#605

IN THE DISTRICT COURT OF
WYANDOTTE COUNTY, KANSAS

DARREN PORTERFIELD,
Plaintiff,
vs. No. 89C1850
EMERGENCY PHYSICIANS SERVICES
OF KANSAS CITY, INC., et al.,
Defendants.

DEPOSITION OF GREGORY L. HENRY, M.D., a Witness, taken on behalf of the Plaintiff before Karen Kellerman, CSR, pursuant to Notice on the 30th day of August, 1990, at the Ann Arbor Briarwood Hilton, 610 Hilton Boulevard, Ann Arbor, Michogan.

ORIGINAL

APPEARANCES

Appearing for the Plaintiff was MR. JOHN R. MENCL of CURTIS, MENCL & HALAS, P.C., Suite L, 3600 South Noland Road, Independence, Missouri 64055.

Appearing for the Defendant Allin and Emergency Physicians Services of Kansas City, Inc., was MR. DAVID R. ERICKSON of BLACKWELL, SANDERS, MATHENY, WEARY & LOMBARDI, Suite 1200, 9401 Indian Creek Parkway, Overland Park, Kansas 66210.

Appearing for the Defendants Brooks and Soucek was MR. MICHAEL OLIVER of WALLACE, SAUNDERS, AUSTIN, BROWN & ENOCHS, 10111 Santa Fe Drive, Overland Park, Kansas 66212.

Appearing for the Defendant Providence-St. Margaret Health Center was MR. KENNETH J. REILLY of McDOWELL, RICE & SMITH, Suite 357, 2500 Holmes, Kansas City, Missouri 64112.

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Q. would you state your full name for the record.

A. Gregory L. Henry, M.D.

Q. What is your present address?

A. 1850 Washtenaw, Ann Arbor, Michigan.

Q. It is my understanding you are a board certified emergency room physician.

A. Yes, I am a board certified emergency physician and an examiner for the boards.

Q. I want to start off by trying to have a complete understanding of what you have reviewed in preparation for forming your opinion. Why don't we just start going through these depositions, and you tell me what the deposition is.

A. All right. My opinions that I express today are based on the following pieces of information.. The deposition of a Kevin Kuebler.

Q. And for the record, that deposition of Kevin Kuebler is August 1988. Some of these

people have more than one deposition.

of October, '89. Deposition.of Nurse Laura Jobe, 23rd October, '89. Deposition of Nurse Cynthia Ambrose, that's 23rd October, '89. Deposition of William Brooks, October 11, '89. Deposition of Kevin Kuebler, 12 October, '89. Deposition of Donald Goodwin, 23 July, '89.

MR. ERICKSON: I think that's '90.

MR. MENCL: It has to be '90.

A. I think it is, but it's written on the front as '89. Then I have deposition of Walter Levy, M.D., 23 January, '90. I have the deposition of Joseph Coppola, 22nd January, 1990. Wendy Marshall, M.D., 9 February, 1990. Charles Carton, July 31, 1990. Clark Watts, M.D., on 18 July, 1990. Kevin Fogarty, July 6, 1990. Michael Rydquist, July 6, 1990. And then I have excerpts from Providence-St. Margaret medical records. And I have a summon and complaint with regard to this matter, and I have a chronology of events with

file at this point.

track of the time that you spend doing things on this matter?

A. My billing office would have a record of any time that's been billed to the defense firm. I don't have that billing record with me, but I can -- I certainly can obtain how many hours so far into this case, I would imagine that at this point in time there are maybe 12, 15 hours involved in this case.

Q. In going through all the depositions and analyzing the information?

A. Yes, exactly.

Q. How much are you charging Mr. Erickson for this review of materials?

A. My standard charge is $150 an hour for nonblocked-out time, for casual reading time. For a blocked-out time, such as meetings, depositions or trial, it's $250 an hour.

Q. And did you spend any time in particular preparing for this deposition by, you know, rereading things, reviewing records?

A. Yes. I'm sent, prior to this deposition, probably about two hours of just researching things, and then I had a -- let's see. I had one meeting prior to this -- immediately preceding this deposition with defense attorney. That would be the sum total of preparation for this.

Q. So would the two hours include the meeting with --

A. No, it would not.

Q. Oh, okay. That's exclusive. All right. The copy of the petition that was sent to you, was that anything more than just background?

A. That's only background. It just allows me to know who the players are and what the allegations are.

Q. Did you bring a CV with you?

A. I did not.

MR ERICKSON: I already gave you one.

A. I'll be very happy to send you a new CV.

(Henry deposition Exhibits 1-2 were marked for identification.)

Q. (By Mr. Mencl) Doctor, is Exhibit 2

the chronology of the medical. records that were sent to you by Mr. Erickson?

A. Yes, it is.

Q. I notice that's typewritten. Are the handwritten marks, marks that you put on there?

A. Yes, they are.

Q. It is my understanding that you have developed some opinions on whether or not Dr. Allin, the emergency room doctor, deviated from appropriate standards of care in treating Mr. Porterfield, and an opinion on causation, the cause of his spinal cord injury. What I am wondering is, are some of these depositions simply background that weren't particularly important in forming your opinions? I know that myself, sometimes I send a whole lot of depositions to an expert just to be on the safe side because it may be important.

MR. ERICKSON: Is that a question about what you typically do? I was going to object, but then you changed the question, and what you just said is not a question.

Q. (By Mr. Mencl) All right. With that preface, are any of these depositions that you looked at, after you reviewed them, do you

consider them simply background, or do all of them contain information that's important?

A. Well, I divide the depositions into two groups, those which are the depositions of experts, are people who are commenting on the situation. They are background, but they do not way. After all, that's just another expert's opinion of what's happened in the case. However, the depositions of those people who are material fact witnesses in the case or involved in the provide some of the basis on which my opinion was derived.

Q. With a patient like Darren Porterfield, the type of injuries he sustained on that Friday night, November 20, 1987, what courses of action for an emergency room physician would be appropriate?

MR. ERICKSON: Objection. The question is overly broad and vague.

A. I can comment on your question, I think; in pieces.

Q. (By Mr. Mencl) Okay.

A. It is broad, but I will begin sort of

sequentially moving. I think that the principal job of the emergency physician in an unselected emergency department, where you see everything, is stabilization, initial stabilization, identification of those problems which are immediately life-threatening, and then proper disposition of the case. I mean, getting the case to a continuing care physician who will assume control, because this is what I do for a living everyday. It's what I did last night, so if I look a little tired, I saw five or six Garren Porterfields, or potential Garren Porterfields last night when I practiced.

And in my role, my view of the role of the emergency physician is the initial stabilization and mustering the correct forces together, bringing those people together who will manage the problem. But the initial stabilization of any one patient is always balanced against the fact that, you know, you are seeing multiple patients who you must treat, so I answer view it as the be-all, end-all of care. It is the initial management phase.

Q. You mentioned you had occasion to see some patients last night who are like Garren

Portafield. What prompts a question of in general, of all the traffic accident victims that are seen in a typical emergency room, can you give me an idea of what rough percentage involve or have alcohol on board, have alcohol or drugs in their system?

A. Obviously, it depends on where the study is being done. I mean, if you're using as your control group the Mormon Tabernacle Choir, it may carry a different result than a control group if you're using people outside of Run D.M.C. concert. Let me just tell you that the data would suggest that in this country, 50 percent of all people involved in serious injury or fatal auto accidents, at least 50 percent, have a toxic level of alcohol on board. Now, you can break that down further, if you would like, and --

Q. When you say toxic,' do you mean like, is it what lay people would think of as legal intoxication?

A. That's right. I'll use the phrase legal intoxication, which varies from state to state, but if you use the point one standard which is, you're close in most states. That happens to be what it is in Michigan, that that's the level

at which we're talking about. Actually, there's a very good British study which looked at all people coming to emergency departments between 10:00 p & and 8:00 a.m. in the morning, no matter what they came for, having cut fingers, stubbed toe, abdominal pain, and found that just about 50 percent of those people had significant alcohol level on board. So --

Q. And this study that concluded that at least 50 percent of the people in serious traffic accidents had alcohol or drugs on board, was that prolonged stretched over a period of time where, you know, they would study weeks and weeks? They weren't looking at, for example, just a weekend?

A. No. Those are taking like years' statistics, and taking all comers.

Q. So in your opinion, based on your own experience, on a weekend, on a Friday or Saturday night, is there been a higher percentage of the traffic accident victims that come in with above a legal level of alcohol in their system?

A. I will say that subjectively speaking, from my own experience, from the local experience, that's true. That is my gestalt. That is correct. I do not have a study which would defend

case, I've been provided with just a very, very general statement that you are going to testify that Dr. Allin did not deviate from the standard of care and that Dr. Allin did not cause Mr. Porterfield's spinal cord injury. You probably have some more specific opinions in that regard.

A. I do.

Q. Okay. Why don't we start with the opinions regarding the standard of care, and then we'll talk about causation,

A* I think that --

MR. ERICKSON: Doctor, there is no question pending.

Q. (By Mr. Mencl) Doctor, would you tell me your opinion on standard of care?

A. What do I think the concept is, or do you want what I consider the standard of care in this case?

Q. The standard of care -- what should have been the standard of care in this case.

MR. ERICKSON: Objection. The form

of the question makes no sense. It's also overly broad and vague.

MR. OLIVER: I also would object that it's argumentative. It assumes the standard of care that was applied in this case was inappropriate.

MR. ERICKSON: Why don't you ask him some specific questions that make better sense, please. And I'm not trying to give you a hard time, but I think you'll get to the heart of the matter a little sooner that way.

Q. (By Mr. Mencl) Doctor, are you of the opinion that the care Dr. Allin gave on Friday, November 20th, and the early morning hours of the next day, was appropriate when you match it against standards of care that you're knowledgeable about?

A. Yes. Considering the chart and the deposition testimony, I believe that his actions were perfectly consistent with the standard of care.

Q. Can you explain to me specifically why, why you feel, that way?

A. Well, I believe that the -- in a case, in a patient such as Darren Porterfield, the

standard of care requires that one initially, when a patient is brought in from an auto accident in which there is significant alteration of mental status, that the standard of care requires that one go, proceed through the basic trauma stabilization process, which includes cardiac status, or airway management, breathing, cardiac status.

Q. I've seen an acronym in some of the medical literature called the A, B, C's.

A. Yes.

Q. What we're talking about, airway, breathing, circulation?

A. Yes.

Q. And then there is there another C for cervical spine?

A. Two other C's.

Q. What are they?

A. Cervical spine immobilization, or consideration, and the other one is compression of obvious hemorrhage so that you don't let people bleed to death. I mean, that would be a consideration after you make sure that they're breathing, so those are consistent with the standard of care. At least the actions of Dr.

Allin at this point in time are perfectly consistent with the standard of care.

Once the initial stabilization phase is complete and you realize that they aren't going to die on a minute-to-minute basis anyway, then you do a secondary survey looking more carefully at the limbs, looking at the chest and the abdomen and the neurologic status of the patient, and decide what further testing may be appropriate.

Usually at that point a decision is also made as to the appropriate service or the appropriate followup physician who will become, involved in the care of the patient, so it is important, and it is required by the standard of care that the emergency physician get a followup

responsibility of the patient.

MR. ERICKSON: Hold it. Wait a second. You changed the question. First you asked him about the A, B, C's in general, and then

at the end you asked him about the C-spine. That's a double pronged question, and I need to object for that reason, in that it's compound.

Q. (By Mr. Mencl) Let me rephrase it. What did Dr. Allin do to initially stabilize Porterfield's cervical spine?

A. I think he continued the stabilization which had been presented from the EMT's, which is the usual state. I mean, obviously, EMT's vary in their aggressiveness and in their quality. If one knows that the patient has not been immobilized, then you may want to immobilize them before you send them for studies. If the patient is already immobilized, you just ascertain that that immobilization is adequate, and then you can send the patient for studies with that immobilization in place.

Q. Was the immobilization in this case a hard cervical collar, typically called a Philadelphia collar?

A. Yes. It was a -- it was an extrication-type collar, which is used by most of the EMT services,

Q. Is it your understanding that Porterfield came in from the paramedic unit, not

only with a hard cervical collar, but with sandbags on his head and on a back board?

A. Yes, which is again a typical mode of immobilization.

Q. Once a patient is in the emergency room, do the sandbags help to immobilize the spine, or is that something that is only useful during transportation?

A. Well, sandbags are just a mode of immobilization. I mean, the effect of immobilization is to prevent rotation, flexion, extension in several planes of motion. Now, some places do not use sandbags. Some people use a tape system, I think that it's perfectly reasonable to use sandbags. Some people have come up with other methods. I don't think one is any better than the other. You just need to maintain a system which prevents some sort of anteroposterior motion and some sort of lateral motion of the spine.

Q. Well, but wouldn't the hard cervical collar alone prevent that motion?

A. The hard cervical collar alone can prevent the AP motion pretty well.

Q. By "AP," what --

A. Anterioposterior. That's putting the chin to the chest. By putting an actual physical barrier between the chin and the chest, it will prevent that motion.

