

1     STATE OF OHIO                     )  
    )  
 2     COUNTY OF CUYAHOGA            )  
 3                                       COURT OF COMMON PLEAS  
 4     JANICE KANE, E/O                     )  
       RICHARD ALLAN RABIN,                )  
 5                                        )  
                                       Plaintiff,        )  
 6                                        )  
                                       vs.                )  
 7                                        )  
       MARSHALL LEED, et al.,            )  
 8                                        )  
                                       Defendants.        )

No. 401658

Judge Jones

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 10                                       - - -  
 11                                       DEPOSITION OF BRUCE DAVID JANIAC, M.D.

12  
 13             DATE:           December 4, 2001 at 2:00 p.m.  
 14             PLACE:          The Toledo Hospital  
                               Department of Emergency Medicine  
 15                               2142 North Cove Boulevard  
                               Toledo, Ohio 43606

16  
 17             REPORTER:       Kim M. McKinney, RPR  
                               Notary Public

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APPEARANCES:

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(Via Telephone Participation)

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On behalf of the Plaintiff:

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1                   BRUCE DAVID JANIAK, M.D.,  
2   a Witness herein, called by the Plaintiff as if upon  
3   Examination, was by me first duly sworn, as hereinafter  
4   certified, deposed and said as follows:

5                                 - - -

6                                 EXAMINATION

7   BY MR. FINELLI:

8   (Via telephone participation)

9                 Q.    Dr. Janiak, correct?

10                A.    Correct.

11                Q.    Okay. J-A-N-I-A-K?

12                A.    Correct:

13                Q.    My name is Dan Finelli. My partner, Ron  
14   Margolis, is sitting next to me. We both represent the  
15   estate of Mr. Rabin in this case where you agreed to  
16   provide medical expert testimony on behalf of the  
17   defendant, Dr. Ferrini.

18                         I'm going to be asking you several  
19   questions throughout the course of this afternoon. Most  
20   importantly, your answers need to be verbal so that I  
21   can hear them and the court reporter can transcribe  
22   them.

23                         If you do not understand any question I ask  
24   you, please stop, I will rephrase it so you understand  
25   it prior to giving your answer. Because I'm going be

6

1     relying on your answers for purposes of trial, fair  
2     enough?

3             A.     Okay.

4             Q.     Okay.  Anything in your CV that has changed  
5     in the last five years?

6             A.     I would think so.

7                     MR. FINELLI:  Okay.  I think I have a  
8                     current one.  Can you mark the current CV  
9                     as Plaintiff's Exhibit Number 1?

10                    MR. SHROGE:  Sure.  Just a second,  
11                    Dan.

12                    (Court Reporter marked Plaintiff's  
13                    Exhibit 1.)

14                    MR. SHROGE:  All right.  I think  
15                    we're ready.

16             Q.     Okay.  What I'd like to do is actually go  
17     through a series of questions.  And then once we're done  
18     with that, you can fill in the blanks if I missed  
19     anything as far as your current CV, fair enough?

20             A.     I'll try.

21             Q.     Okay.  Are you still the director of the  
22     department of emergency medicine at Toledo Hospital?

23             A.     Yes.

24             Q.     And does the majority of your practice  
25     include the responsibility for the professional

1 component of staffing, making sure that health care is  
2 delivered in an appropriate quality?

3 A. Yes.

4 Q. Okay. And does the majority of your  
5 practice also include the quality aspect, which includes  
6 tort review, evaluating physicians and handling --  
7 handling quality issues and patient care issues?

8 MR. SHROGE: Dan, when you say  
9 "majority", can you be more specific than  
10 that?

11 MR. SHROGE: The majority of his  
12 professional practice as director of the  
13 emergency room at -- emergency medicine at  
14 Toledo Hospital.

15 A. Well, you left out in that list seeing  
16 patients, which I do a lot. So if you add that to it,  
17 then the answer is yes.

18 Q. Okay. So the majority of your practice  
19 would include what I just mentioned as well as seeing  
20 patients?

21 A. Absolutely.

22 Q. Okay. Are you still on hospital  
23 committees?

24 A. Yes.

25 Q. Okay. Are you on the executive committee?

8

1 A. Yes.

2 Q. Credentialling committee?

3 A. Re.

4 Q. Budget committee?

5 A. Yes.

6 Q. Any other committees?

7 A. Medical -- or actually it's a quality  
8 steering committee, which is the general quality  
9 committee for the institution.

10 Q. Roughly how many times do these committees  
11 meet on a monthly basis?

12 A. Executive is once a month. Quality  
13 steering is no more than every other month. Credentials  
14 is every month. Oh, and budget, that's probably twice a  
15 year.

16 Q. Okay. What is the purpose of the quality  
17 steering committee?

18 A. It reviews departmental performance as  
19 measured against the department's own quality  
20 initiatives. For instance, if -- if the orthopedic  
21 surgery department is interested in having a  
22 postoperative knee surgery infection rate of below one  
23 percent, then we would review their actual statistics  
24 and -- and see how they're doing and then make  
25 recommendations, of course, if they are not meeting



1 their own goals.

2 Q. And you'd make those recommendations to the  
3 department head?

4 A. Correct.

5 Q. Okay. And what is the purpose of the  
6 credentialling committee?

7 A. To evaluate those physicians who are  
8 applying to become medical staff members, to review  
9 their applications, to approve or deny their  
10 applications and to make suggestions in terms of the  
11 criteria for which physicians are allowed to practice at  
12 this institution.

13 Q. And as -- as part of the quality steering  
14 committee, do you have an opportunity to review the --  
15 the patient care within the emergency room department?

16 A. You know, that's -- that's an excellent  
17 question. The emergency department's quality committee  
18 is actually now been divided amongst the various quality  
19 subcommittees, which are medical, surgical, pediatric  
20 and OB/GYN. And so quality issues and/or studies with  
21 regards to these areas are taken care of on the -- at  
22 those subcommittee levels.

23 Q. So if the -- if I understand you correctly,  
24 the emergency room physician performing obstetrical care  
25 or gynecologic care in the emergency room would come

10

1 under the subcommittee for OB/GYN as far as review?

2 A. If -- if we were going to do a review, for  
3 instance, of our compliance with ordering appropriate  
4 testing for STDs, that probably would come under --  
5 either OB/GYN for females or medical quality for males.

6 Q. Okay. And as part of that quality steering  
7 committee, are there any guidelines, manuals or  
8 standards that are published in -- with respect to  
9 overseeing the emergency room department patient care?

10 A. None.

11 Q. Doctor, are you still head of the  
12 Professional Emergency Services, Inc.?

13 A. Yes.

14 Q. Okay. And that's a corporation which, as a  
15 contractor, provides the professional components of ER  
16 care 24-7 at Toledo Hospital?

17 A. Yes.

18 Q. Physicians are all employees of that  
19 corporation?

20 A. Yes.

21 Q. How many employees currently today as far  
22 as physicians?

23 A. Hang on a second while I calculate. 20  
24 full time, and probably another 10-plus that are part  
25 time.

1 Q. Okay. You've expanded.

2 A. Yes, we have in the last six months.

3 Q. Of those 20 full time, are they all  
4 emergency room physicians?

5 A. Well, yes. Two are pediatric emergency  
6 specialists, but they're all emergency specialists.

7 Q. Okay. Are you still working Tuesday  
8 mornings 7:00 to noon and every third Thursday of the  
9 month?

10 A. No, that's changed because of my increased  
11 staff.

12 Q. Okay. Tell me your work schedule.

13 A. There isn't any, unless you want to know  
14 what it was two weeks ago. The last two weekends I  
15 worked. And I'm scheduled to work four out of the next  
16 seven days from 4:00 to midnight. And then I'm working  
17 14 shifts in -- in January and February, March, April,  
18 May and June, as of right now.

19 Q. Are the shifts made every month?

20 A. Well, they're actually scheduled into  
21 perpetuity. Anyone on my schedule would know what their  
22 scheduled to do three years from now if they care to  
23 calculate it out.

24 Q. Okay. Are you listed as a physician on  
25 those blocks of shifts that are made monthly?

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A. No, not until the last minute when we find out who is sick or dead or injured or on vacation.

Q. Okay. So the reason you only staff the ER yourself is to basically fill in for someone who is sick or not able to provide their -- their shift?

A. That's right. But, of course, if you have 20 physicians full time, you can see there's a lot of openings --

Q. Okay.

A. -- which is why I see about 2500 patients a year.

Q. The majority of your clinical practice, is that doing chart reviews, preparing lectures for residents and teaching?

A. No, I said right now the majority of my clinical practice is actual clinical practice. The minority would be doing chart review. Although in the last week it was more chart review than clinical. But I'm -- I'm going on the year-long activity, so the majority is seeing patients.

Q. Is that changing month to month, or does it remain pretty steady?

A. Well, we've been so much busier, I would say it -- it changes. You know, a year ago I was probably working -- seeing patients 70 percent of the

1 time I am now. I'm -- I'm -- but I'm busier now than I  
2 was then.

3 Q. Okay. What percent of your clinical  
4 practice is seeing patients compared to the chart  
5 reviews, preparing lectures, teaching, the  
6 administrative committees, the budget committees --

7 A. Well --

8 Q. -- and the quality health care?

9 A. Well, I'll answer it this way, the  
10 nonclinical aspects are still in the range of 10 to 15  
11 percent. And the clinical aspects are 80, 85 percent.

12 Q. Okay. And as part of your clinical  
13 practice you still do chart reviews?

14 A. Yes. I spent hours doing them last week.

15 Q. Okay. And those chart reviews are, what,  
16 emergency room chart reviews?


17 A. Correct.

18 Q. Okay. What do you do chart reviews for the  
19 emergency room?

20 A. Well, I think that's my job. I -- I've  
21 just -- I've put that onus upon myself as to -- as to  
22 see how we document our records and make sure that the  
23 physician that I have, especially now younger physicians  
24 that I've just hired, are documenting appropriately.  
25 And if they aren't, then I need to go talk to them about

14

1 it.

2 ~~Q.~~  Q. And why is that important to document  
3 appropriately?

4 A. Well, it -- I think it's good health care  
5 to document appropriately. And, also, it -- it gives  
6 the world a record of what we have done. Now, does that  
7 mean we're always perfect at it? No. Does that mean  
8 that it's -- I believe it's malpractice to not document  
9 something? No, but it is an area of documentation.

10 Q. And what does document appropriately mean?

11 A. I -- it -- it really depends on each  
12 individual patient. Because the whole analysis is -- is  
13 based on the patient's chief complaint.

14 Q. Doctor, have you published any articles on  
15 spinal cord injuries?

16 A. No.

17 Q. Have you published any articles on  
18 neurogenic bladder?

19 A. No.

20 Q. Published any articles on bladder  
21 dysfunction?

22 A. No.

23 Q. Is there a list of publications in your CV?

24 A. Yes. It should be on the --

25 Q. Okay.

1           A.     -- pages --

2           Q.     I have it.

3           A.     -- 7 and 8.   Okay.

4           Q.     Doctor, have you reviewed any articles  
5 dealing with the issues in this case prior or after  
6 authoring your report of June 18th, '01?

7           A.     Boy, I cannot believe I -- in doing this  
8 for 20-something years I haven't read an article about  
9 spinal cord injury prior to this, but I don't remember  
10 when.  I mean, it would be -- could be eight or ten  
11 years ago.

12          Q.     All right.  Let me -- let me clean that up  
13 a little bit.  Have you reviewed any articles dealing  
14 with the issues in this case --

15          A.     No.

16          Q.     -- prior or after authoring your first  
17 report of June 18th, '01 for purposes of -- of rendering  
18 an opinion in this case?

19          A.     I have not.

20          Q.     And my -- my copy's a little fuzzy.  Is the  
21 date June 18th, '01, your report?

22          A.     I have no idea without looking it up.  Let  
23 me look in my folder.  That's correct.

24          Q.     Okay.  And same question with regards to  
25 articles.  Have you reviewed my medical literature for

16

1 purposes of rendering an opinion in this case?

2 A. No, I have not.

3 Q. Okay. Do you know Dr. Ronald Gordon?

4 A. I know a -- I don't think so. I -- I'm  
5 hesitating because I think I know a Ronald Gordon who is  
6 a radiologist in Toledo. But I don't know this Ronald  
7 Gordon.

8 Q. Okay. He would have been the emergency  
9 room doctor that saw Mr. Rabin on June -- or July 20th?

10 A. No, I -- I would not know him.

11 Q. Okay. Do you know Dr. Vincent Ferrini?

12 A. I do not.

13 Q. Do you know Dr. Gail Gallen?

14 A. Gail who?

15 Q. Gallen.

16 A. Gallen, no, I don't.

17 Q. Okay. How about Dr. Michael Jastremski?

18 A. No.

19 Q. Dr. Sam Kiehl?

20 A. Yes.

21 Q. And how do you know Dr. Kiehl?

22 A. Sam and I were active in the Ohio chapter  
23 of the American College of Emergency Physicians back in  
24 the late '70s, and maybe as early as '80 or '81. So we  
25 were on -- I believe we might have been on the board



1 together. But we were certainly involved at the same  
2 time at -- see him at all the meetings.

