 Q What percentage of patients who have had
 21 their, in your experience, Doctor, what percentage of
 22 patients who have had their cecal bowel removed go on
 23 to experience frequency of bowel movements?
 24 A Probably all have a slight increase in

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1 frequency, meaning instead of a single bowel movement
 2 a day it would be common for them to have two or
 3 three. It would be my estimate that probably less
 4 than 20 percent would experience frequency on the
 5 magnitude of what is being described for Mr. Baldwin
 6 in the most recent records that I have reviewed.
 7 Q Would it be less than 10 percent perhaps?
 8 A Oh, it might be. I would say 10 or 20
 9 percent is a reasonable number.
 10 Q Of the patients who have experienced a
 11 problem with bacterial enterocolitis is one of the
 12 sequela of that frequency of bowel movements?
 13 A No. Once the disease has been
 14 microbiologically cured the patient should return to
 15 bowel habits that would have been characteristic of
 16 their pre-infection state.
 17 Q Is there an entity known as chronic
 18 enterocolitis?
 19 A There is chronic ulcerative colitis and then
 20 there is sort of the chronic irritable bowel
 21 syndrome. There is no real evidence that this patient
 22 had those kinds of symptoms prior to his operation in
 23 the fall of 1992. There is certainly no histological
 24 evidence or other evidence to support a diagnosis of

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1 ulcerative colitis so it's always reasonable to
 2 entertain potential other diagnoses. But I would say
 3 at that point the weight of the evidence would support
 4 the conclusion this his frequent bowel movements
 5 reflect rapid gastrointestinal transit from removal of
 6 his right colon and other segments of his small
 7 intestine.
 8 Q Has the entity of chronic irritable bowel
 9 syndrome, have studies been performed on Mr. Baldwin
 10 to rule out that problem?
 11 A If they have I certainly don't see them. And
 12 very commonly chronic, chronic spastic colitis and so
 13 forth, irritable bowel and so forth, almost is a
 14 diagnosis of exclusion. There is not much in the way
 15 of a definitive diagnosis that one could do in terms
 16 of a specific study to identify those entities.
 17 Q Is there an incident of patients who have
 18 appendicitis or who have had appendicitis that also
 19 have other bowel problems, be it diverticulitis or
 20 colitis?
 21 A I would say that the presence or absence of
 22 appendicitis would not be a variable that would
 23 increase or diminish with the likelihood of having an
 24 intercurrent secondary chronic disease. So it would

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

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

9 A Diverticulitis co-existing with appendicitis.

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

14 A Well, I mean, given the fact that probably 50
15 percent of people with a normal life expectancy
16 develop diverticulitis it would certainly imply that
17 50 percent of patients that have had appendectomies
18 will probably have diverticular disease at some point
19 in their subsequent life. So, yes, I have certainly
20 seen patients that have previously had an appendectomy
21 that develop diverticular disease but I, I would
22 caution that there is no evidence to support, in my
23 judgment, a causal relationship between appendectomy
24 and the subsequent development of either irritable

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

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

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

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

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

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

1 bowel syndrome or diverticular disease.

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

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

1 patient, as well?

2 A No question that that's true.

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

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

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

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

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

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

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

22 A I have reviewed no depositions.

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

1 Mr. Baldwin have been taken. Doctor, I understand you
2 were out in this neck of the woods for a while
3 practicing?

4 A Well, I not only was practicing in that neck
5 of the woods, I actually have been raised in that neck
6 of the woods so I know the northeastern, north central
7 parts of Ohio pretty well.

8 Q Did you know Dr. Sogocio?

9 A I did not.

10 Q Okay. Dr. Sogocio, I don't know if Donna had
11 explained to you Dr. Sogocio's deposition was not
12 taken because shortly before the filing of this
13 lawsuit he was diagnosed with essentially an
14 inoperable brain tumor and died before, became
15 incompetent and died prior to his deposition could be
16 taken in this case. So all we have to go with Dr.
17 Sogocio is what is in the records. Okay?

18 A Okay.

19 Q Doctor, I would ask that if it is your intent
20 -- well, let me back up. Have you been told anything
21 by Ms. Kolis, or Mrs. Kolis, regarding the testimony
22 of the defendants in the case?

23 A I have not been told anything about the
24 contents of the depositions whatsoever.

1 through this, per se, and I'm sure we'll cover the nut
2 of what is in here but I take it this report
3 essentially sets forth your criticism of the case; is
4 that fair?

5 A That's fair.

6 Q Okay. And we'll go into that a little more
7 in detail because I represent different physicians and
8 it really isn't broken down as to who these criticisms
9 are directed to. Are you with me?

10 A I understand that.

11 Q I appreciate it. Do you believe that you --
12 let me back up. Did you do any literature search?

13 A No, sir, I did not.

14 Q Plan on doing one?

15 A No, sir, I don't.

16 Q Okay. Anything else that you have reviewed
17 other than the medical records in this case?

18 A No, sir, I really have not.

19 Q Made any notes or anything?

20 A I guess I may have a scratch here or there or
21 an underline here or there in the records but, no
22 formal notes other than the report that I prepared for
23 Theado that's dated October the 1st of 1993.

24 Q Thank you. I appreciate that. Have you made

1 Q Do you believe that it is necessary for you
2 to render the opinions regarding the care of the
3 defendants that you will be rendering at the time of
4 trial?