Now, the side-to-side motion, the lateral rotation, if you put sandbags on either side of the head, that will help to prevent that, but some people will prevent that by actually taking strips of tape and taping the head to a board, or they will use a strap off the back board that prevents side-to-side motion of the head.

Q. Okay. So the use of either tape or sandbags in conjunction with a cervical collar would be appropriate.

A. Yes. Again, there are certain cervical collars, which depending on how they fit on the board, will also prevent that motion, but there are multiple systems to do this.

Q. Right. But in talking about this Philadelphia collar --

A. Yes. And the Philadelphia collar usually puts something beside the head or a piece of tape or something like that.

Q. For a patient like Darren Porterfield, would t e standard of care required that to

immobilize his cervical spine that he be continued, not only in the hard cervical collar, but with the sandbags or tape?

MR. ERICKSON: Are you talking about in the hospital or in the ambulance?

Q. (By Mr. Mencl) In the hospital.

A. I think that you could use tape. Some places use a blanket., If they take the sandbags and tape off, they just put a blanket on either side of the collar. Some places have a board wedge that goes on the collar, You don't have to use a sandbag. You don't have to use the tape. But you usually use something which stops them from moving around.

Now, some people merely just, they have straps on their cot and on their board which prevents that kind of motion. And some of it, by the way, depends on the activity level of the patient., We have a lot of fighting drunks, obviously, in whom immobilization techniques may vary, so that it will depend on the psychological state of the patient.

Q. In a patient like Mr. Porterfield, does the standard of care require that the doctor make a written order in the medical chart to keep the

neck or cervical spine immobilized if he has not yet ruled out the possibility of cervical fracture?

A. No. I mean, I did this five times last night. I never wrote an order to maintain something that was already started. Now, if it has not been begun, then you write an order to let that process commence, and it should be assumed that that will remain in force until an order to stop that has been written or has been given, so that if a process is already going -- it's like oxygen. If the oxygen is on, we don't write an order to say maintain oxygen. We write one where we want to change that.

Q. Okay. So is it your opinion that once the cervical collar or any type of immobilization device is on the patient's neck, that it takes a doctor's order for that to come off?

A. That's the way it should work, yes, that the immobilization of the neck is something which would require a doctor's say-so to discontinue.

Q. Would the order to discontinue that, should that be documented in the chart?

A. It should be.

Q. Now, is that something that's typically written by the physician or written by the nurse?

A. If it's a verbal order, you occasionally will see "verbal order, Dr. Henry, remove cervical spine immobilization." Occasionally the doctor will actually write it down himself, but someone should note that they've been given permission, because usually the nurses and the techs are all trained not to remove the immobilization until they've been specifically directed to do so.

Q. So is it a fair statement that in your opinion, a nurse, either an ICU nurse or an emergency room nurse, would not have the discretion to remove a cervical collar from a patient like Darren Porterfield without a doctor's order?

A, Depending on the situation. Obviously, if you need immediate access to the neck where a patient's vomiting and drowning in his own vomitus, you may do something. But let's say as a general rule they would not have that discretion to discontinue cervical spine immobilization unless so directed.

Q. Could you tell from your record or any

A. I can't tell you whether he kept -- I don't see a specific order to take them off. I can't tell you whether they were taken off. As a matter of fact, I never see a specific order by the doctor to discontinue anything, so I can't tell you whether he gave an order or didn't,

Q. would that be the same thing with the cervical collar, that -- what I mean is with the removal of sandbags, is that something that should require a doctor's order?

A. well --

MR. ERICKSON: Objection. It misconstrues what Dr. Henry has already told you, or he indicated that there are lots of different ways of immobilizing a patient in a hospital and it doesn't need to necessarily be with sandbags.

A. Certainly we may -- we often remove the sandbags and just leave a tape or something like that on the head if we're sending a patient to x-ray because we're going to do a shoot-through of the neck, so we want as little scatter or as little absorption as possible, and so it is very common to leave people in a collar and remove the

sampling so that we can get a decent picture of the area. So that's pretty standard.

Q. (By Mr. Mancl) You mentioned after the A, B, C's were done, then there's a secondary survey.

A. Yes.

Q. And maybe the chronology could be helpful for you. When exactly did Dr. Allie perform the secondary surveys?

A. I think his secondary survey was performed as he was doing his primary survey, I mean, since they didn't have to surgically establish an airway. Since he was already taking breaths, since he had a pulse, then he has other physical exam findings on the chart. Now, I'm sure that he did -- it's hard to say which minute on a minute-to-minute basis that he actually did that, but that -- everything else is really secondary survey of the patient.

Q. Well, if a doctor does secondary survey as part of the primary survey and then two hours later checks back with the patient and does another survey, do you call that a secondary survey as well?

A. It's just a re-review of the patient.

I mean, there's a primary and secondary survey. Those are initial evaluations. If two hours later he does something else, that's really a re-evaluation of the patient

Q As part of the secondary survey, is it important for an emergency room doctor to determine whether a patient like Darren Porterfield has any movement of his extremities?

A. Well, certainly it's part of the process. I mean, clearly, in an awake patient, it's not a very difficult thing to determine. In a patient with altered mental status, it may be extremely difficult to determine because there is a clear difference between voluntary movement and involuntary movement, and involuntary movements are movements, but they're not under the control of the brain itself, so you can make a patient with a complete spinal cord injury move just fine

Q. But you would have put some -- well, how would that happen with a complete spine --

A. Because you have a reflex. After all, the spinal cord reflex still works, and certain stimulation; I mean, if you actually take a patient who is paraplegic, quadriplegic, take their leg, you can push on the bottom of their

foot, and you can get a continuous motion, called a clonus. You can actually stroke the bottom of their foot and get a triple response leg withdrawal, so movement by anyone who is actually, you know, sophisticated in the discussion of movement would be divided between those things which are voluntarily done, and those things which are done at a reflex level. The problem with altered mental status patients or comatose patients is you don't know why they're moving something, so it's hard to say that they've got, quote, unquote, movement and decide whether it's voluntary or involuntary.

Q. What if a patient like Darren Porterfield was observed making random movements of his arms and legs without any stimuli, without any painful stimuli?

MR. ERICKSON: Hold on. I need to object. That asks the doctor to assume facts that aren't in this case, and that won't be in this case, or if they are, maybe you should give him more specific information as to what exactly about Darren you're asking. Or if you're asking in general, for some general comment that's not related to Darren, then don't include his name in

the question. The question for those reasons is unfair and vague and confusing.

Q. (By Mr. Mencl) Do you remember the question?

A. Yes, I do.

Q. Okay.

A. Again, it is impossible to comment on that without knowing the specific circumstances, because certainly patients who have a disconnection between their brain and their spinal cord can still have movements, even random-type movements. They can still have reflex movements going on, not generated by a stimulus, but not voluntary either, so I would have to actually know -- I would have to actually observe the movement to decide.

Q. Well, do you believe that Dr. Allin was able to determine that night whether Porterfield had movement of his extremities or not?

A. Not well, no.

Q. Not well?

A. I mean, he --

Q. What do you mean by "not well"?

A. Because the patient was -- he had just an altered level of consciousness that he would

not know, and was not able to determine whether the patient had voluntary control of various aspects because he couldn't ask the patient to perform certain activities, so -- and, of course, the spinal cord is regionally organized so that to actually test all these modalities carefully, you need, to some extent, the cooperation of the patient, and clearly, clearly with altered mental status, that's very difficult to do.

Q. If Mr. Allin couldn't tell for sure whether Warren Porterfield had movement of his extremities, would it be important to assume a spinal cord injury if that's the case, if he can't tell?

MR. ERICKSON: Objection. The question asks about whether Mr. Allin could tell for sure whether Warren Porterfield had movement, and I think you're mixing apples and oranges, John. The doctor here was just telling you the difference between movement versus volontary movement. For that reason, I think your question could be misconstrued or wagwa. I think he could tell for sure that the guy was not moving. You may not be asking him that.

MR. MENCL: What?

MR. ERICKSON: What he said was that you can't test someone who was unconscious and comatose to tell whether they have voluntary movement. You can observe movement but you can't tell what it means, and you just said the term movement, and you didn't include voluntary movement, and for that reason your question is confusing and misconstrues what I'm objecting to it.

A. And I do remember your question.

Q. (By Mr. Mancl) All right. Okay. Would you go ahead and answer it?

A. Yeah. I believe your question refers to what should be the assumption of an emergency physician if a patient, if you cannot tell what the movement status of that patient is, what should be your assumptions, what should be your rule-out and what should be your thought process, really.

Q. Exactly. Exactly.

A. Okay? So my feeling about it is this that you should assume an injury until proven otherwise, maintain your basic immobilization and wait until the dust settles, and when the patient

wakes up or when you can get a better examination, then you can make a decision.

So what I would say is when the patient is in the emergency department, at that moment in time, their status is indeterminant. It has not been decided, so that I tend to -- it is my feeling that the standard requires that you don't draw any conclusions.

What you can say is I don't see a focal problem at this point in time, but I don't know, and that information then should be conveyed to the team that's going to take him over so that. they can then follow up on that or check on that as necessary.

Now, we frequently see patients whose x-rays are initially thought to be normal who we immobilize, and later, when they wake up, find that they do have some problem. So this is not, not an uncommon situation.

Q. Is it your understanding that while Darren Porterfield was in the emergency room, that Dr. Allin never did rule out a cervical spine injury?

A. Not completely, no.

Q. And if an emergency room doctor doesn't

rule it out completely, he should continue the immobilization, is that correct, of the cervical spine?

A. Yes I don't -- I think -- I don't think he should discontinue it.

Q. Okay.

A. And so I think that -- I mean, that's why there are trauma surgeons and people who will follow the case up who understand all the nuances of that, and I think that -- I think that you shouldn't make assumptions that you can't back up.

Q. Did you note in Nurse Ambrose's deposition a passage where she said that once Porterfield got to the ICU floor, there as a phone call made to Dr. Allin, and that Dr. Allin authorized the removal of the cervical collar?

MR ERICKSON: Objection. That misstates what Nurse Ambrose said in her deposition, and --

MR. MENCL: How does it misstate it?

MR. ERICKSON: I don't think Nurse Ambrose said that she spoke directly to Dr Allin

MR MENCL: Well, I don't think I said that either>

MR. ERICKSON: That's the way your question sounded.

MR. OLIVER: I think it is

MR ENCL: I said there was a phone call.

MR. ERICKSON: By someone who said they thought they talked to Mr. Allin. What is your question? Whether he remembers seeing that in the deposition?

Q. (By Mr. Mencl) Yeah. Do you remember seeing that passage in the deposition?

A. I remember understanding between these two depositions that there is a conflict of fact.

Q. Right.

A. Which no expert can resolve.

Q. Exactly That's for the jury.

A. That's right.

Q. Right.

A. Okay. So what I can say is that I found nothing -- no one can testify that they actually spoke to Mr. Allin. I know that there is a discussion of some type of phone call to some source who thinks that was what was said. Now, I find nothing -- I find no order written to discontinue the immobilization, and I find no one

who actually spoke to Dr. Allin. I am aware of this conflict of fact in the record.

Q. Right.

A. And I can't resolve that.

Q. Let me ask you to assume for the sake of discussion, assume that there was in fact a phone call that night from an ICU nurse to Dr. Allin, and if Dr. Allin indeed did tell the nurse that they could take the collar off, wouldn't that be below the appropriate standard of care?

question to the extent that it asks the doctor: to assume facts that aren't in evidence, that won't be in evidence, and also to the extent that it asks the doctor to specifically not assume that perhaps that conversation did not take place or that the nurses talked to somebody else, and that maybe you should have sued somebody else here, John.

MR. MENCL: Can you -- will you read back the question?

A. I understand the question. Assuming' all the caveats just mentioned --

MR. ERICKSON: Also, I need to add another objection now. You leave out the question

about whether that had any bearing on this case when you asked him about whether there was a deviation from the standard of care, which I think also is something that needs to be included in his answer.

Q. (By Mr. Mencl) You can go ahead and answer.

A. Again, assuming all caveats, which are --

Q. By caveat -- what I want you to assume are the facts that I just gave you.

A. Right. And as added to or at least amended by defense counsel, all these other various factors, I can say this. That the act of not maintaining the cervical spine immobilization until one is comfortable with cervical spine evaluation falls below the standard of care. Now, by that answer, I do not mean to imply a causative or a proximate cause relationship between that violation of the standard and any harm that may have befallen Mr. Porterfield.

Q. Okay.

A. You know, I'm not saying that there was any relationship between --

Q. Well, I didn't ask -- yeah, right. I didn't ask you about the causation of it.

A. Right.

Q. Just so I can get a clean, sort of clean answer on the record, if there was a phone call to Dr. Allin when Darren Porterfield got to the ICU floor, and if Dr. Allin authorized the removal of a cervical collar, based on the records that you have reviewed, would that be below the standard of care?

MR. ERICKSON: Same objections as I previously stated with regard to asking him to assume facts that aren't in the case and to specifically exclude facts or other alternatives that may have occurred, and also that the question leaves out an important issue of causation.