3 Q. Do you know Dr. Kiehl socially as well as  
4 professionally?

5 A. No, I don't. I've been -- when he was  
6 director at Riverside, I've been to his department once;  
7 that was about ten years ago. Other than that, never  
8 had dinner with him, or lunch even.

9 Q. Okay. From your knowledge of Dr. Kiehl,  
10 could you state that he is a competent and reputable  
11 emergency room physician?

12 A. Yeah, I would say he was a -- would be  
13 recognized as a -- as a colleague who we think probably  
14 would be practicing reasonable emergency medicine. The  
15 problem is, is that even though he may think the same  
16 thing about me, I've never watched him practice and he's  
17 never watched me practice. So as far as I know, there's  
18 no problems with him -- with his practice.

19 Q. Okay. Fair enough. Do you know Dr. Larry  
20 Marshall?

21 A. Do not.

22 Q. Doctor, are you there?

23 A. Yes.

24 Q. Okay. Did you hear my last question?

25 A. Quote, "Do I know Dr. Larry Marshall",

18

1 unquote. And my answer was, "Do not".

2 Q. Okay. I'm sorry, I didn't hear that.

3 A. That's all right. I think this machine is  
4 actually breaking up a little bit.

5 Q. Okay. Have you spoken with any of those  
6 doctors we've just mentioned since your involvement in  
7 this case?

8 A. No.

9 Q. Can you tell me the materials you reviewed  
10 prior to authoring your report?

11 A. Yes.

12 Q. Okay.

13 A. They are some office records of Dr. Mathew,  
14 George Mathew; Southwest General Hospital emergency  
15 visit. Well, there was one from the 12th of February of  
16 '98. I don't think that was as relevant;  
17 emergency visit for the 17th of April of '98, which  
18 probably wasn't very relevant; some Parma Community  
19 Hospital records dated 8, July, '98; 20, July, '98 and  
20 23, July, '98; Fairview Hospital records from the 25th  
21 of July '98 through the 3rd of August of '98;  
22 depositions of Lawrence Marshall; James Saul, S A U L;  
23 Vincent Ferrini, F-E, double R, I-N-I; Dr. Sawhny. Hang  
24 on a second; Dr. Barkoukis, B-A-R-K-O-U-K-I-S; Dr.  
25 Gordon; and then a brief scanning, and I mean brief, of

1     Janice Kane.   I think that's it.

2             Q.     When did you review the deposition of  
3     Janice Kane?

4             A.     I didn't review it.  I said I scanned it  
5     briefly; that was this morning.  And I believe I left  
6     out an expert letter from Dr. Kiehl.  I don't know if I  
7     have anybody else's.  Dr. Jastremski and Dr. Kiehl, I  
8     don't know if I -- I think that's it.

9             Well, nope, that's not it.  There's a  
10    letter from -- I guess it's from you guys; it's from Mr.  
11    Margolis.  So that's all in my file.  And that's --  
12    that's the end.

13            Q.     Doctor, do you have -- is your file in  
14    front of you right now?

15            A.     I do.

16            Q.     Okay.  Do you have your billing with you as  
17    well?

18            A.     I might have one.  Hold on a second.  I  
19    guess -- I guess there's nothing in there about billing.

20            Q.     Okay.  You were asked to bring that for the  
21    deposition?

22            A.     Say that again.

23            Q.     I believe you were asked, as far as a  
24    deposition notice, to bring that?

25            A.     I -- I really don't know.  I can find it

20

1 for you if you want.

2 Q. Is there any correspondence from the firm  
3 of Reminger & Reminger or Mr. Walters?

4 A. Yes.

5 Q. Okay. Can you mark your file as Exhibit  
6 Number -- Plaintiff's Exhibit Number 2?

7 MR. SHROGE: Dan, is it okay if after  
8 the fact we make a copy, and then we'll  
9 mark it?

10 MR. FINELLI: That's fine.

11 MR. SHROGE: Okay.

12 MR. FINELLI: That's fine.

13 Q. Doctor, are there any other papers,  
14 articles or texts in front of you?

15 A. Well, my CV is in front of me, but I think  
16 we went over that. There's a copy of my letter we  
17 already went over, June 18th. And I think that's all;  
18 nothing else.

19 Q. Doctor, obviously I'm not there, so if you  
20 could kindly let me know, as well as the court reporter,  
21 if you refer to any materials when answering my  
22 questions, fair enough?

23 A. Sure.

24 Q. Okay. And, likewise, if any written or  
25 verbal messages are relayed to you by the defense

1 attorney?

2 A. Okay. Does -- that obviously leaves out  
3 sign language then.

4 Q. Okay. Was there anything removed from your  
5 file by you or anyone else?

6 A. No, sir.

7 Q. What's the percentage of medical-legal work  
8 you do annually as part of your profession? And we're  
9 talking, roughly, last ten years, on average.

10 A. Well, I guess if you're talking income, I  
11 would say 10 percent.

12 Q. Okay. And how about cases per year that  
13 you review?

14 A. On average, I would guess it would average  
15 out to 10 years; I would say about 20, 15 to 20.

16 Q. Per year?

17 A. Correct.

18 Q. Okay. And of those cases that you review  
19 15 to 20 per year, can you give me -- can you tell me  
20 what percent that you review for the plaintiff and what  
21 percent you review for the defendant, on average, within  
22 the last 10 years?

23 A. It's probably just a little bit over 80  
24 percent defense, and -- and the balance plaintiff.

25 Q. Fair enough. Doctor, when was your last

22

1 trial testimony?

2 A. Boy, it certainly was in the -- within the  
3 past couple of months. It was in -- was in Cincinnati;  
4 within the last 40 days, I think.

5 Q. And that was -- was that live testimony or  
6 video?

7 A. Live.

8 Q. Okay. Are you planning to provide live  
9 testimony for this trial?

10 A. Yes.

11 Q. When were you first contacted by Reminger &  
12 Reminger on this case?

13 A. Well, you'll have to wait just a second.  
14 I'm referring now to letters in the file, okay?

15 MR. FINELLI: Mike?

16 MR. SHROGE: Yeah.

17 MR. FINELLI: Can we mark those  
18 letters as Exhibit -- Plaintiff's Exhibit  
19 2?

20 MR. SHROGE: Yeah. They're part of  
21 his file.

22 MR. FINELLI: Okay.

23 MR. SHROGE: That's what you asked me  
24 to mark earlier, right?

25 MR. FINELLI: Okay.

1                   MR. SHROGE: Yeah, we'll mark that at  
2                   the end.

3           A.     11th of May of this year.

4           Q.     11th of May this year?

5           A.     Yes.

6           Q.     Who contacted you?

7           A.     Well, let's see, the letter came from  
8     Stephen Walters.

9           Q.     Okay. And what was your understanding of  
10    your role in this case?

11          A.     To review the above captioned matter, which  
12    is Janice Kane versus Richard Alan Rabin, on behalf of  
13    my clients, Dr. Vincent Ferrini and Community Emergency  
14    Physicians; obviously to give an opinion as to whether I  
15    thought the standard of care was met in my specialty,  
16    which is emergency medicine.

17          Q.     Did Mr. Walters contact you verbally before  
18    sending that letter?

19          A.     You know, I -- I would guess so. I have no  
20    way of -- I don't mark that down. I don't know, but I  
21    can't imagine somebody would send me a letter without  
22    calling first to ask if I had time to review a case.

23          Q.     Okay. The percentage of plaintiff and  
24    defense medical review that you told me about 80 percent  
25    defense, 20 percent plaintiff, how about in the last few

24

1 years, is that roughly the same, or changed?

2 A. No, I think it's changed a bit.

3 Q. And what is it the last three years?

4 A. It -- it may be closer in the last two  
5 years to 75 percent defense and 25 percent plaintiff.

6 Q. Okay. Doctor, do you have any copies of  
7 plaintiff reports that you have authored in the last ten  
8 years?

9 A. Boy, I --

10 MR. SHROGE: Are you asking whether  
11 he's got them here with him today?

12 MR. FINELLI: Well, if he has them  
13 with him today or in his files or --

14 MR. MARGOLIS: Retrievable by some  
15 means.

16 MR. SHROGE: Objection.

17 A. I don't know how I would -- the only way I  
18 could retrieve them would be to go through, by hand,  
19 every file I have. There is no other mechanism.  
20 They're not in a computer. There's no notes. There's  
21 nothing anywhere that would say that there is or isn't  
22 one.

23 Q. Okay. Have you ever done previous work  
24 with Attorney Steve Walters?

25 A. Yes.



1 Q. How many times?

2 A. I would imagine five or six.

3 Q. Last time being when, other than this case?

4 A. I think there's another case within the  
5 last couple of months or a year.

6 Q. What's the allegations in that case?

7 A. I wouldn't have any idea.

8 Q. Okay. Any work with Reminger & Reminger  
9 other than Mr. Walters?

10 A. Yes.

11 Q. Roughly how many times?

12 A. Probably a total of 20, maybe 25.

13 Q. Have you been an expert -- medical expert  
14 on any other case with issues similar to this case?

15 A. I do remember a case of a patient who had  
16 a -- had a traumatic spinal cord injury who had a  
17 preexisting ankylosing spondylitis; that was one.

18 I remember a case of a missed cervical  
19 spine fracture and a paraplegia in a patient who had a  
20 cardiac arrest; that was up in Michigan. And I believe  
21 I spoke for the defense in both of those cases. Both of  
22 those are probably over five years old.

23 Q. Did any of those cases involve any  
24 autonomic neuropathy of organs?

25 A. Those two did not. I'm -- I'm still

26

1 searching my mental file if there are any other cases  
2 like that. Could -- give me a second to think about it,  
3 okay?

4 Q. Sure.

5 A. No, the only other case I can think of is a  
6 spinal cord abscess; probably two cases of that. But --  
7 but they did not present with neuropathy.

8 Q. Over the years you've been doing this type  
9 of work, have you worked with any plaintiff firms in  
10 Cleveland?

11 A. Yes.

12 Q. Who would they be?

13 A. I -- I wouldn't remember. I've got a  
14 couple. One case I know, I testified in trial in  
15 Cleveland against the Cleveland Clinic. And I've got  
16 a -- got a -- another one that I think is against the  
17 Cleveland Clinic, but I -- I don't remember the names of  
18 the -- of the firms. Hang on one second, though.  
19 There's a -- a lady, Cole; is that right? That sound  
20 right?

21 Q. Not to me.

22 A. Hang on a second. Donna Kolis, K-O-L-I-S.  
23 I think she's from Cleveland.

24 Q. Yes.

25 A. Right. I've done a -- I think I've

1     reviewed three or four cases for her in total.

2             Q.     Okay.

3             A.     I did not accept all of them. But I've got  
4     one with her right now.

5             Q.     Other than firms, any other attorneys that  
6     you recall -- plaintiff attorneys in Cleveland that you  
7     worked for?

8             A.     No, I -- I just can't remember their names.  
9     No.

10            Q.     Same question relative to the Akron area?

11            A.     Boy, I don't know if I've ever done a  
12     plaintiff's case in Akron. I just don't remember.

13            Q.     Okay. Let's talk a little bit about Janiak  
14     Consulting, Inc. That's an entity which receives the  
15     monies you generate from doing medical-legal consulting  
16     and review, correct?

17            A.     Yes.

18            Q.     Okay. Are you a shareholder of Janiak  
19     Consulting?

20            A.     Yeah, I -- well, yeah, I guess if there's  
21     stock, I'm the sole -- sole shareholder.

22            Q.     There's no shareholders or employees Janiak  
23     Consulting?

24            A.     Correct.

25            Q.     And the number of years in existence for

28

1 Janiak Consulting?

2 A. Wow, 15, 20.

3 Q. Okay. Does Janiak Consulting file separate  
4 tax returns?

5 A. Yes.

6 Q. And what is the amount of revenue generated  
7 annually by Janiak Consulting, Inc.?

8 A. Well, that, you'd have to go get an  
9 accountant to answer the question after you got a judge  
10 to issue an order. But I can tell you that it's  
11 probably in the range of 50,000. I think that's the  
12 most it's ever earned. I -- I'm not 100 percent sure,  
13 but that sounds right.

14 Q. And that would be gross?

15 A. Yes.

16 Q. And who receives the revenue at the end of  
17 the fiscal year for Janiak Consulting?

18 A. The federal government takes some. And if  
19 there's any left over, they give it to me.

20 Q. Okay. Does Janiak Consulting advertise its  
21 services?

22 A. No.

23 Q. Do you advertise your services for  
24 medical-legal review?

25 A. No.

1 Q. How many hours a week do you spend working  
2 on Janiak -- as Janiak Consulting?

3 A. Well, I would probably -- since I read on  
4 the weekends, I probably would -- be four hours, I would  
5 guess; four -- four to six hours a week. This last week  
6 was quite a bit more, because I was in an airplane for  
7 eight hours and I read most of the time.