5 A I believe that the best opinion is the one
6 that is derived from the objective evidence in the
7 medical records and so it would be my intention to
8 address really only issues that are identified in the
9 record and not rely on deposition testimony.

10 Q I appreciate that, Doctor. All I'm trying to
11 do is find out what you're going to say at the time of
12 trial so I'm not surprised then.

13 A And you won't be surprised.

14 Q Thank you. Also in that regard, Mr. Theado
15 had provided me a copy of a report that you had issued
16 in this case. Do you have that in front of you?

17 A I do, sir.

18 Q Okay. Are there any other versions of this
19 report floating around that you had authorized?

20 A That is the only version.

21 Q Okay. Were you asked to amend this version
22 by Mr. Theado?

23 A I was not.

24 Q Doctor, again, I guess I'm not going to

1 any assumption of facts in this case to reach or
2 render your opinions?

3 A Well, I guess we always assume some things to
4 be true. I'm assuming that the, the physical findings
5 and the medical records to be true as presented to me.
6 My assumption is that the facts in the record are
7 accurate.

8 Q Okay. And when you say you assume that the
9 facts in the record as they are reported are accurate
10 that is by way of the physical findings, the exams and
11 what the various physicians who saw this patients had
12 at various times found at those various periods of
13 time, you don't take issue with the validity of
14 anyone's findings?

15 A No, I would accept the recorded, the
16 recordings in the records to reflect the observations
17 and the interpretations of the individuals who were
18 evaluating the patient. I have no reason to believe
19 that any of the information that's been recorded is in
20 any way false.

21 Q Okay. And that includes the information
22 generated and recorded by Drs. Reardon, Sogocio and
23 Dr. True?

24 A I would agree with that.

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1 Q Thank you. Why don't we jump right into it.
 2 A Okay.
 3 Q Why don't we just go chronologically here.
 4 What are you critical of with regards to the care
 5 rendered by Dr. Reardon?
 6 A My primary criticism of Dr. Reardon's care
 7 would be very, very specific and to one very specific
 8 point and that is, is when this patient was presented
 9 with, admitted to the hospital on October the 27th of
 10 1990 the patient was sent to Dr. Reardon with a
 11 diagnosis of rule out appendicitis. The patient was
 12 admitted by Dr. Reardon with a potential diagnosis of
 13 appendicitis. I would agree with Dr. Reardon in his
 14 decision to seek a surgical consult but my biggest
 15 criticism of Dr. Reardon is the fact that a 22 year
 16 old patient with no reason to have prostatitis was
 17 started on systemic antibiotics and that the
 18 initiation of systemic antibiotics in the patient
 19 where the potential diagnosis of appendicitis is at
 20 issue can clearly obscure the natural history of the
 21 disease and the clinical presentation that the patient
 22 will have subsequent to that point. And so I would
 23 make the very firm criticism that the initiation of
 24 Doxycycline backs the critical element in the

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

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

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

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29

1 Doxycycline?

2 A I believe on the, on the morning of the 29th
3 I believe is when the order was written.4 Q Okay. Doctor, how long would it take after
5 you had stopped a patient on antibiotics to evaluate
6 him for a non-masking of the signs and symptoms of
7 appendicitis by antibiotics?8 A Well, I think that that that's a tough
9 question to answer but clearly the patient needs to be
10 off the antibiotic for a period of time and if the
11 patient still has symptoms that was potentially
12 repable to acute appendicitis I believe they should
13 remain off of antibiotics until a final decision has
14 been reached and, in which case I can't give you a
15 hard and fast answer to the question other than to say
16 it was appropriate to take the patient off of the
17 antibiotic and in my opinion it was inappropriate to
18 re-initiate the antibiotic for a diagnosis that
19 virtually would be unheard of in a 22 year old male.

20 Q Meaning mesentery adenitis or prostatitis?

21 A Prostatitis is my understanding from the
22 records as to the justification for initiation of
23 Doxycycline.

24 Q Okay. And where do you glean that

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1 A Pain and discomfort with voiding would be the
2 patient's presenting symptoms. It would usually be
3 associated with white blood cells and bacterial
4 microorganisms in the urine and on physical
5 examination would be identified with the diffuse
6 severe tenderness of the prostate gland on rectal
7 examination.8 Q Doctor, I can't find the orders in my sheets
9 here.10 A Actually, the orders I think were not in my
11 initial book.12 MS. KOLIS: You know
13 what, Chip, let me just say this,
14 anything you think -- you can keep this
15 on the records, I don't care. You have
16 worked with me before and I always get
17 complete hospital chart. So I gave him
18 another set just making sure he had
19 every single piece of paper from the
20 hospital.21 MR. BODIE: Okay. Well,
22 Donna, I don't have a release so --23 MS. KOLIS: If you don't
24 have an order I can send you all the

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1 information?

2 A It's from the orders when the Doxycycline was
3 initiated and I believe that actually is, the
4 discharge summary indicates that Doxycycline was
5 initiated for prostatitis. And so I believe the
6 record is fairly clear that that's the indication.
7 Mesentery adenitis is generally a non-specific
8 condition of the intestinal mesentery and is more
9 commonly associated with little kids that have
10 operations for appendicitis and would generally be
11 thought to be viral in origin and not something that
12 would be amenable to treatment with antibiotics.

13 Q Mesentery adenitis is not?

14 A Is not.

15 Q How is it treated?

16 A Leave it alone and it goes away.

17 Q Okay. What is prostatitis?

18 A Would be an infection of the prostate gland
19 itself.

20 Q Can 22 year old gentlemen get it?

21 A They can get it but it would certainly be
22 highly unusual.23 Q What are the physical findings of
24 prostatitis?

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1 hospital records.