A. Yes. It would fall below the standard to remove cervical spine immobilization until one felt comfortable with the cervical spine.

Q. (By Mr. Mencl) Okay. Did Dr. Allin ever feel comfortable with removing immobilization from Mr. Porterfield's C-spine?

A. No, not according to his own deposition testimony.

Q. would it be important if an emergency room doctor had not yet cleared the C-spine to clearly communicate that fact to the next

physician who was going to take charge of the patient?

A. Well, I think it's important to convey to him what you have done to a certain point in time, what you obtain. That physician will then decide whether he considers it adequate or inadequate as he manages the patient in the hospital. Some physicians may want more or fewer x-rays. Some may want special views. I think that you -- I think you have an obligation to tell them what you have done, and whether you think that's adequate or inadequate is going to be the judgment of the physician assuming control of the case, because he then must take responsibility for the management of the patient.

Q. Well, if you're a board certified physician in emergency medicine, and the next physician is not board certified in emergency medicine, is there anything that would be inappropriate in an emergency room doctor giving his opinion as to what should be followed up on?

MR ERICSON: Wait. I need to object to that question because it's irrelevant. You're switching it around and asking is there anything wrong with him giving additional

information. That's not the issue in this case, John. The issue is whether what he did met the standard of care, not whether it would have been okay to do more. Also, your question is flawed in that it seems to assume that at certain points in time patients get transferred from one board certified emergency room physician to another board certified emergency room physician, which I suspect doesn't happen as a matter of practice.

Q. (By Mr. Mencl) Let me approach it this way. With a patient like Darren Porterfield, based on the records you have reviewed, based ,on the fact that he had a lateral C-spine and an AP view, and those are the only imaging views of the cervical spine, based on the fact that there's nothing written in the chart about immobilization, within the appropriate standard of care, what should be communicated to the next physician?

A. Exactly what you've done.

Q. Which would be what in Mr. Porterfield's case?

A. These two views that have been obtained. Immobilization has been maintained. That at some point in time the next physician will: reevaluate the patient, take a look at the patient

and decide whether further studies are required

Q Well, in your opinion, to clear the cervical spine in somebody like Mr. Porterfield, would those two views alone be sufficient?

A. As a matter of fact, to actually, to fully clear the C-spine requires the combination of both history, physical and the radiographic studies so that, no, those two views are not adequate to fully exonerate the cervical spine as a causal problem.

Q. But just focusing on the radiographic aspect, are additional views required to radiographically clear a cervical spine?

A. Yes. To completely clear it, yes.

Q. What additional views?

A. One usually considers the open mouth odontoid as important That allows you to look at the lateral masses of C2 -- C1, rather, as they sit in relationship to C2. You need to see obliques. Now, there is a debate as to how important the obliques really are, but between an AP, open mouth odontoid, lateral and the oblique, those are the usual five used which are obtaining, understanding the fact that you could still have cervical spine injury and no finding on those

films.

Q. What about i instead of an odontoid wire and an elique, Porter felt would have had a CT scan of the cervical spine? Would that have been okay too? I mean, would that be another way to --

A. Well --

MR. ERICKSON: Wait a second. I need to --

Q. (By Mr. Mancl) Would that be another way to radiographically clear the C-spine?

MR ERICKSON: Is your question, can you clear the C-spine by doing a CT scan?

Q (By Mr Mancl) Well, my question, I guess is predicated on the fact that it's -- I think you're saying that you can clear the C-spine in more than one way if you have sufficient plane films, and I guess what I am asking is if you have CT of the neck, is that a different way to clear -- is there more than one way to skin a cat, I guess is what I'm asking.

MR ERICKSON: I need to object to that question since we're not talking about skining cats.

MR OLIVER: No foundation.

MR. ERICKSON: John, I want you to ask a straightforward question that makes sense.

MR. MENCL: You keep objecting as if my questions don't make sense.

MR. ERICKSON: Well, you stopped that last question about halfway through your sentence and were expecting Dr. Henry to answer, and then you never asked him another question that was straightforward and made sense.

Q. (By Mr. Mencl) Dr. Henry, if Darren Porterfield's cervical spine would have been CT scanned on Friday night, would that have been an appropriate way to radiographically clear the C-spine?

A. Well, it may have been a way to do it.

why we have myelograms. We have MRI's and we have

is another approach that could be used. We don't usually use that approach in trauma patients early on simply because of immobilization questions and the patient has to be perfectly still, and there are a lot of other questions which arise, particularly with patients who are intoxicated,

but it is a method which can be used. Probably the most regional method is just maintaining immobilization, waiting until the patient sobers up and trying to get cooperation and trying to get proper films is my usual method of doing things

Q. Did you see in the records where Darren Porterfield had a CT scan of his head, chest and abdomen?

A. Yes.

Q In your opinion, was there any medical reason that contraindicated doing a CT scan of his neck?

A. Contraindicated it?

Q. Right.

A. Well, only that you've got the patient immobilized, you basically don't want them to spend more time than they have to down at the CT scanner, particularly when they're intoxicated or have altered mental status, because obviously, you're not going to communicate with the patient, then, because they have to be in the scanner, so there are good medical reasons for not spending a lot of time doing t e scan

Q How much time does it take to do the CT scan?

A. It depends on the generation scanner that you have and how the images are being produced and what kind of cuts you are making, because you can produce, to do refined cuts, looking for very subtle things, subluxation, for example, requires you to do very careful sections, looking, so it can take considerable time.

Q. Assume you're doing point-five millimeter cuts.

A. Yeah. The patient may have to be in there for another 15, 20, 25 minutes.

Q. How long does it take to do a CT of the abdomen?

A. Again, depends on how many cuts. He may be in there for 10 minutes, 15 minutes.

Q. Can you specifically tell me what it was about Darren Porterfield's medical condition that contraindicated doing a CT scan of his neck?

A. Well, that's the reverse of how we usually view things in medicine. It would be -- because there is no contraindication of me having one right now. The question is, is there an indication for me to have one right now.

Q. And those are two different things; right?

A. Right. They're totally different views. I mean, I can tell you that there is one specific thing which contraindicated it. By the same token, I can tell you that as a usual course of practice, we do not -- we do not do them without strong indication. And so it's just viewing the situation from two different --

Q. Haven't you ever had patients who had been in a car accident, thrown through a windshield, ejected from a car, where you did a CT of their head and a CT of their neck at the same time?

A. I --

MR ERICKSON: I need to object to that because what he's done in taking care of his patients is totally irrelevant to this case. The facts might be altogether different that he's just told you, John, is you look at what somebody requires in the way of medical treatment, not at how can possibly do under circumstances.

Q. (By Mr Mancl) Thank you. Try just to make an objection. I think going into your background and experience, I think is something I'm entitled to do Do you remember the question

A. Yes. The answer is yes, I have done

both, but it would depend on the findings of the patient at a particular point in time, and there are those who would argue that the CT of the neck has both pluses and minuses compared to the actual plane films, so it is a -- since it is a process of looking at bones, x-ray probably is better at looking at bone than CT. Where you're talking about intracranial contents, i.e., the brain itself, CT is a far superior way of looking at intracranial contents, so they are not equivalent studies, nor do they carry with them the same specificity and sensitivity in the two areas, and so it's a -- it is a -- it is a much more complex question than assuming that the CT will pick up all findings because it does not. It has a miss rate which may be equal to or greater than plane films.

Q. Are you aware that Porterfield had a CT a couple days later of his neck?

A. Yes.

Q. Didn't that show multiple fractures in the cervical spine?

MR. ERICKSON: Objection. I think that misstates what they found on the CT. It just sort of generalizes. If you want --

Q. (By Mr. Mencl) It does generalize it. Do you recall --

A. I recall that he had one, and --

Q. Do you recall seeing the report?

A. Yeah. And that -- I recall seeing the report. And it just so happens in that case, it did pick up some abnormalities, but it should not be assumed that the CT scan is a superior method of looking at the cervical spine than well-done plane films because that is really not correct. It doesn't -- it is not the equivalent of comparing skull films, for example, to CT's in,the brain. They're totally different kinds of processes.

Q. Well, was there anything that, say medically contraindicated doing obliques, oblique plane films on Porterfield Friday night?

A. Yeah. Well, oblique plane films are usually done with the cooperation of the patient. You know, and -- and having them turn at certain directions. Obliques are very difficult to get in somebody who is in a collar. I am not -- I am not a strong advocate of the obliques in somebody who is in a collar just simply because it's difficult to position the patient correctly.

Q. I notice you've been provided with the deposition here of Dr. Brooks.

A. Yes. That's the first radiologist?

Q. By the way, have you looked at any of the films in this case, the imaging films?

A. Yes.

Q. Where are they? You didn't bring them with you?

A. No. They were brought the first time I met with defense counsel.

Q. And you weren't given a copy?

A. I wasn't given a copy. I looked at the films.

Q. Do you remember looking at the initial lateral film?

A. Yes.

Q. Did you see any abnormalities in that film?

A. Well, it's almost an unfair question because I knew the end of the play. I mean, I looked at that film, and, you know, it's always easy once you know the answer to figure out exactly where the murder is in Agatha Christy novels. Since I knew the outcome, I could say, well, is that a questionable -- I would say this.

That when I looked at that, to have missed or to have not been able to read the abnormality in that film, to me, would not have constituted a violation of the standard of care. I mean, it's very subtle question. Again, it's always nice to know the answer. If you put up 100 of those films to look at, would I pick out that one? The answer is probably not, no.

Q. And I assume in your practice you probably look at a lot of cervical spine films.

A. I looked at about five last night.

Q. For a radiologist like Dr. Brooks who practices at Providence-St. Margaret Hospital, would you look at roughly probably the same number that he does?

MR. ERICKSON: Wait a second. That calls for total speculation on his part, First of all, you're asking him, Dr. Henry, to compare his practice to a radiologist's, and then you're' talking about a radiologist in a different city that he doesn't know anything about.

MR. MENCL: I don't know if he knows anything about it or not.

MR. OLIVER: I can't help because I don't know how many films he looks at in a year,

John, so, you know, I mean --

MR. REILLY: I object. No foundation. No qualification. He doesn't know.

A. Yeah. I think that's fair. I don't know what he looks at.

Q. (By Mr. Mencl) Okay.

A. All I can comment on is I see a different selected group of films than a radiologist does. I mean, I see those people who have acute problems who come from the emergency department. I don't look at cervical spine films for osteophytic involvement and all kinds of qther processes, so --

Q. Well, let me ask you this. When it comes to trauma patients in automobile accidents, do you read your plane films yourself, or do you always consult with a radiologist?

A. I always do the initial reading myself, but there is also an overread, a quality ove'rread by the radiologists simply because the -- in the heat of battle in the emergency department, where you're really running, things, subtle findings can be missed, and so a quality overread is probably a desirable element from someone who is less immediately followed in the case.

day, or how much of a time lag is there?

A. It varies, If the radiologists are in the hospital, they may read them in 15 minutes. If it's after 5 o'clock, then they will read them the next morning, usually at 7 or 8 **o'clock** in the morning. Or if we have a serious question, they can be brought in that night to read the films with us. Actually, the new system, we actually television-send them to their homes.

Q. Is it important in a patient like Darren Porterfield for the emergency room physician to convey the mechanism of injury to the radiologist?

A. We usually just put trauma, and they understand what we're looking for. I mean, it --

Q. You wouldn't tell them specifically that this is a patient that was ejected?

A. No. No. I don't want to prejudice his view, I want him to read what's on the film. I've got a trauma film, and he really, his job is to look at that film knowing that it is trauma, and that's really all he needs to know, because it doesn't matter whether he fell off a two-foot step ladder or went through a car window. I mean, he's

supposed to read what he sees on the film.

Q. Well, I would think certain mechanisms of injury would help a radiologist look for certain injuries that typically occur because of that injury.

A. Well, there's a very strong school of thought that says the radiologist should have no information. He should just read exactly what he sees. After all, it's the job of the clinician taking care of the patient to take that reading and put it in context with the history and the physical to decide an outcome. I mean, overreading and underreading of films is a serious question in radiology. A lot of studies have looked at that issue. Do you prejudice the outcome of the film by giving them history? The answer is maybe you do.

Q. In Porterfield's case, if you assume that Dr. Brooks looked at the C-spine films Friday night and read them as normal, would it be appropriate for Dr. Allin to still continue the immobilization of the C-spine?

MR. OLIVER: Let me object to the question, first of all as the interpretation of the films were read as normal. I think the

evidence is not clear in the case whether the finding was normal or typical or all right or not grossly abnormal, and so pick and choose one of those words as being the specific word that was said, I think misstates the evidence.

MR. ERICKSON: Also, John, this question is repetitive. He's already told you about what films need to be taken.

Q. (By Mr. Mencl) You can go ahead and answer.

A. I think that if the emergency physician is told by the radiologist that the initial two films do not show a gross abnormality, I think the emergency physician could then use that information in making some decisions.