8 Q. Can you give me an estimate of the number  
9 of discovery depositions you do, roughly, in a year?

10 A. Say, 15, 12 to 15.

11 Q. And how about the number of trial testimony  
12 per year, either video or live?

13 A. It's got to be four to five.

14 Q. Do you still refer to the texts of  
15 Tintinalli and Rosen for ER care?

16 A. Yeah. I have a copy of Rosen and a copy of  
17 Tintinalli right here; I do look at them occasionally.

18 Q. Since we last spoke, any other text that  
19 you refer to for ER care?

20 A. Well, yeah, actually there's a -- there's a  
21 couple new books out that my new doctors have brought in  
22 called Five-Minute Consults. But I can't remember the

23 name of the auth -- the editor or the publisher.

24 But that's the name, Five-Minute Consults.

25 I think there's one for peds and one for adult medical.

30

1 They're -- they're kind of helpful because they're --  
2 everything is in a graph or tabulated form.

3 Q. And -- and the text we just mentioned and  
4 these Five-Minute\_Consumts, would those be the types of

5 texts you would refer to if you wanted to brush up on  
6 spinal cord injuries or neurogenic bladders?

7 A. Actually, probably not. I will probably  
8 refer to either -- probably look in the literature  
9 for -- for that. Because the approach of spinal cord  
10 injuries changes -- is changing a fair amount. So I'd  
11 probably look in the Journal of Trauma if I were looking

12 for something like that.

13 Q. Okay. The report of June 18th, '01, is  
14 that the only written report by you?

15 A. Yes.

16 Q. Were there any drafts made prior to that  
17 report?

18 A. I don't believe so.

19 Q. And how would that have been written?  
20 Would you dictate that and then have your secretary  
21 transcribe it on the computer?

22 A. Exactly.

23 Q. That report would be located in a disk or  
24 hard drive on the computer?

25 A. That is correct.

1 Q. Did you discuss your findings with Mr.  
2 Walters or any attorneys at Reminger prior to authoring  
3 your report?

4 A. I would say almost certainly.

5 Q. Okay. Can you tell me what was discussed?

6 MR. SHROGE: Objection.

7 A. You know, I -- there would be no way I  
8 would remember that. Obviously I would call back and  
9 say I believe this is a very defensible case and -- and  
10 tell them why. But I can't remember the -- the content  
11 of the exact discussion.

12 Q. Okay. I believe you mentioned earlier you  
13 looked at some other expert reports, one from Dr.  
14 Jastremski and one from Dr. Kiehl, correct?

15 A. Yes.

16 Q. Any other expert reports that you reviewed  
17 in this case?

18 A. That's the only ones I have in my folder.  
19 I haven't seen any others.

20 Q. Are you aware that Mr. Walters also  
21 retained the services of Dr. Gail Gallen, an ER doctor,  
22 who has also authored a report in this case?

23 A. No.

24 Q. Do you know whether Mr. Walters will be  
25 utilizing you or Dr. Gallen at trial in this case?

32

1 A. No.

2 Q. Doctor, one thing -- going back to your  
3 report. When I asked you about any drafts prior to the  
4 report, you did not believe so?

5 A. Yes.

6 Q. Can you clarify that? I mean, do you have  
7 a habit of -- of producing drafts prior to your final  
8 report?

9 A. I'll tell you exactly what my habit is,  
10 because there's no secret.

11 Q. Okay.

12 A. I will dictate a report and then call an  
13 attorney and read it to him.

14 Q. Okay.

15 A. And the attorney will say, "You know what,  
16 you got the name of the defendant wrong, or the name of  
17 the plaintiff wrong"; or, as you well know, an attorney  
18 may say, "I don't like that wording at all. And I think  
19 it should be this -- some way or another"; and I'll  
20 either agree or disagree.

21 But In this particular case, it's -- by the  
22 way, the suggestion that I change something is so rare  
23 that I -- I -- I don't believe it happened in this case  
24 at all. It's just a one shot deal.

25 Q. Okay. But you have no certainty?



1           A.     That's exactly -- only death and taxes are  
2     certain.

3           Q.     Okay. Have your hospital privileges ever  
4     been revoked or suspended?

5           A.     No.

6           Q.     What insurance company do you currently  
7     carry your liability or malpractice coverage with?

8                     MR. SHROGE: Objection.

9           A.     I'll have to ask you for some help at that,  
10    because Kentucky Medical has so many name changes. And  
11    I -- I get asked this question a lot, and I'm just too  
12    dumb to remember. But is it APC; something like that?  
13    Whatever the current incarnation of Kentucky Medical is,  
14    is my carrier.

15          Q.     It's not ProNational, is it?

16                     MR. SHROGE: Objection.

17          A.     I don't know.

18          Q.     Okay.

19          A.     I -- I just -- they change names so fast  
20    and in such a short time period, I've just forgotten who  
21    they are. But I -- ProNational does not sound correct  
22    to me.

23          Q.     Do you know who your agent is for Kentucky  
24    Medical?

25                     MR. SHROGE: Objection.

34

1           A.     I use a -- a company here in Toledo called  
2     Picton Cavanaugh, and my agent's name is Kathy Turley.

3                   MR. MARGOLIS:   Doc, I hope it's not  
4                   FICO.

5                   THE WITNESS:   No, I'm still with PAE,  
6                   actually. Uh-oh, I didn't like the tone of  
7                   that laughter.

8                   MR. MARGOLIS:   Listen, nobody lost  
9                   more with PIE than us.

10                  THE WITNESS:   You know what, I can  
11                  sympathize with that. And some day I'll  
12                  take you up in my Leer jet that they let me  
13                  use, and we'll talk about it.

14                 Q.     Well, Doctor, what's your typical hourly  
15     rate?

16                 A.     \$300 an hour for material review. \$400 an  
17     hour for a deposition and trial and the like.

18                 Q.     Okay. Can you tell me, roughly, how many  
19     hours you've spent to the present time working on this  
20     case?

21                 A.     Yeah, just -- just give me a second; that  
22     won't take long.

23                 Q.     Okay.

24                 A.     I would say somewhere around five.

25                 Q.     Fair enough. Anyone else other than

1 defense counsel contact you about this matter or supply  
2 you with information about this case?

3 A. No.

4 Q. Did you receive any correspondence from  
5 anyone else other than defense counsel?

6 A. No.

7 Q. Briefly, can you tell me the process of --  
8 of how you review cases? And what I mean by that is --  
9 I mean, do you take notes first, or you read all the  
10 medical records? How do you go about reviewing these  
11 types of cases?

12 A. Sure. Step 1 would be to review the --  
13 well, a Step 1 is to request that if I -- if they ask,  
14 to request that they just send me the records and not  
15 really say much about the case on the phone.

16 Step 2 is to review the -- the medical  
17 records. And then after I've reviewed the records if  
18 there's other material, i.e., the depositions, the  
19 complaint, et cetera, then I will review that.

20 And then the last step is to make the phone  
21 call.

22 Q. Okay. Prior to authoring your report?

23 A. Correct.

24 Q. In this case, have you taken any notes  
25 or -- or dictated any notes as part of your process?

36

1           A.     Yeah. Oh, I forgot to answer that part of  
2     the question. What you would -- if you were here, what  
3     you would see on the face of the depositions would be a  
4     circle around a number. That number would be the amount  
5     of time I spent reading the deposition --

6           Q.     Okay.

7           A.     -- the date I read the deposition and then  
8     other numbers which would be page references. Those  
9     page references would be something that I found  
10    interesting as I was reading the deposition. And other  
11    than that, I can't tell you how it would fit in until  
12    I'm all done.

13          Q.     Okay. Do you -- do you highlight those  
14    references or those -- those --

15          A.     Well -- well, for instance, on the  
16    deposition of -- of Barkoukis, I have "25". So when I  
17    turn to page 25, what I see on that page is an incline  
18    that goes from the top to the bottom, which meant, in  
19    general, it was an interesting page.

20          Q.     Okay. And staying on his deposition, any  
21    other pages notated?

22          A.     Sure, 26, 38 and 41.

23          Q.     Okay. Anything else on Barkoukis?

24          A.     No.

25          Q.     How about Dr. Ferrini?

1           A.     Well, now, I got to be a -- I've got to be  
2     fair here. On Ferrini, I -- I've got, actually, a  
3     couple of words written on the front, and I -- I think I  
4     should tell you about that.

5           Q.     Okay. I'm listening.

6           A.     Okay. I'll go over the whole list right  
7     now.

8           Q.     Okay.

9           A.     Page 10, the word is "No". Page 23, the  
10    word is "No". Page 28, page 31, "Wasn't it documented  
11    on the previous visit?" Page 33, 49, 51, 53-54, 57, "Of  
12    course." 69, 70 72, "Yes." That's it for Ferrini.

13          Q.     All right. How about Dr. Gordon?

14          A.     Gordon: 43, 47, 48; that's it.

15          Q.     All right. How about Dr. Sawhny?

16          A.     Sawhny: 6, 10, 11, 13 and 16 with the word  
17    "exactly" appearing after page 13.

18          Q.     All right. And how about Dr. Saul?

19          A.     No references.

20          Q.     Okay. He's clean, huh?

21          A.     Well, I don't know. I might have been  
22    sleepy that day.

23          Q.     All right. Any other depositions you  
24    reviewed that we didn't talk about other than scanning  
25    Ms. Kane?

38

1           A.     I have -- I have Lawrence Marshall, didn't  
2 I tell you that?

3           Q.     I might have missed that.

4           A.     Okay.

5           Q.     Any references on that?

6           A.     Sure. 13, 18 and the word "documentation".  
7 20, "untrue". 25, 26, 31, 36, 43, 47-48; 32, "The  
8 neurosurgeon can wait, but the emergency physician  
9 can't?" 55 56, that's it.

10          Q.     Okay. You haven't had an opportunity to  
11 review Dr. Jastremski's depo, I -- I take it?

12          A.     You are correct.

13          Q.     Okay. Did you request any further  
14 information other than the documents which had first  
15 been supplied to you other than the depositions?

16          A.     No, I requested nothing.

17          Q.     Doctor, any materials that you requested  
18 that were not provided?

19          A.     I'm not sure I understand that question.

20          Q.     Have you requested any materials on this  
21 case that were not provided to you?

22          A.     Oh, no.

23          Q.     Okay. Have you done any research on this  
24 case? And I might have asked this before, I apologize.

25          A.     It's okay. No.

1 Q. Okay. Were you aware of the previous or  
2 current medical malpractice cases against Dr. Ferrini?

3 MR. SHROGE: Objection.

4 A. No idea.

5 Q. Doctor, I want to basically tell you where  
6 and I'm headed. I want to talk a little bit about  
7 diabetes, and then I want to talk a little bit about  
8 spinal cord injury, okay?

9 A. Sure.

10 Q. Are you familiar with -- and this is  
11 basically referencing diabetes mellitus. Are you  
12 familiar with the <sup>lipoides</sup> lipoides classification of patients  
13 with neuropathic voiding dysfunction?

14 A. No.

15 Q. Do you agree that with a neurogenic bladder  
16 there occurs a disruption of the bladder innervation  
17 at various levels in the nervous system?

18 A. I think I would say dysfunction rather than  
19 disruption. Disruption sounds like a, you know,  
20 physical severance.

21 Q. Okay. Other than that, you would agree  
22 with that?

23 A. Sounds right.

24 Q. Tell me, how does diabetes effect the  
25 bladder?

40

1           A.     I don't think it -- well, except for a  
2     predisposition to infection, I don't think it has a  
3     direct effect on the bladder. It probably has more of  
4     an effect on the nervous system.

5           Q.     Okay. So how does it effect the nerves  
6     which eventually effect the bladder?

7           A.     I think I know the theory. I'm not sure  
8     whether it's true. But I think it has to do with  
9     microvascular disease, the same underlying problem with  
10    kidney disruption and peripheral neuropathy that occurs  
11    in diabetics.

12          Q.     Okay. So that the nerve system that  
13    innervates the bladder would be injured by vasculopathy?

14          A.     That sounds right.

15          Q.     Okay. Can you tell me what the first  
16    clinical changes are -- are that occur in a diabetic  
17    related neurogenic bladder?

18          A.     No idea.

19          Q.     Would you agree that clinical peripheral  
20    diabetic neuropathy is defined as symptoms of peripheral  
21    nerve involvement associated with abnormal signs?

22                   MR. SHROGE: Dan, are you -- I mean,  
23                   if you're reading from a text, are you  
24                   asking him to agree with that definition in  
25                   that text?



1 MR. FINELLI: I am making a  
2 statement. I am not reading from a text,  
3 I'm reading from my notes.

4 MR. SHROGE: Okay.

5 A. And could you please read it again?

6 Q. Sure. Would you agree that clinical  
7 peripheral diabetic neuropathy is defined as symptoms of  
8 peripheral nerve involvement associated with abnormal  
9 signs? In other words, you have -- you have abnormal  
10 clinical signs as well as symptoms of peripheral nerve  
11 involvement?

12 A. No, I wouldn't agree with that.

13 Q. Why not?

14 A. I think you can have subjective findings  
15 without objective findings.

16 Q. So you could have symptomatology without  
17 objective findings?

18 A. Right.

19 Q. Okay. Fair enough. Would you agree  
20 there's a progressive nature of the nerve conduction  
21 abnormalities in diabetic neuropathy?

22 A. I would say that that's possible. It's not  
23 100 percent. And the clinical course is variable.

24 Q. Okay.

25 A. But it's not necessarily progressive in

42

1 every patient.