2 MR. BODIE: Okay.

3 MS. KOLIS: I assumed you
4 had a complete set of records.5 MR. BODIE: Unless I have
6 a release I can't get them.

7 BY MR. BODIE:

8 Q The orders for Doxycycline, those were given
9 on what day?10 A That was started on the, the order was
11 written on the morning of the 29th and the first dose
12 was given at 1:00 o'clock p.m. on the 29th.

13 Q And that order was by whom?

14 A By Dr. Reardon.

15 Q Okay. Are you aware that that was after the
16 evaluation of the general surgeon on the day before?

17 A I am aware of that.

18 Q And you are critical of his decision to
19 administer, readminister an antibiotic to this, this
20 patient on the 29th?21 A Yes, sir, I am. And just so that, in keeping
22 with the spirit of full disclosure so you don't have
23 any surprises, you'll notice Dr. Reardon's note on the
24 afternoon, 5:55 p.m., he basically provides a physical

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

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

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

17 Q Was the patient febrile?

18 A He was not febrile at that point.

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

22 A Not necessarily at this point.

23 Q Why not?

24 A Because the duration of antimicrobial action

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

9 Q What's the half life of Erythromycin?

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

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

22 A Two days would be a long time.

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

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

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

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

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

1 A That is correct.

2 Q And he was observed in the hospital on the
3 27th, correct?

4 A That is correct.

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

6 A That is correct.

7 Q And on both days he was not on antibiotics?

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

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

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

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

20 A That's correct, there are.

21 Q What are they?

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

1 this case.

2 Q Great.

3 A Since obviously female patients would bring
4 in a whole sedentary of potential considerations. But
5 in the male patient the diagnosis of an acute renal
6 stem, patients having urinary tract infection,
7 patients having initial onset of regional enteritis,
8 patients having mechanical diverticulitis. One can
9 see cecal or right sided diverticular disease of the
10 colon that would present with right lower quadrant
11 tenderness.

12 But the fact is that if you put all of the
13 alternative diagnoses together they have a probability
14 of less than 10 percent compared to a 22 year old
15 patient with right lower quadrant pain and rebound
16 having an appendicitis. So the overwhelming
17 probability issues here favor a diagnosis of acute
18 appendicitis as opposed to the alternatives.

19 Q Okay. Is it also consistent with the
20 presentation of mesentery adenitis?

21 A Well, mesentery adenitis in a 22 year old is
22 outside of my nickel of experience. I have never seen
23 it in somebody 22 years old. Mesentery adenitis is a
24 surgical diagnosis of having done an operation on a

1 A Yes, I am.

2 Q You're aware that that was negative?

3 A That's not surprising.

4 Q Why not?

5 A That implies occult blood so I would guess
6 that the overwhelming majority of patients with acute
7 appendicitis would have no blood in their stool
8 whatsoever.

9 Q You're aware that Dr. Segocio shortly after
10 Dr. Reardon's exam noted no rebound?

11 A That's what he indicates.

12 Q Okay. Are you saying that that's incorrect
13 or that --

14 A I'm saying that the weight of the evidence of
15 the preceding examiners beginning back at Westech and
16 running through Dr. Reardon's several examinations
17 favor that there was rebound tenderness 30 minutes
18 before Dr. Segocio does his examination. Dr. Reardon
19 identifies rebound tenderness so I guess we have
20 disputed facts in the record.

21 Q The decision to take a patient to surgery is
22 not that of the family practice doctor, that is the
23 decision of the surgical consult, correct?

24 A I would agree with that.

1 child or an adolescent with the clinical diagnosis of
2 appendicitis only to find out at the time of operation
3 that the appendix is normal and that one has a whole
4 array of lymph nodes that are identified in the
5 mesentery. And for all practical purposes there is no
6 way of establishing a diagnosis of mesentery adenitis
7 in an adult. I know of no way to accurately do that
8 short of an operation and removal of the appendix and
9 actual observation of the mesentery.

10 Q Is right lower quadrant pain with rebound a
11 sign and/or symptom of mesentery adenitis?

12 A Oh, it could be but you can't prove that
13 without an operation.

14 Q Is it also a sign or symptom of prostatitis?

15 A Very unusual. I would say no. Absolutely
16 not. Rebound tenderness implies that there is
17 peritoneal inflammation and prostatitis would not be a
18 disease entity that would cause the patient to have
19 peritoneal inflammation.

20 Q Is a mildly enlarged and embodied prostate a
21 sign and/or symptom of prostatitis?

22 A Well, it potentially could be.

23 Q Are you aware that there was a stool sample
24 taken?

1 Q Okay. So whether or not this patient was
2 going to be explored for suspected appendicitis was
3 not Dr. Reardon's decision but that of Dr. Segocio?

4 A The decision to do the operation was the
5 surgeons.

6 Q Okay. And the surgeon had seen the patient
7 before -- well, let me ask you this. Do you, when do
8 you believe this patient should have been taken to
9 surgery? Let me rephrase that, please. When do you
10 believe that standard of care in this case required
11 that the patient be taken in for surgery?

12 A Since we have the separate individuals
13 evaluating the patient on the 27th who identify right
14 lower quadrant abdominal pain and rebound tenderness
15 in a 22 year old male who has been ill with abdominal
16 pain now for about 48 hours, I would argue that they
17 should have gone to the operating room on the evening
18 of the 27th.