One of the decisions, however, is usually not to remove -- should not be to remove the cervical spine immobilization, but it may mean that they don't have to put the patient in a traction device that night to realign the cervical spine. So the only information he gets from that is that at t at moment in time they don't have to realign the cervical spine.

So if, for example, there was a total dislocation noted, he would that night ask the

neurosurgeons to cranx them down into halo, put them flatx into line or something like that, so that's the kind of information you get from a limited review of the situation, and I think that certainly with trauma patients, we understand the fact that you're going to have to be -- you may be sending them downx to x-ray, getting other films, clarifying the situation as new information comes along.

MR OLIVER: John, can we take a break right now?

(A short recess was taken.)

Q. (By Mr. Mancl) Doctor, if you remember, before we took a break, the previous line of questioning dealt with my asking you to assume that Dr Brooks interpreted the lateral C-spine film as normal on Friday night. But now what I would like to ask you is that if Dr. Brooks, if you assume that Dr. Brooks told Dr. Allin on Friday night that there was straightening of the cervical spine, no other definite abnormalities are seen, if there is continued clinical concern for cervical injury, however, I would suggest at least repeating the lateral view since there are artifacts superimposed upon the

spinous process, in your opinion should that have made any difference in Dr. Allin's course of management of Darren Porterfield?

A. First in answering his question, I am to assume that what was written on the written copy is what he gave him orally.

Q. Right. Right.

A. Having dealt with radiologists my entire professional career, you know, it's a very difficult assumption. The second thing is this should not change what he's going to do. What the radiologist has basically said is that we don't have a complete study, that if clinical condition warrants that we ought to consider other things, you can't tell the clinical condition yet because this patient hasn't woken up, so I think what this is, is putting the physician on alert that although there is no definite abnormality at this time, and I think he comments in the body of'the report that this may be due to muscle spasm or positioning.

The other thing is the artifacts which he notes could certainly be from the collar itself or from the immobilization setup, so that at some future point in time, if it warrants that you need

to reexamine the patient, I think that none of that would change, or should change what Dr. Allin does.

Now, this is a very standard pattern which lets us know that there may be nothing you saw to do at this moment; however, it does not totally exonerate the cervical spine as a potential source of problem should other symptoms arise.

Q. As part of a clinical concern, though, that phrase is used in that report, clinical concern, isn't part of clinical concern, though, the principle, assume a cervical spine injury until you can rule it out?

MR. ERICKSON: Objection. That question makes no sense.

Q. (By Mr. Mencl) Is that --

A. I think you've read huge amounts of things into this. It says if there is continued clinical concern, that is a brainstem reflex taught to all radiologists when they dictate reports, and basically what it says -- it doesn't pick out any specific problem. What it says is, if you think there is something else going on, we need to more clearly define the films, but he's

not sending any particular message, at least that's not my interpretation, of what -- I can't look inside the heart and mind of that radiologist, but that is a very -- that is the standard disclaimer which really says, you know, the x-ray isn't the patient, If you think there is still something wrong, there's something wrong.

Q. Do you have any opinion that Dr. Brooks should have interpreted the film differently than he actually did?

MR. OLIVER: Let me object before Dave objects as lacking foundation in this witness to testify as to the standard of care of a radiologist. I don't think he's been proffered for that purpose.

MR. ERICKSON: That was exactly the point of my objection, John. We've listed Dr. Henry as an emergency room physician on the standard of care of Dr. Allin, and also he has some opinions on causation. He is not a radiologist, and we haven't listed him as an expert witness on the standard of care for radiology.

Q. (By Mr. Mencl) I guess in light of Mr. Erickson's comments, it is my understanding you

don't intend to come to trial and testify to any criticisms of anything that Dr. Brooks did or didn't do.

A. I do not intend to speak to the standard of care of a radiologist. I mean, I understand the -- I can speak to the standard of care of the interaction between an emergency physician and a radiologist, how they communicate, but as to the technical reading of a film by a radiologist, I would not speak to that issue.

Q. Let's talk about the communication between Dr. Allin and Dr. Brooks that night. Is there anything about that communication that you are critical of Dr. Brooks about?

A. No. I mean, if two films are obtained, and he has these reservations, them two films have been obtained In no place that I have ever . practiced is that considered to be a complete cervical spine series, and he's conveyed the fact that this is not a complete series, I certainly can't give you a clean bill of health on the cervical spine, then that's what Dr. Brooks is required to do.

Q. You're not saying that Dr. Brooks should have told Dr. Allin, well, look, let's have

some more films right now before the patient goes to ICU.

A. No, He can shoot the films right then if he wants to, I mean, he's in the radiology suite. He can shoot more films if he wants to.

Q. Well, I believe these films were portable films.

A. Right. But he can certainly call up and say, let's shoot them now. But the point is, most radiologists leave that kind of discretion-making to the clinician. I mean, a radiologist doesn't -- really doesn't treat this kind of stuff, and what he's going to say is, I don't have a complete series to clear you. There may be other things going on. This guy could be dying, I mean, so it depends on what the priority is at that moment in time.

Q. I think at the time Brooks looked at the C-spine films and had a conversation with Allin, and Brooks was looking at the CT scans of the head, chest and abdomen.

MR. ERICKSON: So what's your question? That wasn't a question you said, John. You told us what you thought.

Q. (By Mr. Mencl) Back to talking about

Dr. Brooks and Dr. Allin. If you assume that Dr. Brooks was looking at CT scans of the head, chest and abdomen, and that he looked at the lateral and AP film on Darren Porterfield, in your opinion was there anything that Dr. Brooks should have communicated to Dr. Allin that he didn't?

MR. OLIVER: I'm going to again object to the form of the question. I think you're now getting into what the standard of care of a radiologist is with regard to his duties and obligations and not what the communications are between these two services.

MR. ERICKSON: Same objection.

Q. (By Mr. Mencl) You can go ahead and answer.

A. It seems to me that if Dr. Brooks conveyed which studies were done and what those studies showed, then he -- then at least the interface between the doctor, the radiologist and the emergency physician has been satisfied. After all, it's not his job to decide what the priorities are at any one moment. It's his job to say what is'on the films, and are they a complete series or aren't they. It seems to me he's conveyed that.

Q. Wouldn't Dr. Allin be aware of what a complete cervical spine series consists of if he's the emergency room physician?

A. Yes. I'm sure that Dr. Allin understands what constitutes a complete cervical spine series.

MR. OLIVER: John, let me also make a further objection to this line of questioning.

MR. MENCL: I'm going to get off it.

MR. OLIVER: In case you get back on it, you have assumed throughout this that there is some prevalent national standard of care with regard to communication between a particular physician and a particular radiologist, and I'm not sure there is any evidence of that or that there will be, so I will object to your line of questioning. It makes that assumption.

Q. (By Mr. Mencl) If you recall, Dr'. Allin also had a conversation that night with a Dr. Kuebler --

A. Yes.

Q. -- who was a thoracic surgeon.

A. Yes. General thoracic surgeon.

Q. Based on your recall of their

conversations from reviewing the depositions, in your opinion should Mr. Kuebler have anything that he didn't do, or is this the same --

MR. ERICKSON: Yeah. I mean, we have listed him as an emergency room physician to give opinions on standards of care of emergency room physicians. We're not having him give opinions of Mr. Kuebler. Your own experts have already criticized Mr. Kuebler. Okay? I think he'll probably give you the same answer that he just gave you, which is he knows about the way that emergency room physicians talk to other doctors, but we're not listing him as an expert against Mr Kuebler We don't need to do that in this case. There's already many experts that have testified against Dr. Kuebler.

MR. OLIVER: Anymore. We don't need to anymore.

MR. MENCL: Well, with that representation, I won't ask him whether he has any criticisms of Mr. Kuebler's care because you won't be soliciting that at trial.

Q. (By Mr. Mencl) What did the management of Warren Porterfield switch from Mr. Allin to Dr. Kuebler?

A. When Dr. Kubler accepted this trauma case. My understanding is Kubler was the trauma surgeon on call, and that when Dr. Kubler accepted the phone call, got the phone call and accepted the patient on his service, at that moment in time, the management of this case shifted.

The emergency physician has to be in a position to move on to the next case that's in the department. He can't be expected to practice medicine for people in the hospital on an ongoing basis, so that's why when that phone call is made, the decision is made to admit, Dr. Kubler then bears the responsibility for decisions made about his patient in the intensive care unit.

Q. And when was that?

A. I believe the phone conversation and the acceptance of admission was somewhere around 2:30 in the morning. I would have to actually look at the record, but I think that's pretty close.

Q. On the first page of Exhibit 2, chronology, about midway down there is a -- I see a notation that says, 'Referred to Dr. Kuebler on

11-21-87 at 0210." Do you see that?

A. Yes.

Q. Would that be 2:10 a.m., in the morning?

A. Yes.

Q. Is that your understanding of what the records show?

A. Yes. That's when the contact was made.

MR. ERICKSON: John, just to --

Q. (By Mr. Mancl) Would it be that point in time when the care would transfer the management of the patient?

A. Yes. And I would make this clarification, that the ongoing management of a patient has then been transferred. Now, should the patient have a sudden deterioration in the emergency department prior to movement to the floor, the emergency room physician still has an obligation to reassess the patient and take over care at that moment in time, and there certainly can be areas of overlap when two physicians are simultaneously managing a case, but once the patient has been accepted on the service and is moved to the ICU, that patient is now the patient of Dr. Kepler's

Q. Who wrote the admitting orders?

A. I think the initial orders were written by Dr Allin.

Q. So Dr. Allin would be responsible for those orders.

A. He's responsible for the orders in that it allows the patient to enter the ICU with some directions. He's not responsible for the ongoing care of the patient in the ICU, but he is responsible for that initial fluid rate and those sorts of things.

Q. Did you rely on this chronology in formulating your opinions?

MR. ERICKSON: John, this is as good a time as any to make a statement. I think we've already given you the chronology, and I am under the impression, I think that one of my paralegals prepared that chronology. It is not a chronology in a summary fashion, I don't think What I instructed my paralegal to do was to simply put together in typewritten form the medical records. It's not any attempt to summarize it We've given you the chronology months ago, and if if there is an error that you are aware of, just tell him. It's simply to make the chart more

legible, frankly.

MR. REILLY: I think you're going to find the doctor may have looked at the chronology, but he probably read the chart himself, but you may as well ask the doctor.

A. I did not rely on the chronology for the facts of this case. What it did was allow me to clarify some handwritten materials which were difficult to read, and I basically verified things throughout the chart, so the chronology was useful in clarification. I did not depend on it for any factual information.

Q. (By Mr. Mencl) Did you notice any errors in the chronology?

A. None that stick out in my mind at this moment. There may be some, but it did not stick out in my mind.

MR. REILLY: Was the phone call later than that, John? Do you want the doctor to look at the chart to verify the call to Dr. Kuebler?

MR. MENCL: That's not particularly what I was thinking of.

MR. ERICKSON: If there is --

MR. MENCL: The initial --

MR. ERICKSON: Wait a second. I need to make some objection. If you are aware of some error in this chronology that was prepared by my paralegal and you're somehow trying to trick or trap this witness, that's an unfair question because he didn't prepare it. He said he hasn't relied on it, and I'll take credit for my paralegal. If you have a question about the chronology or are aware of some error, I think you should point it out to the witness.

MR. MENCL: You're talking about my obligations. I think you ought to give him something that's accurate.

MR. ERICKSON: Is it not accurate? If it isn't --

MR. MENCL: You tell me. You tell me if it's accurate.

MR. ERICKSON: I don't know. I told somebody to prepare it to make it easier to read.

MR. REILLY: Gentlemen, gentlemen,

Q. (By Mr. Mencl) Doctor, do you recall. seeing in the records a late entry written by a nurse regarding the removal of the C collar?

A. **Yes.**

Q. Did you place any particular significance on the fact that that was noted as a late entry?

A. I have difficulty in dealing with it because it -- because it's not written as a doctor's order. It's written in a nursing note, not the doctor's order, so there is no specific order given. So in that regard, I have trouble dealing with it.

After all, if he -- if someone had talked to him and said, you know, give him a thousand CC's of normal saline, that would have been written as a doctor's order for co-signature, for voice order, doctor so and so, to be properly signed. So I have trouble only in that I don't know what to make of it. Obviously, it is inconsistent with other testimony, so again, it is open as a fact question to me.

Q. We've been, in a roundabout way, discussing your opinions on the appropriate standard of care and whether Dr. Allin's conduct fell within that standard. Are there any facts that you feel are very important in bearing on Dr. Allin's appropriate care that we haven't talked about?

MR. ERICKSON: Objection. That question is totally vague and ambiguous and unfair to the witness.

MR. MENCL: It's a little broad.

MR. ERICKSON: A little?

MR REILLY: John, do you mean by that, what do you think he did right? Is that what you mean?

MR. ERICKSON: There's lots of facts in this case, and you can look at them all different ways, and it's just a vague and ambiguous question that's incapable of being answered.

MR. OLIVER: Also assume that there are some facts that aren't significant or important.