2 Q. Would you agree that peripheral neuropathy  
3 is the most common complication of diabetes mellitus?

4 A. I don't know.

5 Q. And I'm talking about diabetic peripheral  
6 neuropathy now. Can you -- basically, I want to go over  
7 the -- the symptoms and the physical findings of  
8 diabetic peripheral neuropathy, starting with the  
9 symptoms. Can you tell me the symptomatology of  
10 patients that develop peripheral neuropathy due to  
11 diabetes?

12 A. I think it's variable. But the usual  
13 finding is a -- is a patient's complaining of -- of  
14 pain; tingling; numbness; "funny sensations", quote,  
15 unquote, in an extremity without any objective physical  
16 findings.

17 Q. Okay. Is that in the distal part of the  
18 extremity, proximal, or variable?

19 A. It's variable. But it's usually distal  
20 compared to proximal.

21 Q. Is it symmetrical or asymmetrical?

22 A. I think it's probably, more likely than  
23 not, symmetrical.

24 Q. Is it usually in the distal upper  
25 extremities or distal lower extremities, or variable?

1           A.     Well, that's also variable, but usually  
2     it's in the lower.

3           Q.     Okay. Distal extremities -- distal lower  
4     extremities?

5           A.     Yes.

6           Q.     Okay. Any other symptoms other than pain,  
7     tingling, numbness?

8           A.     Well, some people would have an issue with  
9     proprioception; they're not really sure, you know, where  
10    the -- where their extremity is. But that's -- that's  
11    unusual.

12          Q.     Okay. Let's talk a little bit about  
13    clinical findings. What would you find clinically as  
14    far as the motor concern with peripheral neuropathy due  
15    to diabetes?

16          A.     Usually nothing.

17          Q.     So they have normal motor strength?

18          A.     Yeah. Usually they do, yeah.

19          Q.     Okay. Usually they have normal motor tone?

20          A.     Correct.

21          Q.     They do not have muscle atrophy?

22          A.     Not usually.

23          Q.     How about sensory findings?

24          A.     No, that's where -- that's more of the  
25    objective part of the neuropathy. But, yes, you can

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1 find sensory deficits where they just lose 2-point  
2 discrimination, or they just -- things don't feel normal  
3 to them.

4 Q. Okay. How about pain sensation?

5 A. Well, that can be either decreased or  
6 heightened.

7 Q. Okay. How about temperature?

8 A. I don't think there's much of a deal with  
9 temperature.

10 Q. How about reflexes?

11 A. Once again, I'm not impressed that  
12 they're -- that that's very diagnostic and consistent.

13 Q. So, in general, do they have normal  
14 reflexes with diabetic peripheral neuropathy?

15 A. I would say, in general, they do; more  
16 often than not.

17 Q. Doctor, what is meant by stocking glove  
18 deficit when we're talking about diabetic peripheral  
19 neuropathy?

20 A. Well, it's a -- a deficit that occurs  
21 circumferentially in an extremity with a -- a  
22 demarcation line consistent with the proximal part of a  
23 glove or a -- or a sock.

24 Q. Would that be consistent with what you said  
25 earlier, that it is a distal type deficit rather than a

1 proximal?

2 A. Yes, could be.

3 Q. And talking about the clinical findings as  
4 well as the symptoms -- well, we talked about the  
5 symptoms earlier. Are clinical findings symmetrical  
6 usually, or asymmetrical?

7 A. They're usually symmetrical.

8 Q. Can you tell me if Mr. Rabin, on July 23rd,  
9 exhibited any of these symptomatology, findings? I'm  
10 sorry, we were breaking up there. Did you hear my  
11 question?

12 A. Yes. You asked about Mr. Rabin on the 23rd  
13 of July.

14 Q. Whether he exhibited any symptoms or  
15 clinical findings of diabetic peripheral neuropathy?

16 A. Not in the sense we described. The only  
17 thing he -- he presented with was a difficulty  
18 urinating. I didn't think he presented with peripheral  
19 neuropathy.

20 Q. Okay. Fair enough. Doctor, with regards  
21 to diabetes mellitus, tell me how it effects the  
22 circulation, the vascular supply?

23 A. Well, I think there's a micro and a macro  
24 vascular effect. The micro effect is usually in the --  
25 I think on the arteriolar level, the very small blood

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1 vessels which then change the blood flow and the deliver  
2 of nutrients to end organs, as ends organs could be the  
3 brain, the -- the skin, the peripheral nerves, and  
4 sometimes the central nervous system, the kidneys and  
5 the -- I guess that's -- that's the majority in which  
6 the -- there's a dysfunction of those end organs, which  
7 is a -- gradual and may be progressive or may not.

8 The macro vascular is a -- may be related  
9 to the micro in -- in some pathologic way. But it  
10 really results in the common complications of diabetes,  
11 which are heart attack and stroke.

12 Q. Okay. Let's start with the lower  
13 extremities. Did Mr. Rabin exhibit, at any time, in the  
14 records that you reviewed, and specifically on July  
15 23rd, any complaints of claudication?

16 MR. SHROGE: Dan, just for  
17 clarification, I mean, you referenced to  
18 two things there, anywhere in the  
19 records, and then specifically on the 23rd.  
20 Are you asking the doctor to just speak as  
21 to the 23rd?

22 MR. FINELLI: Let's say and/or.

23 MR. SHROGE: You're talking about the  
24 entirety of the record?

25 MR. FINELLI: Let's just do the 23rd.

1 MR. SHROGE: Okay.

2 MR. FINELLI: All right.

3 A. I did not see the word claudication on the  
4 23rd.

5 Q. In the past medical history, did he have  
6 any evidence of lower extremity ischemic ulcers?

7 A. No.

8 Q. Okay. Did he have any evidence of renal  
9 diabetic nephropathy?

10 A. On the 23rd?

11 Q. Yes.

12 A. I would say no.

13 Q. Did he have any notation or evidence of  
14 diabetic retinopathy?

15 A. No.

16 Q. Did he have any evidence of coronary artery  
17 disease?

18 A. No.

19 Q. Did he have any evidence of carotid  
20 arterial disease?

21 A. I would say no.

22 Q. Fair to say that on July 23rd, he did not  
23 have any evidence of diabetic vasculopathy, macro?

24 A. Well, certainly not in this record.

25 Q. Okay.

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*How'd He Know*

1           A.     I mean, it wasn't tested for, so you  
2     wouldn't know what his carotids would be like or his  
3     coronary arteries. So --

4           Q.     Couldn't you test for carotid bruits when  
5     doing an examination?

6           A.     Sure. But if there's no flow, you wouldn't  
7     hear one. So examination is not particularly sensitive  
8     or specific compared to doing the actual test. But your  
9     question is fair, "Is there any evidence?" The answer  
10    is no. But I'm just pointing out that there wouldn't be  
11    if you didn't look for it.

12          Q.     All right. Fair enough. And if there was  
13    no flow, do you not think the patient would be  
14    symptomatic as far as carotid distribution is concerned?

15          A.     Surprisingly, some people aren't. So, you  
16    know, I would guess -- you know, I'll -- I'll finish it.  
17    More likely than not, he didn't have a problem. I'm  
18    just answering your question.

19          Q.     All right. Doctor, what is diabetic  
20    autonomic neuropathy?

21          A.     Boy, that one I'm not as familiar with.  
22    Obviously it's a dysfunction of the autonomic nervous  
23    system. I'm sure it could present with some respiratory  
24    problems in terms of breathing. It could present with  
25    blood pressure problems. It could present with heart



1 rate problems or gastrointestinal function.

2 Q. All right. Do you agree it rarely occurs  
3 as a predominant form of diabetic neuropathy?

4 A. Yeah, because I haven't seen it. Yeah.

5 Q. Diabetic autonomic neuropathies effect what  
6 organs or systems?

7 A. The ones I just listed, I think. I don't  
8 know if there are any others.

9 Q. Can you tell me the major cardiovascular  
10 abnormalities seen with diabetic autonomic neuropathy?

11 A. No, I'd actually have to look that up.  
12 It's -- it's got to relate to heart rate and the ability  
13 to respond to stress. But I -- I'd have to look it up.

14 Q. Let me -- let me do it this way: Did Dr.  
15 Rabin exhibit, on July 23rd, any major cardiovascular  
16 abnormalities secondary to diabetic autonomic  
17 neuropathy?

18 A. I don't think he exhibited them, whether  
19 they were secondary to that or not.

20 Q. Okay. Did Mr. Rabin exhibit, on July 23rd,  
21 any gastrointestinal abnormalities as it relates to  
22 diabetic autonomic neuropathy?

23 A. I would say no.

24 Q. Did Mr. Rabin, on July 23rd, exhibit any  
25 thermoregulatory abnormalities secondary to diabetic

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1 autonomic neuropathy?

2 A. Not that I'm aware of.

3 Q. On the 23rd?

4 A. Right.

5 Q. I'm sorry, I didn't hear your answer?

6 A. Yes, I -- I did not see anything.

7 Q. Okay. On the 23rd, did Mr. Rabin exhibit  
8 any manifestations of diabetic autonomic neuropathy?

9 A. Not that I could see.

10 Q. Doctor, would you agree that a distal  
11 symmetric predominantly sensory polyneuropathy -- and we  
12 talked about this earlier being symmetric, and now I'm  
13 talking distal symmetric predominantly sensory  
14 polyneuropathy is the most common neuropathy that occurs  
15 secondary to diabetes?

16 A. I wouldn't have any reason to argue that  
17 one.

18 Q. And you agree that Mr. Rabin, on July 23rd,  
19 did not exhibit any signs or symptoms of any diabetic  
20 peripheral neuropathy?

21 A. Yes.

22 Q. Doctor, let's talk a little bit about  
23 spinal cord lesions. Would you agree that the period  
24 immediately after spinal cord injury is characterized by  
25 the absence of any spontaneous reflex activity below the

1 level of the lesion from a period of time?

2 A. As a general statement, no.

3 Q. Why not?

4 A. Well, because there's all different kinds  
5 of spinal cord injury. And the majority of spinal cord  
6 injuries are minor, and so those patients retain their  
7 reflexes. So I -- I disagree.

8 Q. Okay. Let me repeat the question. The  
9 period immediately after spinal cord injury, would you  
10 agree that it's characterized by the absence of any  
11 spontaneous reflex activity below the level of the  
12 lesion for a variable period of time?

13 MR. SHROGE: Dan, can you give a time  
14 frame by what you mean by "immediately  
15 following"?

16 MR. MARGOLIS: You know what, Mike,  
17 this isn't your depo, it's the doctor's.  
18 If he can't understand the question or  
19 feels clarification is needed, he can  
20 indicate so. This is the third time, and  
21 it's -- it's not appropriate to do that.  
22 Please stop.

23 MR. SHROGE: Well, Ron, all I was  
24 asking was a question of what he meant by  
25 that time period, that's all.

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1 Q. Doctor, do you understand the question?

2 A. Forgot it now.

3 Q. Okay. Let me repeat it. Would you agree  
4 that the period immediately following spinal cord  
5 injury, that is characterized by the absence of any  
6 spontaneous reflex activity below the level of the  
7 lesion for a period of time?

8 A. I don't know.

9 Q. Okay. Would you agree that period is  
10 referred to as spinal shock?

11 A. Yes. When you have a -- if you have a  
12 patient that's had a spinal cord injury and there are no  
13 reflexes, I would agree that is frequently referred to  
14 as spinal shock. However, it usually is associated with  
15 hypotension unresponsive to fluid load.

16 Q. Okay. During any period of spinal shock  
17 there is hypotension unresponsive to fluid load?

18 A. No, I said usually.

19 Q. Usually, okay. Would you agree that a  
20 super sacral injury to the cord, above the -- above the  
21 sacrum, results in acute dysfunction of the bladder?

22 A. Boy, I -- that question is -- I don't even  
23 understand the question. Because the cord doesn't go  
24 down anywhere near the sacrum, so I don't know what -- I  
25 don't know what it means.

1 Q. Okay. Would you agree that spinal cord  
2 injury above the level of T6 results in acute  
3 dysfunction of the bladder?

4 A. No.

5 Q. Why not?

6 A. Because there's all different kinds of  
7 spinal cord injuries. And that's such a general  
8 statement that you could not possibly agree to that.

9 Q. Okay. What do you need as far as  
10 clarification to answer that?

11 A. Well, I would need two things. I would  
12 need a -- I would need a textbook, and I need a  
13 description of the injury; i.e., is it a transection of  
14 the cord? Is it an anterior cord compression, a  
15 posterior cord compression? I don't know any of those  
16 things. So the symptomatology is different with all of  
17 those. And I'd actually go back to the textbook and --  
18 and review it.

19 Q. Okay. Would you agree that the primary  
20 injury to the spinal cord is either mechanical or  
21 laceration -- mechanical injury either due to  
22 compression or laceration?

23 A. Yeah, that sounds correct. I mean, in  
24 terms of all -- all the injuries, sure.

25 Q. Okay. And in those instances where you

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1 have mechanical injury either due to compression or  
2 laceration above the level of T6, do you agree that that  
3 results in acute dysfunction of the bladder?