19 Q Doctor, would you agree that you are on the
20 more aggressive end of surgical exploration as opposed
21 to other physicians?

22 A I probably am on the more aggressive side but
23 I think that my opinion would be that there would be
24 an overwhelming consensus in the surgical community

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

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

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

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

17 A On which date?

18 Q The 27th?

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

24 Q What about Dr. Gallagher in the emergency

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

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

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

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

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

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

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

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

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

6 Q How?

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

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

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

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

24 A It does not appear to clinically deteriorate

1 during the interval.

2 Q And, in fact, he becomes hungry, correct?

3 A That is indicated in the records.

4 Q He is afebrile, correct?

5 A That is correct.

6 Q He does not appear to be toxic, correct?

7 A He is not toxic.

8 Q It is noted by others in the records that the

9 abdomen is flat, correct?

10 A I would have expected that.

11 Q It is also noted in the record during that

12 period of time that there is, he has gone from what is

13 noted to be rebound to no rebound, correct?

14 A In 30 minutes, excuse me, no. I think that

15 Dr. Sogocio says there's no rebound but all the, of

16 the previous examiners have identified it as such and

17 so all I can say is that I somehow don't think in 30

18 minutes things completely resolved.

19 Q What about on the 29th, is there any evidence

20 of rebound on the 29th before they start him on

21 antibiotics?

22 A Yes. I believe that we have the

23 identification by Dr. Reardon that there has been no

24 significant change which from his note would link back

1 to his observations late on the 28th. So my

2 interpretation of that is that the patient is still

3 having right lower quadrant pain and rebound but, in

4 fact, he is taking some clear liquid at that point.

5 Q Do the nurses note any rebound on the 29th?

6 A I would not place any particular credibility

7 on the nurses physical examination. The nurses are

8 not the ones that end up making the decisions. So

9 while I generally like to look at the nursing notes

10 the nurses would not know necessarily whether they're

11 supposed to identify rebound tenderness or not.

12 Q Doctor, when do you believe this patient

13 perforated to a reasonable medical probability?

14 A I believe that he perforated subsequent to

15 the 27th and the 28th. I can see no evidence that he

16 perforated necessarily during the hospitalization so I

17 would say that he was perforated in the immediate

18 aftermath of his discharge.

19 Q So he perforated after the 30th?

20 A That would be my best estimate.

21 Q What do you base that on?

22 A The fact that he was able to resume some

23 degree of oral intake and that he remains stable, in

24 general. There would be in the absence of an

1 antibiotic some period of deterioration associated

2 with a perforation so my judgment is that we can see

3 no acute deterioration up until the time that he's

4 placed on antibiotics. So my conclusion is that

5 perforation has not occurred prior to that time.

6 Q So it is your opinion that he had not

7 perforated prior to his discharge, his appendix had

8 not perforated prior to 8-30-90?

9 A That's correct.

10 Q Doctor, in your report you say that within a

11 reasonable medical probability he perforated his

12 appendix on or about August 27th.

13 A Well, I was referring specifically to the

14 admission and the events there. And I would say in

15 fairness that with the antibiotic cover it is still

16 reasonable that he would have perforated in the

17 hospital but that the antibiotic cover would have

18 masqueraded his signs and symptoms.

19 Q Doctor, would you agree that you had all

20 these medical records back when you issued this

21 report?

22 A Yes.

23 Q And you had reviewed these carefully when you

24 issued this report?

1 A And that is why I said on or about.

2 Q So there is at least a three, four, five day

3 curtain of window as to when this patient could have

4 perforated, you would agree with that?

5 A I would agree with that.

6 Q Okay. So would you agree with the statement

7 within reasonable medical probability he perforated

8 his appendix on August 27?

9 A I think within reasonable probability I would

10 doubt that it was on the 27th.

11 Q Well, Doctor, why didn't you put that in your

12 report?

13 A Because with the patient having had

14 Erythromycin I still left open the opportunity, the

15 potential possibility that the 27th may well have been

16 potentially the time of perforation, particularly

17 given that the patient had his biggest fever

18 identification at about that time. I do think this --

19 the reason I put on or about is I believe that the

20 evidence of the patient being able to resume oral

21 intake would be some evidence that would diminish the

22 27th being the specific date.

23 Q Why is that?

24 A Because generally speaking patients don't eat

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1 and drink with perforated appendix acutely.

2 Q They don't get better, they don't improve

3 when they perforate?

4 A They have a transient period of pain relief

5 but they don't materially get better for more than

6 just a few brief hours. I mean, this is nothing that

7 they don't get better for two, three, four days.

8 Q So you don't see a patient who is getting

9 better, getting hungry, before they perforate?

10 A Generally speaking if they are perforated I

11 would not expect the patient to be eating and drinking

12 12 to 24 to 36 hours later.

13 Q What would you expect to see if they

14 perforated?

15 A I would expect -- well, again, this gets to

16 the issue of where the appendix is anatomically

17 located and I believe we have pretty good evidence

18 that this patient had a retro cecal appendix and so we

19 get into the issue of the magnitude of the perforation

20 and that's why I deliberately tried to not point a

21 specific date. That's why I used the terms on or

22 about specifically referring to the hospital admission

23 and it's events. So all I can say is that in general,

24 with a perforated appendix we would not anticipate

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1 antibiotics until the 25th and there is no evidence of

2 the, of his presentation on the 25th to suggest that

3 he even had appendicitis and so --

4 Q But, Doctor, let me interrupt you. You said

5 the diagnosis of appendicitis can be made with right

6 lower quadrant pain.