MR. ERICKSON: Ask him a different question.

MR. MENCL: I'm just fishing for anything --

MR REILLY: I object to fishing.

MR. ERICKSON: Fishing is not allowed. You have to ask specific questions.

A. There's a question on the table you want answered?

Q. (By Mr. Mencl) Yeah, sure, if there is anything in particular.

A. Yes. I think that my opinion has not changed. I think that he comported with the standard of care and that the unfortunate outcome of Mr. Porterfield is in no way proximately related to any action or inaction on the part of Dr. Allin.

Q. Right, okay. Well, that kind of jumps us over to the area of causation.

MR. OLIVER: No. I think that pretty much takes care of causation, John.

Q. (By Mr. Mencl) Is it your understanding that Mr. Porterfield now is a C6 level incomplete quadriplegic?

MR. ERICKSON: I haven't provided Dr. Henry with a lot of information about the plaintiff's current condition. I'll just tell you that. You can see what I've sent to him.

Q. (By Mr. Mencl) Is it your understanding that on Sunday Mr. Porterfield showed signs of paralysis?

A. Yes.

Q. Do you have any opinion that the paralysis occurred prior to the emergency room or

occurred at some point after Mr. Porterfield was in the emergency room?

A. The injury which led to the paralysis occurred at the moment that the accident he was in took place. He had a destabilized cervical spine. He had a dislocation and relocation. That's why the initial lateral spine film actually looks as good as it did, because what happens is the patient's -- the -- they dislocate, they move forward, they bang the spinal cord, and then they have a reflex return action. So he received his initial damage to the spinal cord at that moment in time.

It's not that he had a continuing piece of bone sticking into the cord, because that clearly is not the case. What he suffered was a contusion to the spinal cord with result in ischemia of the spinal cord, which led to the deficits he now has, and --

Q. Are you saying that the ischemia produced delayed onsets of symptoms?

A. Oh, it certainly can. Well, the thing is, you don't know exactly when because he was not of a mental status in the emergency department or throughout that night to properly test him, so you

wouldn't know. But there is no question about the fact that cervical spine trauma and the resultant swelling of the spinal cord, which is a very well-known phenomena, can lead to delayed onset of deficits, and just like if you banged your leg, tomorrow the swelling is worse.

Q. Well, do you see any evidence in this case that he had swelling of the spinal cord?

A. It is sort of -- I think that it would be without question that he did, that he had a traumatic blow to the spinal cord secondary to this subluxation dislocation, and it relocated,. There is no -- I don't think there is any question about that either. He came back into relatively good alignment, but that the physical force of taking the cord and doing that to it when the neural tissue is extremely sensitive, your brain and your spinal cord are extremely delicate tissues, and the resultant trauma and ischemia that goes with that is perfectly consistent with what's seen here.

I've certainly watched patients, who we've had normal alignments on, go on to terrible neurologic deficit, and there was nothing -- there wasn't a piece of intervertebral disc pushing

against the cord we could take out. There wasn't any piece of bone. It was the result of the direct trauma itself which causes the -- which

sort of action when those things broke, when those -- when those facets went forward, you must assume that broke it dislocated it, and that as you get the return movement of the head, you can relocate it.

Q. But couldn't that type of fracture occur without spinal cord injury?

A. Let me say it would be relatively rare. I mean, we get certain kinds of spinal fractures with the actual body. We get fractures to the body as a vertebra. That's not what happened in this case. His fractures are in such a position that you would assume that there must be a dislocation process going along with it. I mean, certainly it makes only good sense of physics.

Q. Couldn't it be a rotational injury?

A. Even if it's a rotational injury, it's caused a rotation of the spinal cord, and the way the spinal cord is set up, sort of embryologically and from every other sort of method is that zones of ischemia move from the inside of the cord out so that when we have rotational injuries in the cord, we have -- there's a syndrome called central

syndrome. These various cord syndromes are not related to direct pressure on the cord, but rather to zones of ischemia due to trauma with the cord. And, you know, it would be -- I think it strains credibility to think that this cord was not contused, twisted or strained during this accident.

Q. So is it your opinion that Darren Porterfield's paralysis was determined at least when he was in the car accident and nothing any of the doctors at the hospitals could have done would have made any difference?

MR. OLIVER: Let me object to the form of the question, John, before the doctor answers. When you say Darren's paralysis, you mean as of today, is it what he's suffering from today? If that's the paralysis you're talking about, you have not given him the subsequent history of changes of his neurological statur'e, after the halo was applied and after the first fusion was attempted and failed and the second fusion was performed, because there were changes. in his neurological status in connection with those.

MR. **ERICKSON:** Also, John, we

haven't sent those records to him and I have not asked Dr. Henry to comment on what Dr. Beatty did or what the course of his neurosurgical care was. He's simply telling you that in his opinion, Darren got hurt on Friday night in the car wreck. Simple as that.

Q. (By Mr. Mencl) The condition that he was in on Sunday, you do have those records?

A. Yes. And I understand your question.

Q. would that condition that he was in on Sunday, would that have occurred even with the best of care?

MR. REILLY: I object. He had the best of care. There is nothing that this physician, expert, has testified to, to indicate that he didn't have the best of care, perhaps absent the care by Dr. Kuebler, but there is no testimony from this witness that he didn't have the best of care.

MR. ERICKSON: Same objection. It's an argumentative question, and it misconstrues what he has told you for the last couple of hours.

MR. REILLY: I think what --

Q. (By Mr. Mencl) It's not your opinion

that Darren Porterfield had the best of care by the doctors and nurses at the hospital. I mean, you're not saying that, are you?

A. Wait a second. I'm commenting on the care given by Dr. Allin, which I find perfectly consistent with the standard of care.

Q. But isn't that different than the best of care?

A. The best of care, in my opinion, is having me see you, but unfortunately, there is only one of me.

Q. That's my point.

A. And I do not pretend that everyone can have that, Okay? So I give the benefit of my teaching and my writing, but I cannot lay fingers and hands on every patient. So assuming that the court system in no state that I know of requires the best of care, what they require is adherence to the standard of care. I would say that the standard of care has been adhered to.

MR. ERICKSON: As he pointed out, John, he is only giving opinions on the standard of care as they relate to Dr. Allin. That's what we've listed him for and that's all he's talking about.

Q. (By Mr. Mencl) My question is here, getting back to causation.

A. Right.

Q. What I want to know, in other words, was the dye cast for him to end up as paralyzed as he was on Sunday, November 22nd, the moment he was in the car accident?

MR. ERICKSON: Are you talking about as it relates to Dr. Allin? Did Dr. Allin do anything that influenced the outcome? Is that what you're asking him? That's different that what you're asking him. I'm telling you that you're asking him to comment on things that we haven't listed him on. We haven't listed Dr. Henry on things that happened or the standards of care that may or may not have been met by other physicians.

MR. REILLY: He may respond that --

MR. MENCL: I'm asking about causation. It doesn't matter whether it was something that the janitor did, it was an act of God or anything, but if a witness is going to testify on Causation, I mean --

MR. ERICKSON: He's told you what his opinion is. His opinion is that Dr. Allin met

the standard --

MR. MENCL: No, he hasn't told the opinion.

MR. ERICKSON: Let me finish my objection,

MR. MENCL: Just make an objection.

MR. ERICKSON: I'm ob:ecting because you're being repetitive. You're arguing. This witness, the record will reflect, has already said in his opinion Dr. Allin met the standard of care and nothing Dr. Allin did or failed to do influenced the outcome in this case. Simple as that, and that's what he told you.

MR. OLIVER: John, the problem with your question, it was so broad that it includes in the causation question things that Beatty may have done or not done, things that Kuebler may have done or not done. It encompasses the entire hospitalization.

MR. MENCL: Just the three days. He's got the recorc s and he's seen the depositions, and I don't see how he can give -- just being fair to the witness, I don't see how he can give a competent opinion on causation unless you, you know, look at what happened to the

patient for those three days, and I think he's done that.

MR. OLIVER: He has.

MR. MENCL: If you'll let him answer the question.

MR. OLIVER: The last question you asked was not that limited.

MR. MENCL: Would you read back that last question,

(The requested portion of the record, Page 76, Lines 4-7, was read by the reporter.)

A. My answer to that question is, within the realm of reasonable medical certainty, that is the case, I am not excluding the possibility that there may be some other harm that might have been done to him that may -- there may be something that may have happened, but within the realm of reasonable medical certainty, he had damage Eo his spinal cord the night that the accident happened, and that all the king's horses and all the king's men were not going to fix that,

I mean, there's tremendous research going on in this, There was just some publications by the National Student Health by

high-dose steroids in spinal cord, would they reduce this kind of injury, but I think within the realm of reasonable medical certainty, considering his injuries, that you were going to have siginificant neurologic deficit in this patient.

Q. This question is along the same lines. So you see any evidence in the medical record or in the depositions of any other contributed factor? By that, I mean, other than the car accident, that contributed to Darren Porterfield's paralysis?

MR. ERICKSON: I need to object, for the same reason as previously stated. I haven't given him all the medical records. He doesn't know all of the details about what Dr. Beatty may or may not have done. You've seen Dr. Beatty's deposition and Dr. Carter's deposition. All we've asked him to do is to do what he's already done, and you're asking him broad questions and he doesn't have enough facts to tell you details.

MR MENCL: Just in response to your objection, my question is focused on the first three days, from November 20th to November 22nd, and I'm just trying to make sure you don't intend to come to trial and say that something

that happened after he left the emergency room caused his paralysis, or contributed to cause it in --

MR ERICKSON: I'm not going to ask him that question at trial. Okay? He's given you his opinions.

Q. (By Mr. Mencl) Go ahead and answer.

A. I think what I said, to reiterate it, was that I cannot rule out the possibility that some other action may have taken place, not reflected in the records, which may -- which may have aggravated or irritated the cervical spine. I can't say that that didn't occur. What I said was, from my training and experience, considering the type of forces involved in an ejection injury, and his type of injury, that these people, in the vast majority of cases, have a neurologic deficit which is not related to the actions or inactions of anyone in the hospital setting.

Now, I cannot with 100 percent certainty rule out that you cannot irritate or aggravate some condition, but I can certainly state that I saw nothing done by Dr Allin, who I've been asked to review this case on behalf of, which in any way

contributed to or changed the outcome of this case.

MR. REILLY: Sounds pretty clear to me.

Q. (By Mr. Mencl) Do you see any evidence in the medical chart that indicates that Darren Porterfield's paralysis, or part of it, was caused between the time he left the emergency room and Sunday morning, November 22nd?

A. What I will comment on is recognition of that paralysis, not that an action caused it, but that as -- in his intoxicated state, I don't think there's an ability to tell the difference between voluntary and involuntary motor activity, and that -- and that clearly as he began to sober up, they began to recognize and they could ask him to do certain things. They may have noticed things.

The other thing is as spinal cord swelling increases, which happens over time with any tissue in the body, that there may have been a greater degree of paralysis. This is very difficult td say since early on, the patient's difficult to evaluate because of his altered mental status.

Q. You're saying there may have been, but you're not saying there was.

A. I can't say that for sure because quite frankly, you can't adequately evaluate somebody who you can't ask to perform certain acts. I mean, if you can ask him to touch his nose to his finger, and he's awake and alert and can talk to you, then you can make some significant decisions about him. If you can't carry on that kind of communication, it's very difficult to decide.

Q. You haven't done any special research on this case, have you, looked at any particular medical journals or treatises?

A. No. My area of interest in emergency medicine is emergency neuro, and so I'm constantly looking at the literature, but I have not made a special search of the literature with regard to this case and there is no -- there is no piece of literature or book, article or individual fact I consider in and of itself to be valid, you know, taken out of context. Nothing I consider authoritative.

Q. You have given a few depositions before.

A. Once or twice.

Q. How many medical malpractice cases have you given depositions in, approximately?

A. About 230.

Q. Is that -- you're serious? 230?

A. I'll give you -- since you're going to go through the numbers anyway, I'll just lay it out for you.

I've reviewed at this point in time about 1,210 cases of malpractice over 14 years. I was involved with Professional Liability Committee of the American College, and am the editor in chief of the new textbook on risk management. I do most of the teaching in this area in the college. I can probably quote more literature in medicolegal stuff than you can. I have been deposed 230 times, approximately. Breakdown of my work has been about 85 percent defense, about 15 percent plaintiff. That has remained constant. I do not advertise in any services. People come to me because of my expertise in the field.

MR. OLIVER: John, this is the kind of witness you need. You don't have to ask any. questions.

Q. (By Mr. Mencl) That percentage of defense-plaintiff, 85-15, is that about the same

for trial testimony?

A. No.

Q. How is it different for trial testimony?

A. Well, I would say I rarely appear at trial on behalf of a plaintiff. Simple reason is, if I give them a positive opinion, the plaintiff's attorney, the case settles.

Q. Can you think of any occasions where you've appeared at trial on behalf of the plaintiff?

A. By trial, you mean live as opposed to a video?

Q. Live or a video deposition, but not a discovery.

A. Right. I understand. See, I've done one Wisconsin case on behalf of the plaintiff where I actually appeared by video. And about ten years ago, I actually appeared on behalf of the plaintiff here in the state of Michigan live at trial.