4 A. Oh, no, I don't.

5 Q. Why not?

6 A. Because there's -- now I'm saying it for  
7 the third time. There's all different kinds of spinal  
8 cord injuries. And you have to know the exact injury to  
9 know whether it would -- it would happen, but the  
10 majority of the time it will not.

11 Q. Okay. If you have spinal cord injury above  
12 the level of T6 that progresses the spinal shock,  
13 okay --

14 A. Yes. Okay.

15 Q. -- does that result in acute dysfunction of  
16 the bladder?

17 A. That can. I don't know what the percentage  
18 is, but I know it can.

19 Q. You just can't tell me how often or what  
20 percent?

21 A. That's correct.

22 Q. Would you agree that during spinal shock a  
23 flaccid paralyzed bladder presents with urinary  
24 retention?

25 A. I would say that would be more likely than

1 not. Because in that same case you'd have a -- probably  
2 a -- a loss of sphincter tone; there would be no -- no  
3 rectal tone. So I would say that's probably true.

4 Q. Okay. And we'll get to rectal tone  
5 shortly. Would you agree that urinary bladder  
6 dysfunction is a typical manifestation of spinal cord  
7 injury progressing to spinal cord shock?

8 A. I -- boy. No, I don't think so. I --  
9 actually I'm going to be even, I think, more specific  
10 than that by saying I don't know. I'd have to -- I'd  
11 have to review that, I don't know that.

12 Q. Okay. Doctor, in spinal cord injury where  
13 someone has bladder dysfunction, can you tell me the  
14 type of neurogenic bladder that develops?

15 A. No, I don't think I could even classify all  
16 the different types of neurogenic bladder. I'd have to  
17 look that up, too.

18 Q. Okay. Well, I'm talking about the type of  
19 neurogenic bladder that -- as it relates to spinal cord  
20 injury.

21 A. Right. I mean, I -- I don't know how to  
22 classify types of neurogenic bladder, so I can't answer  
23 your question.

24 Q. Okay. Can you tell me the type of symptoms  
25 that present with someone that has neurogenic bladder

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1 secondary to spinal cord injury?

2 A. Well, I would guess that the -- the most  
3 common would be that they're -- they're just not  
4 urinating. But I can't tell you whether they have a --  
5 an urge or not, depends on the injury.

6 Q. Can you tell me why they're not urinating?

7 A. Boy, that -- that pathophysiology in terms  
8 of mechanism for micturition, which is the term for  
9 urination, is -- I don't remember that. That's too  
10 complicated for me.

11 Q. Okay. So all you can say that -- and I'm  
12 not trying to trick you or anything. I'm just trying to  
13 summarize what you said. Relative to people with  
14 neurogenic bladders secondary to spinal cord injury, the  
15 only thing you can say about the physiology of the  
16 bladder is that these people cannot urinate?

17 A. Yeah, the -- the connection between the  
18 brain and the bladder may not be working exactly right,  
19 so you can't will yourself to relax the sphincter  
20 muscles and contract the bladder muscles at the same  
21 time. But that's an extremely complicated  
22 neurophysiologic process, that's why I can't answer it.  
23 I don't remember how it works.

24 Q. Would you agree during the period of spinal  
25 shock that the most peripheral somatic reflexes of the



1 cord segments, i.e., the anal and bulbocavernosus  
2 reflexes, most commonly never disappear; or if they do,  
3 most commonly return within minutes of the injury?

4 A. I couldn't tell you.

5 Q. Would patients -- in urinary retention  
6 secondary to spinal cord injury, do the patients  
7 maintain or lose the sensation of bladder distention and  
8 urgency?

9 A. I would say some do and some don't.

10 Q. How about in diabetic neurogenic bladder  
11 with urinary retention, do they maintain or lose the  
12 sensation of bladder distention and urgency?

13 A. Well, I think that's variable. The worse  
14 it is, the more they're likely to lose the sensation.  
15 But I -- I don't know the percentages.

16 Q. Can you tell me the majority of patients  
17 with diabetic neurogenic bladder, whether or not they  
18 maintain or lose the sensation of bladder distention and  
19 urgency?

20 A. I can't.

21 Q. Can you tell me the majority of patients  
22 with neurogenic bladder secondary to spinal cord injury,  
23 do they maintain or lose the sensation bladder  
24 distention or urgency?

25 A. I can't tell you.

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1 Q. Okay. How are the reflexes in the  
2 extremities of patients that have spinal cord injury  
3 with -- also with neurogenic bladder?

4 A. Boy, without the neurogenic bladder, I'd  
5 say they were frequently hyperreflexic initially.  
6 Although, there -- there would be a flaccid period.  
7 With the neurogenic bladder specifically, I can't answer  
8 that.

9 Q. Okay. Just so I'm certain, in patients  
10 with spinal cord injury that have neurogenic bladder  
11 secondary to the cord injury, you can't tell me how the  
12 reflexes are?

13 A. That's correct. I -- I would have to go  
14 look that up again.

15 Q. In patients that have spinal cord injury  
16 with neurogenic bladder secondary to the cord injury, do  
17 they have a positive or a negative Babinski sign?

18 A. Boy, I -- probably -- probably a positive  
19 one, more than likely.

20 Q. More likely positive, you said?

21 A. That's what I think, yeah.

22 Q. Okay. Same question spinal cord injury  
23 with neurogenic bladder, can you tell me about their  
24 sensory examination of the extremities?

25 A. No. Depends on the injury. I don't know.

1 Q. What about the injury do you need to know?

2 A. Well, once again, is it anterior, posterior  
3 cord, transection of the cord --

4 Q. If they --

5 A. -- penetrated injury of the --

6 Q. -- that progresses to neurogenic bladder?

7 A. Yeah. Remember, and I said I needed to  
8 know two things. I need to know that, plus I had to  
9 have the textbook to look up the pathways again.

10 Q. So without the textbook, you can't answer  
11 that?

12 A. That's correct.

13 Q. Okay.

14 A. Same answer -- same question and same  
15 answer.

16 Q. Okay. Fair enough. In spinal cord injury  
17 that progresses to neurogenic bladder, can you tell me  
18 what the motor exam of the extremities is?

19 A. Well, I would say in spinal cord injury,  
20 same answer to that as I said before, I can't tell you  
21 without the injury and the textbook.

22 Q. Okay. That's fair enough. Doctor, with  
23 spinal cord injury, you'd agree the primary mechanical  
24 injury to the spinal cord is either compression -- cord  
25 compression, or transection, laceration?

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1 MR. SHROGE: Objection. Asked and  
2 answered.

3 A. I think the last time you asked that  
4 question you said either --

5 Q. I think I said either compression or  
6 laceration.

7 A. Compression or laceration. If it's the  
8 same question, I have the same answer; yeah, that would  
9 be it.

10 Q. My point is that's the primary mechanical  
11 injury, correct --

12 A. Right. You either --

13 Q. -- compression or laceration?

14 A. -- you either push on the cord, or you cut  
15 the cord.

16 Q. Right. You agree there's a secondary  
17 injury that occurs due to processes initiated by the  
18 primary injury?

19 A. Yes, I do.

20 Q. And in the majority of those patients with  
21 spinal cord injury, there are pathologic changes or  
22 secondary changes that occur due to reduced blood flow  
23 in the spinal cord?

24 A. I believe that is the theory. I think the  
25 question is: What's causing the reduction? But I think

1 your correct.

2 Q. Okay. There's a reduction of spinal cord  
3 blood flow?

4 A. Right.

5 Q. Okay. So that the posttraumatic ischemia  
6 lends further injury to the spinal cord?

7 A. That part I'm not sure of. You see, the --  
8 the -- when you talk about spinal cord blood flow, I  
9 don't think you mean -- I hope you don't mean  
10 generically the whole cord, but to the injured part?

11 Q. Correct. Correct.

12 A. Okay.

13 Q. Just to that localized area?

14 A. Okay. Yeah. Then there's going to be  
15 initial damage to -- direct injury to -- to cells. And  
16 then there can be, as we're talking about now, secondary  
17 damage of decreased flow to the area around the -- the  
18 bruised or lacerated area.

19 Q. Okay. Secondary following the primary  
20 injury?

21 A. Right.

22 Q. Okay. Just so I'm sure, you agree with  
23 that?

24 A. Sure.

25 Q. Okay. So then it would be reasonable for a

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1 patient who develops neurogenic bladder due to spinal  
2 cord injury that he may progress, or she may progress,  
3 to flaccid muscle paralysis of the lower extremities?

4 MR. SHROGE: Objection.

5 A. Is that possible; you're saying? Sure. Is  
6 it likely? I don't think so; but sure.

7 Q. Well, you agreed with me that in a primary  
8 spinal cord injury you can have secondary injury due to  
9 reduced spinal cord blood flow, correct?

10 A. Absolutely.

11 Q. So that you have subsequent damage to that  
12 area of the spinal cord after the primary injury?

13 A. Right.

14 Q. So why would it not be reasonable for a  
15 patient developing neurogenic bladder due to spinal cord  
16 injury to then progress to flaccid muscle paralysis of  
17 the lower extremities?

18 A. Well, I didn't say it was unreasonable. I  
19 just wanted to point out it was more likely than not  
20 that wouldn't happen, because not all injuries are as  
21 devastating as that; that's all.

22 Q. How about in a devastating injury?

23 A. In a devastating --

24 MR. SHROGE: Objection.

25 A. In a devastating injury, which, by

1 definition, produces marked deficit, it would probably  
2 be more likely that there would be progression. But  
3 whether it would progress to flaccid paralysis or not,  
4 I'd go back to my other answer, which is: Show me the  
5 injury and give me the textbook, and I'll try to figure  
6 it out.

7 MR. FINELLI: Doctor, can we take a  
8 one- or two-minute break?

9 THE WITNESS: Yeah.

10 MR. FINELLI: Okay. I'm going to put  
11 you on hold.

12 THE WITNESS: Okay.

13 (Brief recess was had.)

14 Q. All right. Doc, we were talking about  
15 spinal cord injury and the primary mechanism and then  
16 also a secondary injury which produces damage to the  
17 localized area of that cord as well, correct?

18 A. Right.

19 Q. All right. And I asked you about the  
20 reasonableness of someone who has spinal cord injury  
21 developing neurogenic bladder, would it be reasonable  
22 for them to progress to flaccid muscle paralysis of the  
23 lower extremities? And I think you answered it depends  
24 on the type of cord injury?

25 A. Right. But it certainly would not be an

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1     unheard of thing.

2             Q.     Okay. Let me refer you then to the  
3     myelogram report of Mr. Rabin on July 25th, 1998. Do  
4     you have that in your records?

5             A.     Boy, hang on a second. We're going to try  
6     to find it.

7             Q.     It's in the Fairview --

8                     MR. MARGOLIS: Admit.

9             Q.     -- admit.

10                    MR. MARGOLIS: 7-25?

11                    THE WITNESS: 7-25 is the number?

12                    MR. MARGOLIS: No, 7-25 is the  
13     admission.

14                    MR. FINELLI: Is the admit date.

15                    THE WITNESS: Okay. Hang on a  
16     second. Okay. I got the admission. Let  
17     me see if I can find the --

18                    MR. MARGOLIS: At least on our base  
19     number is base number 95.

20                    THE WITNESS: Okay. That will help a  
21     lot.

22                    MR. MARGOLIS: But I don't know if  
23     yours. is the same.

24                    THE WITNESS: Well, it didn't help.  
25     All right. Let me look under radiology



1 reports.

2 A. I got a myelogram.

3 Q. There you go.

4 A. Is that what you're talking about?

5 Q. Yes. Just so we're on the same page, the  
6 impression is (Reading:) Complete extradural block at  
7 C6-C7 starting at C7-T1?

8 A. That's it.

9 Q. Okay. My question then, Doctor, is: With  
10 that type of spinal cord injury as per the myelogram  
11 impression, would it be reasonable to assume that a  
12 patient who develops neurogenic bladder as a result of  
13 that spinal cord injury then progressed to flaccid  
14 muscle paralysis of the lower extremities?

15 MR. SHROGE: Objection.

16 A. You know, I don't -- I don't know. I can't  
17 be that specific in my knowledge. I just don't know.

18 Q. Okay. Fair enough. Doctor, have you ever  
19 treated a patient with neurogenic bladder secondary to  
20 spinal cord injury?

21 A. I would -- I -- I must have, because  
22 there's a number of patients who come in in wheelchairs  
23 that have Foley catheters in, and their histories are  
24 a -- a fracture of the back and transection of the cord.  
25 So I would say absolutely.

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1 Q. Okay. And in those patients, how were you  
2 able to make the diagnosis that the neurogenic bladder  
3 was secondary to spinal cord injury?

4 A. Because the patient would say that  
5 "Everything was fine until I was in my automobile  
6 accident and I broke my back."

7 Q. Okay. So in those types of patients the  
8 spinal cord injury was acute?

9 A. Yes.

10 Q. Okay. If you were the emergency room  
11 doctor instead of Dr. Ferrini on July 23rd, 1998, with  
12 everything else being the same, i.e., the 7-20 visit of  
13 Mr. Rabin and your knowledge of that visit and the same  
14 complaints by Mr. Rabin on July 23rd, what would your  
15 differential diagnose consist of?