7 A And tenderness.

8 Q And isn't that what --

9 A And rebound tenderness. And the records of

10 the 25th does not indicate that, that is not what the

11 record of the 25th says. So the patient did not have

12 classic signs and symptoms of appendicitis on the

13 25th. And so I probably would not have started the

14 patient on Erythromycin on the 25th given that there

15 were some abdominal complaints. But I think there is

16 no reason to believe that this patient had clear

17 evidence of appendicitis on the 25th and I think

18 within reasonable medical probability the patient did

19 not have a perforated appendix on the 25.

20 Q Why do you say that?

21 A Because he didn't have the signs and symptoms

22 of rebound tenderness at that particular time.

23 Q What about the 26th?

24 A Well, I don't know what happened on the 26th.

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1 that a patient would be eating and drinking 6 to 12

2 hours after the event occurred.

3 Q Meaning after the perforation occurred?

4 A That is correct.

5 Q So if he's eating and drinking after the

6 perforation occurs and generally looking better that

7 would speak against a perforation at that time?

8 A In general that is correct, sir.

9 Q So if he continues to improve after he's

10 discharged from the hospital that would speak against

11 a perforation afterwards, correct?

12 A Well, the problem now becomes one of having

13 the compounding antibiotic treatment.

14 Q Well, wasn't there the problem with the

15 compounding antibiotic treatment before the

16 hospitalization, too?

17 A I guess that's again why I said on or about

18 the 27th. I'm not suggesting that the patient

19 perforated before the 27th when he he was on the

20 antibiotics.

21 Q So it could be the 25th he perforated when he

22 was having that problem but it was masked by

23 antibiotics on the 25th?

24 A Well, he didn't get started on the

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1 He wasn't examined again until the 27th.

2 Q Couldn't antibiotics mask the rebound

3 tenderness?

4 A He wasn't on antibiotics at the time he was

5 examined on the 25th. It was in the wake of the visit

6 of the 25th he was started on the drug.

7 Q So it would take some time for the antibiotic

8 to begin to mask something?

9 A Clearly that would be true.

10 Q How long would it take for Doxycycline after

11 it had been initiated to begin to mask something?

12 A Probably 12 hours.

13 Q So we have another 12 hours of Erythromycin

14 going downhill before the Doxycycline is coming in?

15 A Essentially, yes.

16 Q So we have almost until the 30th, or late on

17 the 29th to continue to monitor this patient to see

18 whether this is, quote, being masked because the

19 Doxycycline hasn't been up taken, so to speak?

20 A There was no indication for starting the

21 antibiotic. I think I understand what you're saying.

22 I think you're trying to be too exact with something

23 that is not a very exact science.

24 Q And you're saying that the diagnosis of

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1 appendicitis when a patient is getting hungry, eating,
2 taking food, it can be difficult?

3 A I think it can be difficult. I think that I
4 clearly believe that it can be difficult.

5 Q Would you also agree that although the
6 opinion had been held that inflammation of the retro
7 cecal appendix produces an atypical presentation that
8 that is now known to be incorrect, that the findings
9 are usually the same as an ordinary or anti-cecal
10 appendicitis?

11 A I think that retro cecal appendix can cause
12 an atypical presentation.

13 Q And anti-cecal appendicitis can present an
14 atypical presentation, too? Any type of appendicitis
15 can be atypical?

16 A I would agree with that.

17 Q And appendicitis signs and symptoms when they
18 present can mimic, it's a great my mimicker, isn't it?

19 A Oh, I think that appendicitis can mimic other
20 things and other things can mimic appendicitis. But
21 that doesn't eliminate the strategy of operating on
22 patients when the criteria have been fulfilled.

23 Q And the criteria, the standard of care, the
24 criteria under the standard of care is what, Doctor?

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1 patients are going have a normal healthy appendix?

2 A I would bet that that's probably true for
3 males and for female patients. The normal
4 appendectomy rate may be even somewhat higher because
5 of the vast additional area of potential diagnoses.

6 But for a patient like Thomas Baldwin I would
7 certainly accept a 20 percent rate of normal
8 appendectomy.

9 Q Okay. Finishing up with Dr. Reardon. In the
10 follow-up evaluation and treatment you are not
11 critical of his care then I take it?

12 A Well, we have the continued problems of the
13 patient presenting with the same symptoms. I guess
14 I'm not really as critical of Dr. Reardon as far as
15 the chronic long term problems of not being able to
16 sort out, making a decision to operate since making a
17 decision to operate was really not his decision to
18 make. So being critical, should he have had
19 additional surgical consultation, yes. But when you
20 get into the chronic state of things I would cut Dr.
21 Reardon a little slack and say making the diagnosis
22 when things smolder into a chronic situation are much
23 more difficult. So my principal criticisms of Dr.
24 Reardon again relate to, specifically to the issue of

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1 A For a 22 year old male it is right lower
2 quadrant pain and rebound tenderness.

3 Q So every 22 year old male who presents with
4 right lower quadrant pain and rebound tenderness
5 should be operated on for appendicitis, is that your
6 opinion?