Q. Did either of those cases involve spinal cord injury?

A. No, neither one.

Q. About how many times have you testified

at trial for the answers?

A. Probably about 60 May be slightly more than that.

Q. What is the name of the new text on risk management?

A. It's called Risk Management in Emergency Medicine. It's a 2Z-author text.

Q. Which chapters did you author?

A. Well, I'm editor in chief of the book I also authored certain chapters on doctor-patient interaction. The book is basically -- I've overseen the entire project

Q. Who publishes that?

A. The American College of Emergency Physicians is the owner of the material.

Q. Is it out yet?

A. Scheduled publication date, I think is November of this year.

Q. Have you ever done any work with Dawe Erickson before?

A. I don't believe so.

Q. What about with the Blackwell Sanders firm out of Kansas City?

A. Not that I can aver remember.

Q Do you remember ever testifying in

Kansas City?

A. Never been to Kansas.

Q. I really meant involved in any malpractice cases that originated in the Kansas City area.

A. I think -- I honestly think that this is the only case in my file which is from Kansas. There may have been something in the past but I don't remember.

Q. Approximately how many pending cases do you have that you have been retained to evaluate, but you haven't been notified that they're resolved?

A. I have an active file of about 400 cases, which are in some stages, you know, the usual five-year maturation of these things.

Q. How many do you think those are for the defense?

MR. ERICKSON: He already told you.

A. About 15 percent are plaintiff and about 85 percent defense. That is not indicating, by the way, what reviews I gave to these people . and how many cases I thought that malpractice existed.

Q. (By Mr. Mencl) Right. Right. Well,

when you review a case, how do you define medical negligence?

MR. ERICKSON: Objection. It may call for a legal opinion on his part. He's simply asked to give opinions as to whether somebody met or deviated from the standard of care.

A. I think that -- I think the counsel just summarized it. I mean, I'm asked to decide whether the actions met the standard of care, that which a reasonable physician of like or similar training would do under like or similar circumstances.

Q. (By Mr. Mencl) One of the depositions you've been provided is Wendy Marshall?

A. Yes.

Q. Are you familiar with her?

A. Yes, I know Wendy Marshall.

Q. She is testifying in generally the same area that you are in this case, and she's reached some different conclusions.

A. Au contraire. Wendy Marshall is a trauma surgeon who only sees trauma cases, does not work in'a nonselected emergency department and has ongoing responsibility for the care of the patient. That is a hospital which is a totally

different system for initial evaluation of patient. Her boards are not in emergency medicine. Her training is not in emergency medicine, and she has a completely different approach of the patient. She is much more analogous in this case to Dr. Kuebler, who is the person who then -- who must do the ongoing trauma care of a patient, and hers is quite a different perspective than mine, I would think.

Q. Other than that difference in perspective, do you have any explanation for why she reached different conclusions than you have?

MR. ERICKSON: Wait a second. That ask one expert about why some other expert might have reached different conclusions. That's asking wall. You're just asking him to comment inappropriately on somebody else's thoughts.

MR. REILLY: Calls for speculation.

A. I think reasonable physicians can have reasonable differences of opinion. You know, that's why me make horse racing and multiple

flavors of ice cream, There is no way that I can decide why she reached her opinion, but I certainly believe that I have every bit as much knowledge, training and experience in emergency medicine and what the standard of care is, and I have no intention to acquiesce to her opinion.

Q. (By Mr. Mencl) You don't have any intention to come to trial and say that, well, Wendy Marshall's opinions are wrong because of the following reasons?

MR. ERICKSON: He will say that.

MR. REILLY: I'm going to object. That's what he's been saying all afternoon,

MR. MENCL: Well, we haven't been talking about that.

MR. ERICKSON: The proper way to present testimony at trial is to ask this man's opinions. I'm not going to ask him to give personal opinions about Wendy Marshall. That is not his role in this case.

MR. OLIVER: I don't think the judge would allow that.

MR. REILLY: John --

MR. MENCL: That doesn't mean you guys won't try it.

MR. REILLY: John, he has spent some time today explaining what his opinions are and the basis for them. It doesn't take -- I mean, he doesn't have to sit here now and go line by line and differentiate those opinions and the basis for them from Wendy Marshall's. That's your job. But he has already explained what his opinions are, and it's painfully clear that they are different from Wendy Marshall's.

MR. OLIVER: I think it's pleasurably clear.

MR. REILLY: Pleasurably as opposed to painfully.

A. There is a question on the floor you want answered?

MR. REILLY: I don't know that there is a question on the floor that is intelligible and answerable under -- truly. I mean, you've asked him to -- it's also overbroad in that she has expressed a number of opinions, and you've asked him blanketly to address them all.

MR. MENCL: Fine. You've made your objections.

Q. (By Mr. Mencl) Do you have an answer

to that question?

A. Well, as I remember the question, I have no intention at trial of ever making any personal attacks on Wendy Marshall. I'm sure that she is a fine person and a fine physician, and I would feel, I'm sure she would -- I would be happy to look up in my trauma state and see that she was taking care of me. That does not mean that we do not have differences of opinion about this case, but I -- and I certainly do not acquiesce or claim that she would have greater knowledge in the area of emergency medicine than I do, nor would I think that she would think that she does.

Q. You have been provided with the depositions of Kevin Fogarty and Michael Rydquist, who were paramedics?

A, Yes.

Q. Was this of any particular benefit to your opinions?

A. Well, it was further fact information from people who were on the scene, It --

Q. Were there any real important facts?

MR. ERICKSON: Objection, John. All of the facts in this case are important in a variety of ways, and that question is overly

broad, vague and ambiguous.

Q. (By Mr. Manuel) You can go ahead and answer.

A. I think that it would be hard for me to pick out a bit of fact that is more important than any other. I mean, I have to take the totality of it, and I do.

Q. Well, do you recall what they said about whether Porterfield had any movement before he came to the emergency room?

A. Voluntary movement? I'm not sure whether -- I don't believe they commented on voluntary movement.

Q. If Porterfield had response to pain and moved an extremity in response to pain, I mean, would you consider that voluntary or --

A. No, I would not.

Q. That would be involuntary?

A After all, pain comes to cognition at the level of thalamus. You do not need a volitional act to respond to pain, and quite frankly, we respond to pain at a spinal cord level. If you touch a hot stove, you move your finger away based on a spinal cord response, not on having a process through the brain. So you've

actually moved your hand away before you've ever thought about going ouch.

Q. But if we're talking about spinal cord injury, wouldn't that kind of response to pain be a good finding as far as spinal cord injury?

MR. ERICKSON: Objection.

Q. (By Mr. Mencl) If you forget about the brain?

MR. ERICKSON: Objection. That question is vague and ambiguous. You don't identify what response you're talking about, what pain you're talking about or anything.

MR. OLIVER: I also want to say that it misstates the deposition testimony of both of those paramedics and they testified there was no response to insertion of a large IV.

MR. REILLY: In addition, John, in fairness -- the only movement that was referenced, the witness indicated that he couldn't tell whether it was voluntary or involuntary or whether he influenced the movement himself. Why don't you read him the passage and tell him what you want him --

A. There is a question pending?

Q. (By Mr. Mencl) Yes.

MR. ERICKSON: What is it? I don't recall -- I don't know what it is, John.

MR. REILLY: The question was, wasn't it good to have motion finding --

Q. (By Mr. Mencl) If you're trying to rule out spinal cord injury in a patient who is comatose, isn't a response to pain with movement of a person's, let's say lower extremities, isn't that a significant finding?

MR. ERICKSON: Objection. There are no facts in this case that there was any response to pain with movement of lower or upper extremities.

MR. REILLY: I join in the objection.

MR. MENCL: You know, there's all kinds of evidence of this, but I'm asking him just a general question about principles of medicine.

MR. REILLY: I'm not arguing with your ability to ask the question. My objection is that when you say it's a significant finding, that's vague and ambiguous because this witness. has already'indicated that in this case he believes that there may have been a delayed onset of -- or recognition of symptoms in this patient

-- or a change in his condition due to spinal cord swelling, so I think you need to allow him to include that in his response to, quote, a significant finding

A. Movement to -- movement is a much more complex process, I think, than the legal system can handle, really. For example, if I apply pressure to your face, and you move the hand and take my hand away from your face, that indicates to me that your spinal cord is working, that you moved information up the cord to the brain, which has localized that point, and then you have, as a response, localized a motor response against that, so that certain movements carry with it considerably more significance than another.

So if, for example, I pinch your left shoulder and you move your right hand over to grab my hand, that is a significant finding, that there are certain synapses intact.

If I stroke your leg and your leg moves, or I poke your arm and your arm moves, that does not carry near the same significance because it does not indicate to me that multiple areas of the brain and brainstem have been involved in making

decisions.

I mean, you know, I'm certainly -- that's something I draw out all the time from medical students as to where those pathways go, and would be happy to do so for a jury. But I think that the -- that the concept of movement is more complex than what we would like to think of it here, and so that after all, I can take a frog leg without the frog and stick it in a vat of saline, and I can get twitch response motor movements from the frog leg. That's not the same as, you know, when I frighten the frog with a noise and he hops away. That's a different level of movement.

So I'm -- I mean, the movement question is a complex one that if we're going to develop that, needs to be done systematically and correctly. All I can say is just because you observe a movement in a limb is not the same as a correct evaluation of deciding is information moving up the spinal cord, has it been processed and has it moved back down. That's a completely. different question.

Q. (By Mr. Mencl) What I am getting -- you know, I've seen the term used, purposeful

movement.

A, Right.

Q. And if somebody has random movements of, say, bending their knee and repositioning themselves in bed, turning over from their back to their side, even though -- well, first, would you agree that that's not purposeful movement?

MR. ERICKSON: Which one, John?

MR. MENCL: Either one,

A, Again, I would have to see the context of it. Someone was poking their foot with a needle and they move their leg --

Q. (By Mr. Mencl) No. No external stimuli.

A. Just the leg was moving?

Q. Spontaneous.

A. Again, we can see movement in people who have absolutely no functioning above the level of their spinal cord, so, I mean, I would have to see it in context and watch it happen. I mean, the question is overly vague. I mean, I can certainly come up with scenarios in which it indicates bath. But as I said, if your movement is in a processed response to an activity, then I can tell you what part of the nervous system is

being looked at, what part of the brain is involved, and whether you've actually made synaptic connections up and down the spinal cord. But, you know, the average EMT is not at a level where he's going to be able to differentiate those things.

Q. I noticed in Dr. Soucek's deposition, you've underlined a couple things on page seven, you underline the question:

"So sometime between 8:00 a.m. and 12 noon you reviewed several imaging films on Darren Porterfield?

"Answer: That's correct."

A. That just helped to define the time line for me so that I could go back and check against the chronology that was given out here, and are things correct,

Q. And Dr. Soucek gave an answer on page 13 that a comatose patient will respond to pain, and you underlined that. Is that because you --

A. That's because --

Q. You don't agree with it, agree with it?

A. I mean, a comatose patient does not have to have a response to pain. You certainly have comatose patients who don't respond to pain.

I mean --

Q. It could be either way?

A. Depends on the level the patient is at. It depends on where the involvement is. It may be, you know, depends on what his definition of response to pain is. But no, there are certainly comatose patients who do not respond to pain. I promise you that.

Q. When Dr. Allin initially wrote the emergency room record on November 20, 1989, under the neuro section, he used a phrase, "Responds to pain, no focal deficit." What does that mean?,

A. I think what he had was that he grimaced. That can be a response to pain. Depends on where the pain is applied.

Q. No. He wrote about the grimace later.

A. Okay.

Q. I mean, are you aware --

A. Yes.

Q. -- that he added --

A. Yes, I am aware of that.

Q. But without his added comments, just if you saw a patient like Porterfield and you're reviewing the record and it says, "Neuro, responds to pain, no focal deficit," what can that mean?

A. Well, it means --

Q. Is there a number of things --

A. It means there is no difference on the two sides of the body. That's what focal deficit would mean. Three moved and one didn't, that would be a focal deficit. Now, his "responds to pain," it would depend on what he considers a response to pain.

Q. When you say three moved and one didn't, you are talking about extremities; right?

A. Right. I mean, that might be a focal finding. But if nothing moves, then it is still nonfocal, but it's just indeterminant.

Q. But wouldn't it be more accurate to write nonfocal deficit, or generalized deficit rather than no focal deficit?

MR. REILLY: Object to the for-m of the question.

A. Well, no focal deficit means exactly what it says. There is no focal deficit. That doesn't say there is no deficit. It says there is no one spot. So I guess it would depend on how. the individual uses that phrase.

Q. (By Mr. Mencl) No focal deficit doesn't exactly match the phrase nonfocal deficit.

They're two different terms.

A. Right. Right. That's right. They're different terms.

Q. The part of it that says "responds to pain," wouldn't you interpret that as the extremities moving in response to pain?