16 A. Okay. Now, this is a hypothetical case, I  
17 guess, right?

18 Q. Yes, everything's the same, except you are  
19 now Dr. Ferrini, and Mr. Rabin's presenting to you on  
20 July 23rd; you have knowledge of the July 20th visit,  
21 and Mr. Rabin's complaints are the same on the 23rd.

22 A. Okay. That's why I said hypothetical,  
23 because his complaints were not the same on the 20th  
24 as on the 23rd. So --

25 Q. I'm not -- I didn't mean to confuse you. I

1 mean, his complaints that he presented to you on the  
2 23rd are the same in the hypothetical?

3 MR. MARGOLIS: In other words, the  
4 same as set forth in the 23rd chart.

5 Q. Yeah. They're not the same as the 20th,  
6 but they're the same as set forth on the 23rd?

7 A. Okay. Now -- thank you very much. That  
8 clarifies it. And your question about that is I'm Dr.  
9 Ferrini, what would I do?

10 Q. Yeah. And just so I'm clear, you -- you  
11 had the opportunity, as per Dr. Ferrini's testimony,  
12 that you reviewed the July 20th visit?

13 A. Okay. That's fair.

14 Q. All right. The question is: What's your  
15 differential diagnosis?

16 A. My differential diagnosis would be --  
17 either it would be urinary retention secondary to a  
18 neurogenic bladder or prosthetic hypertrophy.

19 Q. Okay. And what would be the etiology of  
20 the neurogenic bladder?

21 A. From his diabetes.

22 Q. Anything else as far as the etiology of the  
23 neurogenic bladder?

24 A. No, that's all I would have.

25 Q. What would be needed for you to include

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1 spinal cord injury as part of your differential for the  
2 neurogenic bladder?

3 A. A history of spinal cord injury or  
4 something consistent with spinal cord injury; I didn't  
5 see that in this case.

6 Q. Okay. You reviewed the records of July  
7 20th?

8 A. Right.

9 Q. Do you agree or disagree that the findings  
10 of Dr. Gordon and his diagnosis may be consistent with  
11 spinal cord compression?

12 A. I would think they would be inconsistent.  
13 Because it's a radiculopathy, which is more peripheral.

14 Q. Okay. Any other reason?

15 A. No, that's it. Well, his physical findings  
16 didn't show anything except for a diminished grip  
17 strength, but that was it. And that would be consistent  
18 with a radiculopathy.

19 Q. Did he have motor weakness of the upper  
20 extremities?

21 A. Yeah. That's what I just said, yes.

22 Q. Okay. Other than the grip strength?

23 A. I don't think so.

24 Q. How about his reflexes, were they  
25 diminished?

1           A.     Hang on a second. It, says (Reading:)  
2     Deminished reflexes of the triceps and biceps. I  
3     believe he refers to the --

4           Q.     Well, it says diminished reflexes of the  
5     triceps and biceps; does it not, sir?

6           A.     Yeah, but I'm just -- hang on just a  
7     second. I wanted to finish.

8           Q.     Okay.

9           A.     On -- he does refer to the left. I was  
10    just trying to get the side, that's all.

11          Q.     Okay. So along with the decreased grip  
12    strength, he had diminished reflexes, correct?

13          A.     Right.

14          Q.     And he had also had diminished strength to  
15    the triceps and the biceps?

16          A.     Right.

17          Q.     Along with an abnormal x-ray of the  
18    cervical spine?

19          A.     Yes, that's right. Diffuse degenerative  
20    changes, it says.

21          Q.     Okay. Can that be consistent with spinal  
22    cord compression?

23          A.     Yeah, I guess it could be consistent with  
24    a -- a chronic cervical disc. That would be -- that  
25    would be defined as some external compression of the

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1 cord, sure.

2 Q. And that leads to my next question. What  
3 are the mechanical ways a spinal cord can become  
4 compressed?

5 A. You could compress it externally with --  
6 with infection. You could compress it with blood. You  
7 could compress it with fluid. You could compress it  
8 with bony fragments. You could compress it with a  
9 herniated disc. You could compress it with a foreign  
10 body.

11 Q. Okay. Is it reasonable then, based on  
12 these clinical findings by Dr. Gordon, to state that  
13 a -- these can be related to spinal cord compression  
14 either from bony fragments or a disc herniation?

15 A. Yeah, sure. I think that's what happens  
16 when I have cervical disc disease, you get some -- some  
17 irritation of the nerve roots, perhaps some pressure on  
18 the cord, but not always the pressure on the cord.

19 Q. Okay. And based on the clinical findings  
20 of left upper extremity, could you tell me at what level  
21 this would be occurring in the cervical spine?

22 A. I forgot. Probably C6-7 area, C5-6-7.

23 Q. Okay. Based on that answer, Doc, would you  
24 be concerned about progression of a spinal cord injury  
25 when you saw him on the 23rd?

1           A. No, I would think that -- at least not in  
2 terms of an acute progression. I would be concerned  
3 about the fact that he might have a cervical disc, and I  
4 would want him referred for evaluation of that.

5           Q.     Okay. Again, then based on what we talked  
6 about, the clinical findings, what would be needed for  
7 you to include spinal cord injury as part of your  
8 differential diagnosis for neurogenic bladder?

9                     MR. SHROGE: Are you talking on the  
10                    23rd?

11                   MR. FINELLI: Yes.

12           A.     Well, this -- what else would be needed? I  
13 would think a -- a neuropathy or -- or neuropathic  
14 complaints, i.e., radicular pain in the lower  
15 extremities and -- with or without a -- a history  
16 consistent with severe low back problems.

17           Q.     Why would it be a lower back -- lower back  
18 problem?

19           A.     Well, you asked me what I would need to  
20 worry about -- about the spinal cord compression. And  
21 in a patient that presents like this who has diabetes  
22 and complains of inability to urinate, the spinal cord  
23 is not the number one consideration. And without pain,  
24 it's not a -- not very high up there. It's not even on  
25 there.

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1 Q. Okay. I'm not asking you if it's number  
2 one, I'm asking if it's part of the differential  
3 diagnosis?

4 A. Not for me; not in the emergency  
5 department.

6 Q. And you would agree that Mr. Rabin could be  
7 free of pain on the 23rd because he was taking Vicodin?

8 A. I would agree he would have diminished  
9 discomfort. But I certainly wouldn't agree it would  
10 obliterate all the pain, because Vicodin doesn't do that  
11 unless you -- unless overdose to the point of being  
12 asleep, then it could, but not an awake who can talk and  
13 discuss things with you.

14 Q. Okay. I -- I believe we said earlier  
15 that -- and correct me if I'm wrong, that based on the  
16 clinical findings of Dr. Gordon on the 20th, that that  
17 may be consistent with a spinal cord injury, whether  
18 acute or chronic, either from bony fragments or disc  
19 herniation?

20 MR. SHROGE: Objection. Go ahead.

21 A. Well, I think I was speaking generically  
22 when I talked about bony fragments, et cetera. This is  
23 a -- this is a patient who complains of pain for two  
24 weeks in his left upper extremity.

25 And he has a -- findings consistent with a



1    radiculopathy including a -- the -- the sensation and  
2    the pain and the decreased grip strength. So I  
3    certainly wouldn't consider that to be an acute spinal  
4    cord injury, it could be symptoms consistent with  
5    pressure on the spinal cord externally from a disc.

6           Q.    Okay. Fair enough. So that could be  
7    related to spinal cord compression?

8           A.    Yes.

9           Q.    Due to possibly disc herniation?

10          A.    Sure.

11          Q.    Okay. And my question then is: With him  
12    presenting on the 23rd with urinary retention, would you  
13    not consider that spinal cord compression as a  
14    differential diagnosis?

15          A.    I would not.

16          Q.    Okay. Why not?

17          A.    Well, because the guy's got neck problems.  
18    He had severe radiculopathy. It was causing him a lot  
19    of pain. Then he comes in saying he's not having any  
20    pain. So I certainly cannot assume that a man who's not  
21    having any complaints of discomfort in his arm has had  
22    progression of any kind of disease that's going to  
23    involve the bladder, A.

24                    B, the neck and the bladder, in -- in terms  
25    of the spinal cord are so rarely related that it's

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1 not -- it's not a consideration that I think is  
2 reasonable.

3 Q. I'm sorry, I didn't hear last part, the --

4 A. The neck and the bladder are so rarely  
5 related in terms of the spinal cord that I do not  
6 believe it's a reasonable consideration diagnostically.

7 Q. But you would agree they're commonly  
8 related with spinal cord injury to the cervical area?

9 A. No, I think they're not. Spinal cord  
10 injury to the cervical area, A, I said I had to see the  
11 injury and read the textbook. But, B, the spinal cord  
12 injury does not present with a bladder problem, it  
13 presents with pain in the neck or a history of trauma,  
14 it doesn't present with just a bladder problem.

15 Q. Okay. And the reason you would include the  
16 spinal cord compression in your differential on the 23rd  
17 is because at that point he was not complaining of pain  
18 in the area of his radiculopathy?

19 A. Two reasons. He wasn't complaining of pain  
20 there. And secondly, even if he complained of pain in  
21 his neck, I wouldn't think it would be related to the  
22 bladder.

23 Q. Okay. Would you expect on the 23rd the --  
24 Mr. Rabin to have in the left upper extremity decreased  
25 reflexes in the biceps and triceps?

1 A. If he had a -- some disc pressure that was  
2 causing that, it would be very common to have that be a  
3 persistent finding.

4 Q. Okay. Would you expect him to have  
5 decreased strength in his left biceps and triceps as he  
6 had on the 20th?

7 A. Did you -- did you say decreased strength?

8 Q. Yes, on the 20th he had decreased strength  
9 to his left biceps and triceps, which we read. And my  
10 question is: Similar to the reflexes, would you expect  
11 him on the 23rd to have the decreased strength in the  
12 biceps and triceps?

13 MR. SHROGE: Objection.

14 A. And the answer to that is I would not  
15 surprised if that were a persistent finding.

16 Q. All right. Similar to the reflexes?

17 MR. SHROGE: Objection.

18 A. Exactly.

19 Q. Okay. Would the diagnosis -- well, just  
20 give me a minute here. And I apologize if I asked you  
21 this before, but I don't remember your answer.

22 What would be needed for you to consider  
23 spinal cord compression in the cervical area as a reason  
24 for Mr. Rabin's urinary retention on the 23rd?

25 MR. SHROGE: Objection. Asked and

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answered.

1  
2 A. Yeah, you did -- my answer before was that  
3 I would -- I would expect some lumbar radiculopathy; in  
4 other words, low back pain, numbness around the  
5 perineum, loss of sphincter tone, symptomatology  
6 consistent with either pressure on the very low spinal  
7 cord or the cauda equina.

8 Q. And that would make you consider the  
9 cervical spinal cord compression as a potential etiology  
10 for the urinary retention on the 23rd?

11 A. No. No, that would make me consider the  
12 cord compression alone. The cervical spine, I can't  
13 think of anything in this that would make me consider  
14 the cervical spine to be responsible for the urinary  
15 retention.

16 Q. Would you agree that cervical radiculopathy  
17 can cause bladder symptoms if there is an impingement on  
18 the cord?

19 A. Not enough to make it -- me consider it  
20 clinically in the emergency department. I said I'm sure  
21 it's been reported, but I certainly wouldn't consider  
22 it.

23 Q. But for you, that wouldn't be enough for  
24 you to consider that as a differential diagnosis?

25 A. It would not.

1 Q. But you did consider spinal cord injury at  
2 the cervical area as the cause of Mr. Rabin's neurogenic  
3 bladder? What would your medical management and therapy  
4 consist of?

5 MR. SHROGE: Are we talking on the  
6 23rd now, or just hypothetically?

7 MR. FINELLI: No, on the 23rd.

8 Q. If you did consider spinal cord injury as  
9 the cause of Mr. Rabin's neurogenic bladder on the  
10 23rd --

11 A. Sure.

12 Q. -- what would your medical management and  
13 therapy consist of?

14 A. I understand. I would have --

15 MR. SHROGE: Objection.

16 A. I understand. I would ask him to follow up  
17 with a neurosurgeon, within a couple of days would be  
18 reasonable.

19 Q. Within a couple of days you would want him  
20 to see a neurosurgeon?

21 A. Correct.

22 Q. If you thought the urinary retention was  
23 secondary to his cervical spinal cord compression?

24 A. Yes. Correct. Correct. Exactly.

25 Q. Doctor, did Dr. Ferrini, after reviewing

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1 the July 20th chart, did he have any concern that the  
2 urinary retention could be a symptom of progressive  
3 cervical radiculopathy?

4 A. I would say no.

5 Q. Was a neurological exam of Mr. Rabin  
6 indicated on his 7-23 visit?

7 A. I think a -- a rectal exam as part of the  
8 neuro was. I think other than that basically just  
9 seeing that the patient could move around was more than  
10 adequate, because he had just had a neurological exam a  
11 couple of days before.

12 Q. Okay. So that -- given the fact that he  
13 had a neurological exam on the 20th meant that on the  
14 23rd, with him presenting with urinary retention, the  
15 only neuro exam that was indicated was watching him, or  
16 observing him ambulate, and doing a rectal exam?