7 A That's my opinion and that's what I teach my
8 residents and students.

9 Q And that's what the standard of care
10 requires?

11 A In my opinion, that is correct.

12 Q Doctor, in your opinion that's what standard
13 of care requires?

14 A I don't think there is any question, yes,
15 sir.

16 Q Okay. What is the incidence of false
17 positives in operating on these patients?

18 A Well, I think it depends on how aggressive or
19 how non-aggressive you are. But I think most of us
20 would accept a 20 percent normal appendix rate for
21 doing appendectomy.

22 Q So on two out of ten patients that you go in
23 and operate that present with right lower quadrant
24 pain and tenderness, only that 20 percent of those

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1 the Doxycycline being started on the hospitalization
2 on August the 29th.

3 Q Okay. And just so I can clear up your
4 response, Doctor. Am I to understand that therefore,
5 the evaluation and treatment and actions of Dr.
6 Reardon in evaluating and treating Mr. Baldwin after
7 August 29, 1990 were appropriate and within accepted
8 standards of care in your opinion?

9 A I believe that he should have had additional
10 surgical consultation but as I indicated before I
11 believe that things get to be fairly atypical when one
12 gets into the chronic state. Though I am not being
13 critical, I think with the same conviction that I am
14 about the issue of the antibiotic. I think the
15 problems that Dr. Reardon may have experienced later
16 in the patient's evaluation all go back to the initial
17 decision of starting the antibiotics so I don't want
18 to pile on additional criticisms when everything
19 really has their genesis with the initial decision.

20 Q Okay.

21 A Do you understand what I'm saying?

22 Q I'm trying to Doctor. When you say -- but
23 you confuse me when you say he should have gotten more
24 surgical consultation because that to me sounds like

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

6 A Since you want it yes or no I would have to
7 say, yes, that it was beneath the standard of care to
8 not have additional surgical evaluations subsequently
9 in the patient's care when he's continuing to have
10 right lower quadrant pain and tenderness. But I think
11 I have tried to indicate that that's, that those
12 problems still relate back to the original decision.

13 And that original decision relative to the antibiotics
14 happens to be the issue that I am most critical of.
15 But if you have a patient with continued right lower
16 quadrant pain and continued tenderness and continued
17 rebound and he's not getting better, the standard of
18 care would be to get additional surgical consultation.

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

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

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

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

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

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

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

15 Q What if the primary physician isn't
16 contacted?

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

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

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

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

24 A There are a bunch of them.

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

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

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

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

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

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

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

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1 ---
 2 Whereupon, a break was taken at 1:30 and the
 3 deposition was resumed at 1:34 o'clock p.m.
 4 ---
 5 Q We're back after a short break here and we're
 6 talking about when standard of care required to bring
 7 in a surgical consult after the discharge and you said
 8 in that July visit, July '91, correct?
 9 A That is correct.
 10 Q Okay. And what is it about the July '91
 11 period of time that Dr. Reardon saw him in the office
 12 that indicates that a surgical consult was indicated?
 13 A Well, the fact that the patient is now having
 14 right lower quadrant symptoms again and so you now
 15 have symptomatology that has gone across nearly eleven
 16 months time and it would be my opinion that it was
 17 appropriate to have an additional consultation in a
 18 patient that's having chronic and persisting right
 19 lower quadrant pain.
 20 Q How about if it's just generalized abdominal
 21 pain or epigastric pain that continued, would it be
 22 appropriate to send that patient to a GI specialist?
 23 A It might be. And I think if you're now
 24 changing your diagnosis and you're more concerned

1 about peptic ulcer disease rather than appendicitis, I
2 think it's appropriate to consider a GI consult.

3 Q Okay. Isn't that, in fact, what was done in
4 the case?

5 A I don't think I have been critical of the
6 fact that they referred the patient to the GI
7 specialist for an evaluation.

8 Q Okay. I'd like to go to Dr. True. How in
9 your opinion did Dr. True depart from accepted
10 standard of care in his evaluation and treatment of
11 this patient?

12 A My criticism of Dr. True would basically
13 relate to the fact that, that the patient should have
14 had a surgical consultation when he evaluated him.

15 Q You mean when he first evaluated him?

16 A I think that, again, Dr. True falls under the
17 same criticisms that would be leveled against Dr.
18 Reardon, that during the follow-up care, during the
19 follow-up care after the hospitalization and the
20 episodic things, the episodic events that occur in the
21 next 24 months, you have a patient that initially had
22 right lower quadrant pain and rebound and he's now
23 coming back with episodes of the same event and that
24 it would be the standard of care to get a surgical

1 consultation.

2 Q So it is your opinion that Dr. True, when he
3 first saw the patient on February 18, 1992 with
4 complaints of constipation fever and was reported by
5 the patient to him that an upper GI and lower GI were
6 negative, that it was a required under the standard of
7 care of the family practice physician that he obtain a
8 surgical consult?

9 A In a patient is sent again to Dr. True on
10 August 3 of 1992 after once again being seen in the
11 emergency room on July the 25th with, again, having
12 the recurrent problems of right lower quadrant pain,
13 it would be my opinion at that point when the patient
14 is referred to Dr. True for continued follow-up that
15 it would be appropriate that the patient end up having
16 a surgical consult at that point.

17 Q Not before that point?

18 A Well, I'm trying to look and see what the
19 findings were on the first time that --

20 MS. KOLIS: Do you have
21 Dr. True's chart in your stack of
22 records?

23 THE WITNESS: I have it
24 somewhere.

1 assessment of the patient during these reoccurring
2 events and that was not done.