A. No, I don't. I have no idea what he means by that. He has to decide what that means because it may just be a facial grimace. I don't know.

Q. So just from "responds to pain, no focal deficit," the responds to pain" could mean a facial grimace or it could mean movement of extremities, or some other expression responding to pain.

A. It could be everything from tells you to stop doing that to somebody who has decorticate posturing, decerebrate, crossing of the midline. All of those are responses to pain which indicate damage to the nervous system at a different level.

Q. But if it indicated some damage to the central nervous system, wouldn't it be incumbent upon a physician to write a little more detail about it?

A. Well, charting is a very individual

Q. Well, I'm just -- you said that's one possibility about the decorticate posturing, and I guess after reviewing the record and seeing the course of action that Dr. Allin took, I mean, you don't really think that that happened in this case.

MR. ERICKSON: That what happened?

Q. (By Mr. Mencl) That he had decorticate posturing?

A. No, no, I do not think so.

Q. You are an examiner on the American Board of Emergency Medicine?

A. Yes.

Q. Can you explain to me the significance of board certification in emergency medicine?

A. It's a -- board certification is something which takes place in all of the specialties. I believe there are now 23 board certified medical specialties. It's a process whereby if you claim to be -- to have expertise in the field you present your training and experience and your -- to a board, which then decides to test you formally, and our board in emergency medicine

uses both a written examination and an oral examination, and if you've satisfied all three parts, training, experience and examinations, then they -- you can be considered a diplomate of the board.

Q. Is Dr. Allin a diplomate of the board?

A. I believe he is, yes.

Q. would you hold someone to a little higher standard of care who is board certified than you would a physician who is not board certified?

A. No. I hold them -- if they're doing the same job, I hold them to the same standard of care. Same reasonable actions should be taken. If you hold yourself out to do that job, you should do it correctly.

Q. I am going through Exhibit 1 which is your CV. On the second page, I notice that you've got the -- you received the Standing Ovation Award, outstanding lecturer. Was that for a particular talk or topic?

A. Can I see that?

Q. Yes. It's where the question mark is.

A. Yeah. This is the Mid-American Trauma Symposium in November 1986. That talk, I believe,

was on comatose patients, but I can't tell you at this point in time Coma is something I lecture on.

Q. One was outstanding speaker of the year by American College in Emergency Physicians.

A. Yes.

Q. Is that based on a particular talk, or is that based on the quantity of talks you give throughout the year?

A. I'd like to think that it's based on both quantity and quality.

(Whereupon, a discussion was held off the record)

Q. On page three, it says you're president of American Physicians Assurance Society. Explain what t at is.

A. That is a self-insured medical trust insurance company which we own in Bridgetown, Barbados.

Q. Who do you insure?

A. Emergency physicians within our own group, basically. This is a self-insurance mechanism.

Q. Do you utilize any reinsurance, where you pass the risk on down the line to a bigger

company?

A. We have under one condition. I've used some reinsurance, and that's with the Paradyne Insurance Company of Louisville, Kentucky.

Q. Is that the only one you've dealt with?

A. That's the only one, but understanding that reinsurance is always a multi-ticket item, that they then pass that off into the international market, so they have lots of people on the tickets.

Q. And you are not aware of who else they've got on the ticket, so to speak?

A. On the ticket is basically European insurance, Lloyd's Insurance, Scandanavia, those kinds of people.

Q. And you are still president of that Physicians Assurance Society?

A. Yes, I am.

Q. You're chief executive officer, Medical Practice Risk Assessment. Explain what that is,

A. That is a company which we own here in town which teaches coursework and we do evaluations'of hospitals concerning risk management in emergency medicine.

Q. Are you still presently active in that?

A. Yes, I am.

Q. On page four, it's mentioned, you've been a visiting lecturer on medicolegal issues in emergency medicine, and there seems to be, over the years you've spoken on that topic, it seems like many times.

A. That is true.

Q. Could you explain generally what that consists of?

A. Well, it concerns the entire gamut of situations which the emergency department lends itself to, and there are questions on duty to treat, right to treat, various obligations under the law to see certain patients, consent issues against medical advice issues.

Q. Standard of care issues?

A. Standard of care issues. All of those.

Q. Have you ever testified in front of any committee or legislative body in an effort to change the laws of medical negligence?

A. No. I've never personally given testimony to change the law. I have certainly been involved in looking at those questions, but I have never been asked to actually give that testimony.

Q. Tell me how you've been involved in looking at those questions,

A. Well, I have met, as the representative Emergency Physicians, with the American Trial Lawyers Association chapter here in the state, looking at areas where we might cooperate on tort reform. I have been -- I was involved for awhile with the Physicians Action Committee which had proposed some changes to the state legislature, although I did not actually give a talk there, I was involved in --

Q. You were a member of the committee?

A. I was a contributor to the -- financial contributor to the action.

Q. In Wendy Marshall's deposition, there are some blue marks on certain pages throughout. I assume that those are marks you made?

A. Yes.

Q. Have you ever met Dr. Dennis Allin before?

A. I believe we have actually seen each other once. I think he came up to me at a place where I was speaking and introduced himself.

Q. Could it be Las Vegas, Nevada?

A. I couldn't tell you when.

Q. I'm just trying to prompt your memory.

A. No. He did introduce himself to me once, and asked me would I consider looking at a case.

Q. You mean this case or --

A. I can't tell you whether it was this case, but he did introduce himself to me once. I know that to be a fact.

Q. Well, and did you look at that case, whatever case it was?

A. I can't tell you, because I don't know which case he was referring to at that time. But --

Q. Was it a medicolegal type case or --

A. I mean, you know, all I can tell you is that he introduced himself to me once and asked me would I look at a case or something, and that's all I can remember. I mean, I meet thousands of people like that every year,

Q. Do people ask you to look at cases that aren't involved in litigation that --

A. oh, sure.

Q. Just for the benefit of the patient?

A. Yeah. They'll send me interesting

cases, and I have interesting case files. I've collected 300 this year on emergency neuro cases. People write to me all the time and call me.

(Whereupon, a discussion was held off the record.)

Q. You might turn to page 13.

A. Yes.

Q. Where it says "Guest Lecturer, Discussion on Standards Development," on page 13, would you explain to me what that is?

A. Oh, that was a discussion on how the specialty itself should proceed with developing, quote, unquote, standards of care within the specialty, because there is no such thing as a book you can read that says the standard of care. That is currently a fiction forwarded by the legal community, and the question is, to what level should we take the bull by the horns and establish a standard of care which would both set performance standards. It's a double-edged sword you can obviously see.

Q. Right. Right. Sort of like the Joint Commission an Accreditation. The hospital has certain standards for record keeping?

A. Yes, but those are physical standards

relationship to you have certain things in place. This is standards given a specific kind of case, what should you do, what should your order, what should follow-up be, which is a -- which is obviously, as I say, a double-edged sword.

Q. Well, and what is the current status of that? Is the college going to be coming out with some standards or --

A. Well, they have with regard to at least one issue. We have now promulgated and put forward a standard -- it's not a standard. A clinical guideline on chest pain. They are currently working on several others. There is nothing out yet on cervical spine injury.

Q. If you turn to page 15 on your CV, Exhibit 2 --

A. Yes.

Q. -- under Committees, it says you're a member of the Alcohol Therapy Committee. What is that?

A. I was a member, '78 to '80.

Q. What did that deal with?

A. That had to do with the management of alcoholic patients in the hospital, what were the programs available for them, treatment programs,

management programs. What we do, detoxification, that sort of thing.

Q And that just dealt with patients -- I mean, I hear about that there are committees, like there's committee for alcohol abuse in the legal community, and I was wondering if that had anything --

A. Oh, no. This is not a physicians committee. That has to do with programs for patients in the hospital. This is not related to doctors with drug problems.

Q. Down below that, it says you are the Director of Risk Management Emergemc Physicians Medical Group, PC.

A. Right.

Q. You are currently still the director?

A. Yes.

Q. What is that group? What does it do?

A. The Emergency Physicians Medical Group is a corporation which supplies emergency services to a number of entities.

Q. And by "entities," you mean hospitals?

A. Freestanding centers, hospitals, industrial med program. We also supply the doctors for helicopter rescue program.

Q. What percentage of your time in the average month do you spend actually taking care of patients in a clinical setting --

A. This month, I will -- I'll just break it down by hours. This month I have ten shifts clinically. Actually an eleventh shift counting the university. Now, these vary in length. They're scheduled for eight, but you're usually there for ten hours, and so I will probably, this month, spend 100 to 110 hours clinically seeing patients, and then I will spend a certain amount of time administratively, writing, teaching, lecturing, that sort of thing.

Q. Regarding your opinions in this case, is there anything further that you plan to do to finalize your opinions or have you looked at everything --

MR. OLIVER: Object to the form of the question. It assumes his opinions are not as of today finalized.

Q. (By Mr. Mencl) Maybe it does. That was a poorly worded question.

A. I think that any expert -- I would be like any other expert. If presented with a different body of facts, I could modify my

opinion. I have no idea what will come in to me prior to the time of the trial. Presented with a correct set of facts, you know, I will modify my opinion, but it is always based upon those facts which I have at that point in time.

Q. On page 17, it says you were a member of the Professional Liability Committee for the American College of Emergency Physicians.

A, Yes. I mentioned that to you earlier.

Q. Right. You are not currently a member of that committee?

A. I have rotated off that committee because I now sit on the national board.

Q. What were your duties when you were on that committee?

A. Basically I was looking at insurance questions, the availability of insurance, rate structure of insurance, some actuarial questions. We were also looking at risk situations, trying to isolate those areas where the college needed policies, to help improve patient care with regard to liability issues.

Q. You have written a book or eo-authored a book with a Mr. Little?

A. Dr. Little.

Q. Did you contribute to every chapter in the book or were they divided up, Little wrote a chapter, you wrote this chapter?

A. We actually divided up the work; however, once it was divided up and put back together, we both edited the work.

Q. When you edited it, I mean, does that mean that you both are satisfied with --

A. What it says.

Q. With what it says?

A. Yes.

Q. And you are willing to stand behind it?

A. Yes, as much as I am willing to stand behind any published work.

Q. Do you recall which chapters, though, that you initially worked on, on that book, Neurologic Emergencies?

A. I suppose if I had the book in front of me, I could go through it and tell you. I know I wrote the initial one on examination. I wrote the one on coma. I wrote the one on weakness. I wrote the one on dizziness and vertigo. I wrote. the one on back pain. A few things like that.

Q. In that regard, I have a photocopy of the table of contents of that book just to refresh

your memory. You know, if you can, just go through and tell me which chapter you recall that you worked on.

A. Acute Double Vision and Blindness is mine, Neurologic Exam is mine. Neuroanatomy is mine, Altered States of Consciousness is mine, Focal Deficits is mine, Acute Weakness is mine. Double Vision and Blindness is mine. Syncopy is mine, Dizziness is mine. Neck and Back Pain is mine,

Q. Okay. You made some videos on page 19 of your CV.

A. Those that appear on my CV, yes. Call it the Rob Lowe syndrome.

Q. Did any of these videos deal with clearing the cervical spine?

A. No, not that I know of,

Q. Last page of your CV, page 21, under Administrative, you list some references, and one is a Mark Griffin, Esquire, attorney?

A. Yes.

Q. What is your relationship with him?

A. He is our business attorney. Basically I run the business, the Emergency Physicians Medical Group. I am the principal guy who

actually runs the office, and so we have all the usual business sorts of interactions which my company has.

Q. There is a deposition here by Dr. Goodwin, and you have written on the front, "Defense expert, speaks to drugs, alcohol use effects." Were his opinions of any particular significance to your opinions, or was this --

A. It's a tangential issue. He speaks to something which I do not speak on, and although he confirms my feelings on the subject, he did not influence my opinions on the subject in any way.

Q. When you say it confirms your feelings on the subject, I don't believe he really speaks to the emergency room care that was given.

A. No.

Q. So what subject is it that he's confirmed?

A. Well, he speaks to the outcome, to what happens to people who are drug and alcohol abusers, which happens to be a great percentage of my patient population, so, I mean, he just confirms what everybody knows, and it is that, you know, there's a certain group of patients who are going to be difficult, who are going to be

nonproductive, who are prone to problems, and their life expectancy is shorter because of it, and --

Q. But you don't intend to give any opinions at trial on life expectancy?

A. No, I do not.

MR. ERICKSON: No.

Q. (By Mr. Mencl) Okay. So, you know, as far as opinions that you intend to give at trial, that deposition is just background?

A. Background as are all the experts' depositions.

Q. I want to ask you about some underlining you did in Walter Levy's deposition.

A Right.

Q. On page 116, is that of any particular significance?

A. It's not of particular significance. It's just I noted it because somehow it didn't seem to fit with what I had seen, but all I can say is that that's his opinion.

Q. What about on page 120, why did you underline that and put a check mark by it?

MR. OLIVER: John, when you're you, for the record, tell us the line numbers, too

MR. MENCL: I am going to have her attach copies of these particular pages.