17 A. Right.

18 Q. Why is that?

19 A. Well, because I don't know what else you  
20 would do with the neurological findings. If you've -- I  
21 indicated you probably would find the same weakness and  
22 decreased reflexes, but that would make you want him to  
23 follow up with his doctor. So I don't know what you  
24 would find that would make you change what you wanted to  
25 do.

1 Q. And what did Dr. Ferrini find on his <sup>Annual</sup> annual  
2 examination?

3 A. Guaiac negative; mild enlargement of the  
4 prostate, nothing significant; and the something about a  
5 fungal infection, but that's a secondary finding.

6 Q. What's the purpose of doing a neurological  
7 examination?

8 A. In general?

9 Q. On this case.

10 MR. SHROGE: On the 23rd?

11 MR. FINELLI: Yes.

12 \* A. In this particular case, there's no real  
13 reason to do a neurological examination. But when you  
14 do the rectal examination, if you can find good tone,  
15 then you know that there probably is not a significant  
16 problem with the lower spinal cord that's the related to  
17 neurogenic bladder, what you think is a neurogenic  
18 bladder.

19 Q. Did Dr. Ferrini find good tone on his  
20 rectal exam?

21 A. The word "tone" isn't written there. But  
22 I've never found anyone who could do a, rectal  
23 examination without noting the tone. But it did not --  
24 it is not documented.

25 Q. What is the importance of the physician to

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1 document the clinical findings of the physical exam?

2 A. Well, we need to provide information on the  
3 status of the patient right at that time. And then over  
4 time, there may be other health care givers who would  
5 need to know what the patient was like at a certain  
6 point in the past. So it's just good to document.  
7 That doesn't mean we are perfect, but it's good to do  
8 it.

9 Q. Doctor, are you aware of any written  
10 guidelines or standards published by any medical  
11 profession or organizations relative to documentation of  
12 records?

13 A. Well, certainly there's -- I -- I think  
14 there's a -- well, no, let me answer your question  
15 exactly as I understand it. No. The answer is no.

16 Q. What is it about the question that you  
17 would -- you don't understand or understand? I'm --

18 A. No, I understand your question. But you  
19 want to know if I'm aware of a published something or  
20 other which says what has to be documented; and the  
21 answer was no.

22 Q. Okay. What is your basis, if any, that Dr.  
23 Ferrini performed a neurological exam on Mr. Rabin on  
24 7-23-98?

25 A. Well, he says so in his deposition.



1 Q. Okay. And so you're relying on Mr. -- Dr.  
2 Ferrini's deposition testimony?

3 A. Oh, sure.

4 Q. Okay. Did Dr. Ferrini document, on the  
5 emergency room chart of 7-23, any neurologic exam being  
6 performed?

7 A. He did not. There is nothing that is in --  
8 headlined, quote, "neuro exam", unquote; it is not  
9 there.

10 Q. What is the basis, if any, that the  
11 neurologic exam performed by Dr. Ferrini on 7-23 of Mr.  
12 Rabin --

13 A. Just his deposition testimony.

14 MR. SHROGE: I don't know if we heard  
15 that whole question. It sounded like you  
16 were cutting out, Dan.

17 MR. FINELLI: You want me to repeat  
18 it?

19 MR. SHROGE: Yeah, if you can.

20 Q. All right. Just basically what's doctor --  
21 what's the doctor's basis, if any, that the neurologic  
22 exam by Dr. Ferrini on the 23rd of Mr. Rabin, if  
23 performed was, indeed, normal?

24 A. And I said just his deposition testimony.

25 Q. So your opinion in this case is based on

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1 the deposition testimony of Dr. Ferrini, that he  
2 performed a neuro exam on Mr. Rabin on the 23rd and that  
3 that exam was normal?

4 A. Well --

5 MR. SHROGE: Objection. I don't  
6 think -- Dan, that's not fair to the  
7 doctor. I don't think that's what his  
8 entire opinion's is based on.

9 A. As I said before, he also has a rectal  
10 exam, which I consider to be the most important part of  
11 the -- of the neurological exam in this particular  
12 presentation.

13 And secondarily, I guess, if you want to  
14 get into it, at least he -- his note is, quote, "His  
15 neck is soft, supple and nontender", which makes me feel  
16 that there's -- that the pain component -- even if the  
17 guy was on Vicodin, movement of the neck, if there's a  
18 significant continued radiculopathy, it's going to cause  
19 more discomfort in most patients. So that's just added  
20 information, that's all.

21 Q. And When you're talking about the -- the  
22 anal exam, you're talking about the anal and  
23 bulbocavernosus reflex, correct?

24 A. No, I'm talking about the tone of the  
25 musculature.

1 Q. If the neurologic exam on the 23rd would  
2 have been positive --

3 A. Which, by the way, I think I've already  
4 testified that it would not surprise me if he still had  
5 weakness and decreased reflexes.

6 Q. Okay. Would that change your opinion at  
7 all?

8 A. Absolutely not.

9 Q. Is -- is your opinion partly based on the  
10 deposition testimony that Dr. Ferrini performed a  
11 neurologic exam on Mr. Rabin on the 23rd of July?

12 A. Minimally so. I guess I'll go a step  
13 further. If Dr. Rabin had testified that the only  
14 neurological examination he performed was a rectal  
15 examination, I still would be here.

16 Q. Okay. And I just want to -- for the -- for  
17 the record, you mean Dr. Ferrini?

18 A. Yes, I'm sorry. I said the wrong name.

19 Q. Just so I'm clear then, even if Dr. Ferrini  
20 only performed a rectal exam as part of his  
21 neurological -- neurological examination of Mr. Rabin on  
22 the 23rd, your opinion would still be the same?

23 A. Yes, sir.

24 Q. Okay. Do you agree that the diagnosis and  
25 findings of Mr. Rabin on the 20th of July '98 were

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1 related to his spinal cord compression --

2 A. You know, I guess I -- I just --

3 Q. -- at the time you sit here?

4 A. Yeah, I -- I -- I'm sure they were

5 secondary to whatever was going on in his spinal cord.

6 I don't know that he had actual cord compression right

7 at that time. I -- I know that his disease process was

8 what was causing the problem on the 20th. Whether there

9 was actual cord compression or there was just a

10 radiculopathy, that, I'm not sure.

11 Q. But as you sit here today, you would agree

12 that Mr. Rabin had cervical spinal cord injury?

13 A. I think he had -- yeah. I think the MRI

14 taken way back when he had his injury in July was

15 positive.

16 MR. SHROGE: You mean April?

17 A. Or April, sorry.

18 Q. So that -- would you agree, as you sit

19 there today, that the diagnosis and findings of Mr.

20 Rabin on July 20th were related to the spinal cord

21 injury?

22 MR. SHROGE: Objection. Asked and

23 answered.

24 A. I think -- you know, the problem with that,

25 I think they're related to process. And I'm not trying

1 to be crazy here, but I think in that MRI it showed  
2 actual part of the cord. I don't know how big the piece  
3 of the cord was infarcted, which would means -- means it  
4 would be dead.

5 And in that case, you wouldn't expect  
6 radiculopathy pain. You might respect -- expect, maybe,  
7 muscle weakness. You might expect no sensation. But  
8 you wouldn't expect pain. So I don't know what all the  
9 symptoms --

10 Q. -- neurologic deficit to the extremity --

11 MR. SHROGE: Well, let him answer,  
12 Dan.

13 MR. FINELLI: Okay.

14 MR. SHROGE: Were you done, Doctor?

15 THE WITNESS: I think so.

16 MR. SHROGE: All right. Go head.

17 Q. You would also -- but with infarction, you  
18 would have neurologic deficit to that extremity.

19 A. Yes, you could. Sometimes you wouldn't  
20 have anything, depends on which cells are infarcted.

21 Q. Right. You would agree that on July 25th  
22 Mr. Rabin presented to the ER with spinal cord injury?

23 A. Yes, that -- that seems to be pretty clear.

24 Q. So between the 20th and the 25th, i.e., the  
25 23rd, would it not be reasonable to assume that his

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1     neurogenic bladder was secondary to his spinal cord  
2     injury?

3                     MR. SHROGE:  Objection.  Asked and  
4                     answered.

5             A.     The answer would be no.

6             Q.     Why not?

7             A.     Well, two reasons.  The guy was diabetic,  
8     and he didn't have any significant discomfort in his  
9     upper body.  His neurological examination was okay, and  
10    so it's more likely than not he's has a diabetic  
11    neurogenic bladder.  The second reason is he had an  
12    injury.

13            Q.     What facts in this case, Doc, would need to  
14    be present for you to conclude that the standard of care  
15    was not met by Dr. Ferrini on the 23rd?

16            A.     Boy, I --

17                   MR. SHROGE:  When --

18            A.     There could be millions of different --

19                   MR. SHROGE:  Wait a minute, Doctor.  
20                   When, Dan?

21                   MR. FINELLI:  Pardon?

22                   MR. SHROGE:  When?  Facts when?

23            Q.     Doctor, did you hear the question?  I'll  
24    repeat it if you didn't hear it.

25            A.     You asked me on the 23rd.

1           Q.     I'm asking you what facts would need to be  
2 present in this case for you to conclude that the  
3 standard of care was not met by Dr. Ferrini on July  
4 23rd, '98?

5                   MR. SHROGE: He's not limiting it to  
6 the 23rd, Doctor. He's saying this entire  
7 course.

8                   MR. FINELLI: No, I don't need your  
9 -- your qualification.

10                  MR. SHROGE: Well, he just asked  
11 you if you -- that you said the 23rd, and  
12 you said no.

13           Q.     Do you understand the question?

14           A.     I guess not. I thought I did, but I don't  
15 think so now.

16           Q.     Let me repeat the question without any  
17 editorials.

18           A.     Go ahead.

19           Q.     What facts would need to be present in this  
20 case for you to conclude that the standard of care was  
21 not met by Dr. Ferrini on July 23rd, '98?

22           A.     Well, the answer to that, there could be  
23 many facts. This -- he could have presented with  
24 crushing chest pain and there was no electrocardiogram  
25 done. He could have presented with a temperature of 103

*Bladder?*

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1 and there was no workup for infection. He could have  
2 presented with paralysis and there was no -- no  
3 intensive localized neurological workup.

4 So, you know, there's -- there's an  
5 unlimited number of scenarios which -- which are  
6 hypothetical which could conclude -- I could conclude  
7 that malpractice was committed.

8 Q. Those instances that you mentioned, it  
9 would be important to work up those conditions, correct?

10 A. Sure.

11 Q. doctor, what would you expect clinically be  
12 present with Mr. Rabin if his neurogenic bladder was  
13 secondary to diabetic neuropathy on the 23rd of July  
14 '98?

15 A. I think all you would -- all you may need  
16 is urinary retention.

17 Q. Nothing else as far as neuropathy --

18 A. No.

19 Q. -- autonomic or peripheral?

20 A. Correct. You don't need to have anything,  
21 could be just in isolation.

22 Q. Is there any literature, medical literature  
23 that you can refer me to support your statement?

24 MR. SHROGE: Objection.

25 A. No. I -- I didn't do any research.



1 Q. Have you ever diagnosed diabetic neurogenic  
2 bladder?

3 A. In 27 years, I would guess so. But I -- I  
4 can't cite you the case or time.

5 Q. Have you ever diagnosed diabetic neurogenic  
6 bladder in the absence of any symptoms or clinical signs  
7 of peripheral diabetic neuropathy or additional diabetic  
8 autonomic neuropathy effecting other body organs or  
9 systems?

10 A. I -- would say yes. but once again, I --  
11 after 27 years, I can't cite a specific cases.

12 Q. What is the incidence, Doctor, if any, of a  
13 patient having an isolated diabetic autonomic neurogenic  
14 bladder without diabetic peripheral neuropathy or any  
15 other diabetic autonomic neuropathy effecting the  
16 cardiovascular, gastrointestinal or thermoregulatory  
17 systems?

18 A. Did you say the incidence?

19 Q. Yes, if any?

20 A. I have no idea. Well, there has to be an  
21 incidence, but I don't know what it would be.

22 Q. Why does there have to be an incidence?

23 A. Well, because there -- no things are  
24 absolute in medicine. You see everything.

25 Q. More probable than not that you can present

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1 with diabetic neurogenic bladder in the absence of any  
2 symptoms or clinical signs of peripheral neuropathy  
3 secondary to diabetes or in the absence of any diabetic  
4 autonomic neuropathy effecting the other body organs or  
5 systems?

6 MR. SHROGE: Objection.

7 A. The answer to that is I don't know. And in  
8 order to determine how you would find that out you would  
9 have to actually test for all of those deficits, which,  
10 as I said before, it wasn't done in this case because it  
11 wasn't indicated.

12 MR. FINELLI: Doctor, let me put you  
13 on hold for another minute. I want to take  
14 a break.

15 THE WITNESS: Sure.

16 (Brief recess was had.)

17 Q. I want to refer to your report of June 18th  
18 2001.

19 A. All right. Give me just a second to track  
20 that down.

21 MR. SHROGE: I think you either put  
22 it on top or back in your folder.

23 A. Got it.

24 Q. Okay. I -- I want to know the basis for  
25 your statement that the fall is what caused Mr. Rabin's

1 quadriplegia?