3 Q Okay. That was not done by the emergency
4 room physicians either, correct?

5 A But again, the emergency room physicians are
6 under a different mandate because they need to be
7 interacting with the primary care physician that
8 provide the sustained care for the individual. So I
9 believe in reviewing these records that the emergency
10 room physicians were in contact with the primary care
11 physician and that they were coordinating the care of
12 this patient with them so I am not critical of the
13 emergency room physicians because I believe they were
14 not the parties that were accountable for needing to
15 get the surgical consultation when they were
16 interacting with the primary care physician.

17 Q And if this patient doesn't have a primary
18 care physician then would you be critical?

19 A Depending on physical findings, very much so.
20 I think if, if I'm an emergency medicine physician and
21 the patient comes in with nebulous history and has
22 physical findings of right lower quadrant pain with
23 rebound tenderness and no primary care physician, you
24 can believe that I would entertain a surgical

1 MS. KOLIS: Okay.

2 A I don't have the findings in my notes of what
3 was seen in the February visit to Dr. True. That's
4 what I'm looking for at this point.

5 MS. KOLIS: Chip, I just
6 handed him my notebook, okay?

7 MR. BODIE: Fine. You
8 still there?

9 MS. KOLIS: Yes, we're
10 still here.

11 Q It's in the notebook, tab number four, where
12 it says Bedford Medical, parenthesis, Dr. True.

13 A Yes, I have got it right here and I'm
14 actually also looking at the emergency room records of
15 Dr. Reems. Dr. Reems saw the patient on February the
16 16th and noted at that time that the patient had
17 tenderness in the right lower quadrant but that the
18 abdomen was soft and that it was not rigid at that
19 point. He did not identify rebound tenderness and at
20 that point he refers the patient, we have a little
21 problem between the dictated note and the -- let's
22 see. We have, I'm pausing because we seem to have
23 some disputed facts between what was written in the
24 emergency room records and what is dictated.

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

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

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1 history, even though I don't see that indicated here.
 2 So in general, if you have a patient with a 28 month
 3 history of right lower quadrant pain it would be the
 4 standard of care for a primary physician to get a
 5 surgical consult.
 6 Q What if it's mostly epigastric pain and all
 7 the pain goes away after he takes Tagamet or Zantac?
 8 Given that history and that presentation would that
 9 require surgical consult?
 10 A Probably not. So the answer is no.
 11 Q Okay. Are you of the opinion that as of
 12 February '92 or even August '92 there is already an
 13 abscess?
 14 A I think there is no question that that is
 15 true.
 16 Q Had it been operated on on February 18, 1992
 17 what difference would it have made in the outcome?
 18 A I think that's a reasonable argument. That
 19 is to say there is no way I can say within reasonable
 20 medical probability that an operation in February of
 21 '92 would have given a better result than the one in
 22 October of '92.
 23 Q Is there any way -- do you believe that in
 24 January of 1992 that there was an abscess formed?

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

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

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1 Doctor, and I just want to sum up a few things. Dr.
 2 Reardon's number one criticism is that he should not
 3 have put the patient on Doxycycline on the 29th?
 4 A That is correct.
 5 Q That that had masked or halted the
 6 progression of the patient's septic, if you will,
 7 course?
 8 A It changed the natural history of the
 9 disease.
 10 Q Changed the natural history of the disease
 11 and led to the development of the abscess and chronic
 12 condition which subsequently developed?
 13 A That is correct.
 14 Q Okay. That is the entirety of your criticism
 15 as to Dr. Reardon, meaning that is the entirety of
 16 your criticisms of Dr. Reardon in which he departed
 17 from accepted standard of care?
 18 A That is the seminal event in Dr. Reardon's
 19 departure from the standard of care?
 20 Q Okay. And Dr. Sogocio should have seen the
 21 patient again to identify a worsening of the patient's
 22 condition and instructed that antibiotics be deferred
 23 for a longer period of time to let the condition
 24 pronounce itself?

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1 in which you believe he departed from accepted
 2 standard of care?
 3 A I really don't. I'm trying to make a
 4 determination here about whether there were, were any
 5 narcotics given between the interval of Dr. Reardon's
 6 exam and Dr. Sogocio's examination.
 7 MR. BODIE: Donna,
 8 correct me if I'm wrong, I don't think
 9 there were.
 10 MS. KOLIS: No.
 11 A But obviously that is a potential issue that
 12 could be involved in physical examinations in
 13 relatively short period of time showing dramatically
 14 different findings.
 15 Q Got it.
 16 A And so that was the reason why we were, I was
 17 sort of doing this scramble through the records. It
 18 does not appear, it does not appear that there was
 19 Demoral given in the interval of that afternoon of the
 20 28th.
 21 Q Right.
 22 A So with that understanding I have no
 23 additional criticisms of Dr. Sogocio.
 24 Q Okay. Let me just, I'm wrapping up here,

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

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1 Q Did the phone drop?

2 A No, no.

3 Q Okay. The surgical operation for

4 appendicitis, there are risks and complications with

5 that, correct?

6 A There is risks with anything, yes.

7 Q What are the risks of, of appendicitis

8 surgery?

9 A Principal risk would be wound infection. You

10 can have very rarely a, what we call a blown

11 appendiceal stump. You could very, very rarely have

12 injury to other loops of intestine in the process.

13 But overwhelmingly the biggest risk would be a wound

14 infection.

15 Q Okay. With respect to any bowel surgery,

16 would you agree that illius is a risk of procedure?