MR. OLIVER: Okay.

MR. MENCL: To the deposition.

MR. OLIVER: All right. Never mind.

A. Looking at page 120, starting at line 9, question:

"Doctor, is there some reason to think that Darren Porterfield's neck was not cleared after Dr. Kuebler examined the guy at 10:00 a.m. the prior morning and found a normal neurologic functioning?

"Answer: That doesn't clear the neck. Clearing of the neck means you've demonstrated radiologically. Well, quite frankly, that doesn't clear the neck either, because there are limitations of radiographs, so clearing the neck is a combination of a physical examination and the radiographs, and initial radiographic findings can be normal on one who does have a cervical spine injury."

On page 123, at line 18, starting at line 18, why did you note that passage? Again, at 123, line 11, the question:

'Do you see any indication in there or in the physician's orders that Dr. Kuebler directed that this patient's neck be immobilized at that point?

"Answer: I'm looking.

Question: I think the doctor's orders are on page 665.

"Answer: I don't see any indication that he's declared the patient unstable or ordered a cervical collar or similar type of activity.

Since you're not rendering any opinions on Dr. Kuebler, is that of any particular significance?

A. It was just interesting that he thought that he needed to order it when I wasn't aware that there had been an order to have it taken off I wanted to make sure. I wanted to go back and check the orders to make sure there was no contraindicating order here. Maybe there had been, and maybe there wasn't been. But that was important to me with regard to Dr. Allin. And I indeed found that there had not been an order written to remove the collar.

Q. On page 150, you noted a passage about neurogenic shock?

A. Yes.

Q What was the purpose of noting that?

A Just the fact that paraganic shock occasionally does exist. It is a possible explanation of some of the findings early on in the patient, but again, it's only mentioning one possible mechanism.

Q Now, in the deposition of Joseph Coppola --

A. Yes.

Q. -- on page 68, you noted something -- there is a passage regarding:

If you have a vascular problem where there is not sufficient supply to a certain area of the cord, then it could cause more problems?

"Answer: Yes."

What was the purpose of noting that?

A Because it is consistent with the traumatic picture, that if you get swelling of the cord, since t here wasn't anything specifically pushing against a spinal what happens is you get swelling of the cord and then your smaller arterials actually get pressure on them, decreased blood flow, and ischemia to the cord, which could happen over a period of time, so he and I, I guess

on that point, do agree that the mechanism is an ischemic one as opposed to a compressive or a severence one.

Q. Well, if you have ischemic process going on in the spinal cord, and then the spinal cord is compressed because of a dislocation, doesn't the compression compound the problem of what's already going on?

A. Well, that may be the case. I have no evidence in this case that I had such a dislocation or fixed dislocation,

Q. Well, did you ever see the plane films from Sunday, November 22nd, that showed C5 --

A. Subluxation, yes.

Q. Well, if there were problems going on with edema or ischemia of the cord, wouldn't that dislocation make whatever problems were going on worse?

A. I can't say that. I mean, I can't definitely say that.

Q. Why? Why can't you?

A. Because the initial injury itself may have caused'all the problems. I think I mentioned earlier that I could not say 100 percent that there wouldn't be some aggravating incident.

Q. Page 157 of Dr. Coppola's deposition, you underline a passage and circled the word "no." I think that's "no."

A. "Based on the 8:00 a.m. entry, are you able to backdate when most probably the insult to the spinal cord occurred?

"Answer: If I can explain, the initial insult to the spinal cord occurred at the accident, prior to his arrival at the hospital."

I guess I agree with that.

"I believe his subluxation and insult, which caused his permanent damage, occurred some time late Saturday night or early Sunday morning." And I've just written there that I disagree with that.

Q. This indication on page 164, is that just because the doctor says he's not going to render any opinions about reading of the x-rays, and you noted that that's not an issue?

A. That's right.

Q. Now we're going to switch to Jendy Marshall's deposition. You made some underlinings on page 9. Is that some of the background information that you mentioned previously about Dr. Marshall?

A. Yes. It delineated her scope of practice and where she practices.

Q. Page 11, you made a notation, "Cleveland." Any particular significance to that?

A. Just localized where she had been.

Q. What was the purpose of your notes on page 96?

A. Just to show that the fact that -- she reiterated the fact that you don't just CT the neck, and it's just to see what she was saying as to what they did in their trauma unit on C-spine injuries. I was just interested to note it.

Q. I think this is, on page 126, is an area where we got off talking about surgical decompression.

A. Yes.

Q. I don't think that's particularly significant opinions.

MR. ERICKSON: Objection. Same reason as I previously stated. Everything in this case that he's reviewed may have some significance for one reason or the other,

Q. ('By Mr. Mencl) On page 131, why did you make notes on that page?

A. Because there is a comment that says if

appropriately treated prior to giving spinal cord impingement, there really should not be any neurologic impairment. Well, that's not really true. It may be true, but you have to consider the initial spinal cord impingement in this case was the actual time of the accident. So I guess I agree with that. If he had not had an accident, he would not have the spinal cord injury; however, he did have the accident, and I think that's where the initial impingement on the cord took place

Q. On page 122, there is a passage about that if Dr. Kuebler had put a C collar on Darren at that point, then the neurological impairment that Darren eventually has could have been avoided, and she says yes. I take it your opinion is no

A. Absolutely. But I would preface that by saying I'm not here to comment on Dr. Kuebler.

Q. Well, yeah, and I'm not asking you whether Kuebler is right or wrong to put a C collar on, but I'm just saying from a causative standpoint, if he did put a C collar on, it, in your opinion, would not have made any difference with how Darren ended up on Sunday?

A. That's right. I agree with Dr.

Marshall at this point in time that essentially what she's saying here is that Dr. Allin's activities didn't have anything to do with this, and that Dr. Kuebler could have avoided this problem by putting on a collar. I suppose he should have put the collar back on. I just disagree with the fact that it would have made a difference in the outcome of the case.

Q. On page 146, what is significant about the neck being supple or -- this underline here about no muscle spasm?

A. Well, generally, in a fractured neck you have muscle spasm. Obviously Dr. Kuebler examined this person's neck and thought that it was supple at that time, and most people with fractures of the neck actually do splint the fractures by going into spasm. That's the common response to the body.

Q. Is it possible that the neck was supple and had no masses, or is it just a physical impossibility?

A. No, it's not an impossibility. All I'm saying is in usual cases, people with a fractured neck will splint that fracture by tightening down their muscles so their neck doesn't move. Like

all fractures --

Q. If you have a lot of ligaments, though, would that make the neck looser?

A. No, not the supporting ligaments of the spinal cord, I mean, what we're talking about is the muscular response of the large muscles of the neck.

Q. On Marshall Exhibit 1, which is her CV, you circled 1978. What was the purpose of that?

A. I just wanted to know what year in which she trained and went to medical school, that sort of thing.

Q. Now that you know that, does that have any particular bearing?

A. Not on this case. It may if she's good-looking.

Q. On Marshall Exhibit 3-A, you wrote "no" by where it says "failing to order further imaging exams on the cervical spine."

A. This is a comment she made on deviations of the standard of care of Dr. Allin. I disagree with that. It was not his place to order further imaging exams of that patient at that time. He was not doing the definitive care or the followup care of this patient. She and I

disagree on this issue.

Q. Let me ask you about this, about the further imaging exam. If Dr. Allin had done further imaging, that would be within the standard of care, too. I mean, there's -- I'm wondering if you're saying there's two ways he can go. He can choose not to do it and let the next physician follow up, or if he does it, it's within the standard of care, too.

MR. ERICKSON: I need to object to the question. Now it's compound. You've asked three or four different questions in that. The first question you asked looked at the question incorrectly in this case. The question in this case is whether what Dr. Allin did met or deviated from the standard of care, not whether if additional things could have been done, that it also would have been in the standard of care. That's an irrelevant question, John. You can always think of things that would have been in the standard of care. That's not the issue in these cases. The question is problematic from that standpoint. And also in addition to asking for that irrelevant response, it's compound.

Q. (By Mr. Mencl) Let me try to shorten

it up a little bit. If Dr. Allin had done further imaging films while Darren Porterfield was in the emergency room, would you consider that inappropriate because it would be unnecessary?

A. It would depend on the films that were ordered and to what purpose and to the amount of movement the patient was put through and the amount of time that they took, so it would have -- I would have to define that very specifically.

Q. In the back here, there's a general chronology in the Darren Porterfield case, and on page 2 of that, you wrote "yes." I assume that means you agree with that statement that Allin made.

A. Porterfield's medical condition did not contraindicate doing a CT scan of his neck or more x-rays, but nothing indicated it either. Yes, I think that's a statement that is hard to take issue with.

MR. ERICKSON: He's also already said that this afternoon, John.

Q. (By Mr. Mencl) Yeah, I believe he did. On page 3, you underline, "Porterfield had a normal range of motion of all extremities," That's from Nurse Jobe's deposition.

A. Right.

Q. What information does that give you?

A. What that tells me is it's incongruous with what else I'm seeing in the chart. It didn't fit in. Now, if he did have a normal range of motion, it meant that nothing Dr. Allin had done had caused him a problem, but all I can tell you is if this person was actually put through a normal range of motion examination, I'd be shocked. It would surprise me no end to see if this person had actually been put through joint range of motion,

Q. When somebody says "joint range of motion," is that done passively or actively?

A. Well, I don't know. But, I mean, if they've actually asked him to move through a range of motion, I'm sure he didn't.

Q. And what if they did it passively?

A. If they did it passively, then that just indicates that he had no stiffness of his joints, so he did not immediately develop arthritis.

Q. Does that tell you anything about spinal cord injury?

A. No, it doesn't.

Q. You noted here on page four from the Jana Ward deposition, which you haven't been provided, but Porterfield moved his leg by bending his right knee. His knee came up six to seven inches off the bed. Did you take that into consideration in forming your opinions, or did you not because you didn't actually have the deposition?

A. All I know by looking at that is that that's a spinal cord level response. Moving the leg like that is again, it goes back to my analogy of having the frog's leg twitch in the saltwater bath. That does not indicate that he has volitional movement.

Q. On page five, you noted in Jobe deposition excerpt where she talked about how she normally places her hands against a patient's, feet and has him flex his feet against her hands, and she's sure she did this with Porterfield, and would have called the doctor if she had -- if he had not done it. You put a little star by it.

A. Just to me, it appeared to be inconsistent, but then again, what can I say? I mean, I don't know whether she did or didn't.

Q. If she did, if you assume that she did and he did flex his feet, would that indicate a functioning spinal cord?

MR. ERICKSON: I need to object to that question, John, for a couple of reasons. One, that's your summary of her deposition testimony. It may not be accurate, and I think you're asking him to assume things that aren't going to be in evidence and that are not facts in this case. Also, asking him to talk about the truth or veracity of another witness.

Q. (By Mr. Mencl) You can go ahead and answer the question. If you assume that she did that, would that indicate a functioning spinal cord?

A. It may indicate that if he's truly moving in response to a direct question or a command to move, that doesn't mean that he's got -- doesn't have damage to the spinal cord which is going to be irreversible. It means at that point in time that he's still carrying neurological information. But again, it would be how she did it.

Q. This one exhibit says Allin, DC. Dr. Allin made the comment that he could not

reasonably get obliques on Friday night. Do you agree with that?

A. Yes, I think I mentioned that, that having a patient collared with the usual problems of attempting to get the patient immobilized and getting obliques may be more difficult.

MR. MENCL: I believe that's all the questions I have, Thank you.

GREGORY L. HENRY, M.D.

Subscribed and Sworn to before me this 11th day of September, 1990.

Susan L. Jennette

Notary Public

SUSAN L. JENNETTE
NOTARY PUBLIC-WASHTENAW COUNTY, MICH.
MY COMMISSION EXPIRES 2-5-91

County of Washtenaw

State of Michigan

C E R T I F I C A T E

I, KAREN KELLERMAN, a Certified Shorthand Reporter of the State of Kansas, do hereby certify:

That prior to being examined the witness was by me duly sworn;

That said deposition was taken down by me in shorthand at the time and place hereinbefore stated and was thereafter reduced to writing under my direction;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel, or financially interested in the action,

WITNESS my hand and seal this _____ day of _____, 19__.

_____

KAREN KELLERMAN, CSR

IN RE: Porterfield vs. Emergency Physicians Services

CASE: 89C1850

CORRECTION SHEET FOR THE DEPOSITION OF: Gregory L. Henry, M.D.

PAGE	LINE	CORRECTION	REASON FOR CHANGE
41	2	regional should be reasonable	
78	25	Should be National Institutes of Health	
87	17	Should read "I know of Weekly Medical	

I CERTIFY THAT I HAVE READ MY DEPOSITION IN THE ABOVE CASE, AND REQUEST THAT NO CHANGES BE MADE.

X I CERTIFY THAT I HAVE READ MY DEPOSITION IN THE ABOVE CASE, AND I REQUEST THAT THE ABOVE CHANGES BE MADE.

SIGNATURE OF THE DEPONENT OR WITNESS

2/11/90
DATE