17 A Well, illius is a risk of the procedure but

18 illius is also a risk of the fundamental disease

19 process as well.

20 Q Meaning the fundamental disease process of

21 appendicitis?

22 A That's correct.

23 Q Would you agree that bowel obstruction is

24 also a fundamental risk of the disease process?

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1 A That is a risk with any form of perforation

2 or peritonitis.

3 Q Of which you would include appendicitis?

4 A Yes, sir.

5 Q Would you agree that there is no significant

6 difference in the risk of developing bowel obstruction

7 with the removal of a normal appendix versus the

8 removal of the perforated appendix?

9 A There is less of a risk of bowel obstruction

10 in removing a normal appendix than there would be for

11 one that is perforated.

12 Q How about the difference between an inflamed

13 appendix versus a perforated appendix?

14 A I would say there is less risk with the

15 inflamed appendix as opposed to the perforated

16 appendix.

17 Q Would you agree that bleeding, infection,

18 potential of a colostomy and damage to surrounding

19 organs are also a risk of an appendiceal surgery?

20 A Colostomy is unlikely but there is always a

21 risk. I believe I already did testify to the fact

22 that injury to other loops of intestine is a risk with

23 the operation so, yes, I would concur with that, that

24 is a risk.

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1 Q Doctor, we know what his surgical course was

2 after the identification of the abscess or appendiceal

3 mass, however you want to describe it, and we know the

4 extent of the complication that occurred following

5 that surgery.

6 A Yes.

7 Q The complication, that specific complication,

8 meaning the bowel obstruction, can that occur in the

9 absence of negligence?

10 A Certainly.

11 Q Okay. Can it just be a risk of the procedure

12 that was performed in this case?

13 A That's correct.

14 Q Okay. When, if you can say, at what time had

15 this surgery been undertaken that these events you

16 believe would not have transpired? I guess I better

17 phrase that better. Had surgery been undertaken

18 earlier when would it have made a difference?

19 A In my opinion, during the hospitalization on

20 August the 27th.

21 Q Of 1990?

22 A That is correct.

23 Q Okay. And had it taken place after that,

24 meaning at anytime after that, can you say whether it

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1 would have made any difference or not in the outcome

2 in this case?

3 A I think you can say that earlier operation

4 has a greater probability than the delayed operation,

5 but a delayed operation beyond the point of the

6 chronic abscess cavity formation probably would not

7 have made a difference.

8 Q Do you have an opinion as to when the chronic

9 abscess formed?

10 A Oh, I'm sure it was within the, the few

11 months immediately following that August admission, so

12 we're talking within two or three or four months as it

13 developed during that period of time.

14 Q So by Novemberish of 1990?

15 A That would be a reasonable estimate.

16 Q Okay. So essentially after November '90,

17 surgery after November '90 would not have made a

18 difference in this case?

19 A Surgery after November of 1990 would have in

20 all likelihood required the same operation as was

21 performed in October of '92.

22 Q With the same percentage of risk of the same

23 complications that developed in the case?

24 A I believe so.

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1 Q Doctor, I think we have covered all your
2 opinions as to departure of standard of care in the
3 case. It sounds as if we have gone over a number of
4 your opinions regarding what the actions of these
5 individuals caused, as well. Does that jog with your
6 recollection as well?
7 A I believe so.
8 Q Okay. And I think we have gone over the
9 damage issue as well, you know, about what difference
10 it would have made?
11 A Yes, sir.
12 Q And the period of time that it would have
13 made any difference, correct?
14 A I agree.
15 Q Doctor, have we covered all the opinions that
16 you plan to give at the time of trial regarding
17 departure from accepted standards of care in this
18 case?
19 A I believe we have.
20 Q Doctor, have we gone over all your opinions
21 that you plan to give at trial in this case regarding
22 how you believe those departures caused the injuries
23 to Mr. Baldwin?
24 A I believe we have.

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C E R T I F I C A T E

1
2 I, Jodi Jefferies, a Notary Public within and for
3 the State of Ohio, duly commissioned and qualified, do
4 hereby certify that the within-named witness, DONALD
5 E. FRY, M.D., was first duly sworn to testify the
6 truth, the whole truth and nothing but the truth in
7 the cause aforesaid; that the testimony then given by
8 him was by me reduced to Stenotype in the presence of
9 said witness, afterwards transcribed by the use of a
10 computer under my supervision, and that the foregoing
11 is a true and correct transcription of the testimony
12 so given by him as aforesaid, and that the reading and
13 signing of the witness was not waived.
14 I do further certify that this deposition was
15 taken at the time and place in the foregoing caption
16 specified.
17 I do further certify that I am not a relative,
18 counsel or attorney of either party.
19 IN WITNESS WHEREOF, I have hereunto set my hand
20 and affixed my seal of office at Toledo, Ohio, on
21 this ____ day of October, 1997.
22 My commission expires April 3, 1999
23 Jodi S. Jefferies, aka
24 (Jodi S. Cozza)
Notary Public
In and for the State of Ohio

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1 Q Doctor, have we also gone over all of the
2 opinions that you have previously given to Ms. Kolis?
3 A Yes, sir, we have.
4 MR. BODIE: I have no
5 other questions. Thank you.
6 THE WITNESS: Okay.
7 Thank you.

8 - - -
9 Whereupon, the deposition was concluded at 2:04
10 o'clock p.m.
11 - - -

22
23 _____
24 DONALD E. FRY, M.D.

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