2 A. Well, we know he had preexisting spinal  
3 cord problem from his accident. We know the MRI showed  
4 some damage. We know he had some impingement.

5 Q. Which -- which MRI are we talking about?

6 A. The April one.

7 Q. Okay.

8 A. Okay. And the guy falls, and then he comes  
9 in with -- with a transection, basically, of his cord.  
10 That transection would not be likely, as a matter of  
11 fact, it would be extremely unlikely, to be a  
12 progression of his 23rd presentation.

13 Because if he was progressing like that, he  
14 would have had significant obvious deficits on the 23rd  
15 that you could just see. The guy would be perhaps  
16 paralyzed or falling all over or --

17 Q. All right. Let's -- let's talk about the  
18 transection.

19 A. -- whatever.

20 Q. Did he have a transection?

21 A. Well, it's a block.

22 Q. A block, not a transection?

23 A. Yeah.

24 Q. Okay. Is there a difference?

25 A. I -- I think there's an anatomic

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1 difference, but probably not a functional difference.

2 Q. Okay. And you mentioned the fall. Is --  
3 give me the basis that you have that Mr. Rabin fell or  
4 the mechanism of how he fell?

5 A. Well, then I'll have to refer to the  
6 record, which I can do. He came in on the 25th saying  
7 that he couldn't feel anything in his legs. He talked  
8 about his previous history of his arm, his neck pain and  
9 his previous visit. And then he says he's been having  
10 some -- some Dem -- he took some Demerol and Vicodin.

11 Q. Where -- where are you reading, Doctor?

12 A. I'm reading from the records of -- oh, it's  
13 Michelle St. Marie's record, the 25th. Weren't you  
14 asking me about the 25th?

15 Q. Yes. Yes. I was asking you about your  
16 knowledge of the fall, because you state the fall is  
17 what caused his quadriplegia?

18 A. Right. Well, superimposed on -- on his  
19 preexisting cervical spine injury. It's interesting, by  
20 the way, just as a parentheses, that under -- on St.  
21 Marie's record it says (Reading:) Rectal tone reveals --  
22 rectal exam reveals minimal tone, which would go along  
23 with the -- with the block issue.

24 Q. And we don't know if he had minimal tone on  
25 the 23rd, because there's no documentation, correct?

1           A.     Well, you are correct. I already agreed  
2     that it didn't say no tone, but I also said you can't do  
3     a rectal examination without feeling the tone; it's just  
4     impossible.

5           Q.     Doesn't that depend upon the examiner?

6           A.     Not in this case. It's so obvious, it does  
7     not depend on the examiner.

8           Q.     What is so obvious?

9           A.     I'm sorry.

10          Q.     What is so obvious?

11          A.     The lack of tone, the ease with which you'd  
12     do the rectal examination?

13          Q.     Okay. Wouldn't that depend upon the  
14     subjective findings of the examiner? I mean, you  
15     weren't doing the rectal exam, Doc. There's nothing  
16     documented. So wouldn't it depend upon the examiner  
17     himself?

18          A.     Yeah. What I'm saying is, sure, there is  
19     a -- it is subjective in -- because it's a -- a pressure  
20     feeling around the finger. But what I'm saying is, is  
21     that we're not going on a scale of 1 to 10 of a pressure  
22     change from 10 to 9, we're going on a 10 to 0. And  
23     that's why it's -- they -- each examiner's going to get  
24     the same finding.

25                     At any rate, the answer to your other

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1 question is if you look at the emergency department  
2 record, nursing triage notes, (Reading:) Patient states  
3 collapsed on the floor after taking pain meds, unable to  
4 stand, numb on the right side, can't move both legs. So  
5 the patient fell on to the floor.

6 Q. Okay.

7 A. And I believe in his deposition and in the  
8 little piece I looked at of -- of Kane's deposition,  
9 there were -- well, it's not his deposition, it's  
10 another deposition -- is the patient rolled -- either  
11 rolled out of bed and fell to the floor or -- or got up  
12 out of bed and fell to the floor, one of the two.

13 He -- his comment -- as I remember, his  
14 comment was that he thought that he -- this happened  
15 because of the amount of pain medication he had been  
16 taking.

17 Q. So basically what -- from what I heard you  
18 saying is he either rolled out of bed or stood up and  
19 his legs collapsed?

20 A. Yeah, he said he couldn't stand up, or he  
21 fell over, right.

22 Q. Okay. If you stand up and your legs  
23 collapse, isn't that consistent with a decreased motor  
24 weakness and motor strength of the lower extremities,  
25 paralysis of your lower extremities?

1           A.     No. No, it's not -- not consistent with  
2     that. It's consistent with -- what would be consistent  
3     is if you couldn't get out of bed because you couldn't  
4     move your leg; that would be consistent; or you couldn't  
5     stand up. But if you can stand up, then that's not  
6     consistent with this -- with this profound deficit that  
7     he had.

8           Q.     How about rolling out of bed, would that be  
9     consistent with paralysis to the lower extremities?

10          A.     I can't -- no, I -- I can't imagine anybody  
11     would be able to -- you know, you need your legs to roll  
12     usually. Because if you roll with your trunk, you're  
13     going to -- I mean, just imagine it, trying to roll with  
14     your trunk alone, then what happens is your -- your head  
15     goes out first, your legs drag behind you and you sort  
16     of slide out of bed front to back. It doesn't --

17          Q.     And you would possibly land on your head?

18          A.     And break your neck.

19          Q.     There were no fractures in this case, were  
20     there?

21          A.     Well, maybe you injure your cord then.

22          Q.     Okay. Doctor, you said the fall would have  
23     caused the quadriplegia because there was superimposed  
24     previous spinal cord injury?

25          A.     Right.

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1 Q. So absent the previous spinal cord injury,  
2 if he would have fell, he would not have been  
3 quadriplegic?

4 MR. SHROGE: Objection.

5 A. Well, we don't know that for sure. I think  
6 it -- it certainly would be less likely, I agree. But I  
7 think that if you fall and injure your neck, you fall  
8 and injure your neck.

9 This -- this patient obviously had a -- had  
10 enough problems with his the -- the bony ligamentous  
11 structures of his neck that he had some spinal cord  
12 compression, which is evidenced on the MRI, the same guy  
13 who didn't go to the neurosurgeon for follow-up. So --

14 Q. And that's prior to the 25th, correct?

15 A. Yes, exactly.

16 Q. Okay. So that would have been present on  
17 the 25th? I'm sorry --

18 A. Yes. Yes, the -- the findings on the MRI,  
19 that one in April, yeah, he would still have findings  
20 similar to that, absolutely.

21 Q. And that would also be present on the 23rd?

22 A. Sure.

23 Q. Doctor, did you rely at all on -- on that  
24 statement, that the fall caused his quadriplegia, from  
25 the May 20th, 1999 letter authored by Dr. West?



1           A.     I haven't even seen such a letter. I don't  
2 know about it.

3           Q.     Do you have that as part of your records?

4           A.     Dr. West, no. I don't even know who Dr.  
5 West is.

6                   MR. FINELLI: Mike, do you have that  
7 as part of your records?

8                   MR. SHROGE: I'll take a look, but I  
9 don't know if he -- I don't think he's got  
10 that. I'm looking in the -- the -- the  
11 index of his medical records, and no.

12          Q.     All right. Doc, would you agree that as  
13 far as the diagnosis and treatment of his spinal cord  
14 injury you would defer to the specialization of a  
15 neurosurgeon?

16          A.     Sure. Once a -- a potential injury has  
17 been identified, then the treatment's the neurosurgical  
18 part of it.

19          Q.     All right. Doc, just a few cleanup  
20 questions. As part of your Professional Emergency  
21 Services, does that group have any publications or  
22 guidelines regarding standards of emergency care and/or  
23 documentation of records?

24          A.     No, sir -- well, now, nope. I'm sorry,  
25 that's wrong. I -- we do have a corporate policy that

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1 charts should be dictated within 48 hours of seeing the  
2 patient. And that is expected to be complied to at 90  
3 percent level.

4 Q. If you're an employee or a -- a doctor  
5 that's been employed by -- what's it called --  
6 Professional Emergency Services, what documents or  
7 materials are you provided with? Any manuals or --

8 MR. SHROGE: Objection.

9 A. Yes, there is a benefit manual, and then  
10 there's a -- a contract, and then there's a -- a --

11 Q. Any procedural manual'?

12 A. No, not at all.

13 Q. Any manuals on guidelines of care in the  
14 emergency room?

15 A. None.

16 Q. Doctor, any cases where you testified in  
17 and the jury found against the side testified for?

18 MR. SHROGE: Objection.

19 A. Yes.

20 Q. In you own legal history, have you ever  
21 been sued for medical malpractice?

22 A. Yes.

23 MR. SHROGE: Objection.

24 Q. How many times?

25 A. Once.

1 Q. One time. And the disposition of that?

2 A. You know, I'd have to go look it up. I  
3 haven't heard from it for a couple of years. I think  
4 it's probably dropped.

5 Q. Okay. Doctor, does the standard of care  
6 include the duty to reduce the risk harm to the patient  
7 as far as reasonably possible?

8 A. Sure. You want to reduce risk of harm to  
9 the patient as long as you have a reasonable assessment  
10 of the likelihood of that -- of that risk.

11 Q. Does the patient deserve to have the  
12 standard of care provided to him or her that maximizes  
13 their chance of survival?

14 A. Well, I think the standard of care is what  
15 the average competent physician would do under the same  
16 or similar circumstances. And that -- that means that  
17 in order to meet that standard, you perform in a -- in  
18 an adequate, shall we say, average way. Now, that  
19 doesn't mean there isn't some other brilliant thing that  
20 couldn't be done. But by definition, if you don't do  
21 it, that doesn't mean you've committed malpractice.

22 Q. What if you do it negligently?

23 A. Then you would. If it's been found to be  
24 negligent, then that would be malpractice.

25 Q. Are you familiar with JCAHL?

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1 A. Yes, indeed.

2 Q. And do you agree that medical records  
3 should incorporate all significant clinical information  
4 pertaining to a patient as per the JCAHL manual?

5 MR. SHROGE: Objection.

6 A. I agree that we should try to put in all  
7 the significant information. But I have no idea what  
8 the JCAHO manual refers to as significant information.  
9 I would actually question whether it even has anything  
10 in it.

11 Q. Doctor, did Michael hand you any Cleveland  
12 Brown's tickets when he met with you today?

13 MR. SHROGE: Objection.

14 A. Just to -- just to let you know that, if he  
15 did, I would not go.

16 Q. All right. A serious question. Have you  
17 ever attended a social function of Reminger & Reminger?

18 A. Never.

19 Q. Okay. Have you ever attended a function  
20 which was complimented by Reminger & Reminger?

21 A. Never.

22 MR. FINELLI: Just give me a minute.

23 I think we're done.

24 (Brief recess was had.)

25 Q. Doctor --

1 A. Yes, sir.

2 Q. -- one last question.

3 A. Sure.

4 Q. Six parts to one question. When you first  
5 evaluated this case, you did not have the benefit of the  
6 deposition materials, correct?

7 A. I can tell you exactly. I wrote my letter  
8 in June, so it appears that I read the depositions of  
9 Sawhny, Saul, Gordon, Ferrini, Barkoukis, and that's --  
10 that's it.

11 Q. Doctor, how do you reconcile the  
12 discrepancies between the deposition testimony of Dr.  
13 Saul and the deposition testimony of Dr. Ferrini?

14 MR. SHROGE: Objection.

15 A. I -- I wouldn't know unless we -- unless  
16 you gave me specifics, as I don't remember those  
17 details.

18 Q. Okay. If you -- and I can give you the  
19 page and number if you like. But, basically, in Dr.  
20 Saul's deposition, he states he does not recall Ferrini  
21 telling him of urinary retention. And in Dr. Ferrini's  
22 testimony, he states he was told -- he told Dr. Saul of  
23 urinary retention?

24 A. Well, I think the record --

25 MR. SHROGE: Objection.

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1           A.     -- yeah, the record written by Ferrini  
2 indicates that there was a referral to Dr. Barkoukis who  
3 is a urologist. And I think that's the urologist that  
4 Dr. Saul uses. So, A, it would make -- make perfect  
5 sense -- that that's what was discussed. And, B,  
6 it's -- how would you expect a doctor to remember all  
7 these conversations anyhow? So I can accept the fact  
8 that he just doesn't remember.

9           Q.     Okay. So this occurring several years  
10 earlier, you would not expect a physician to remember  
11 all these conversations?

12                     MR. SHROGE: Objection.

13           A.     Yeah, I -- I would not be surprised if he  
14 or she did not; let's say that.

15           Q.     And how do you know that Saul uses Dr.  
16 Barkoukis as a -- his referring urologist?

17           A.     I thought he said that in his deposition; I  
18 could be wrong. If I -- if I am wrong about that, then  
19 I don't remember how I -- how I figured that out.

20           Q.     Did Mr. Walters tell you that?

21           A.     I -- I don't remember. It -- it could be,  
22 though; I'm not denying that. I just don't know.

23           Q.     And -- and, Doctor, with regards to Dr.  
24 Ferrini and Dr. Barkoukis, their conversations, how do  
25 you reconcile the fact that Dr. Barkoukis stated he was

1 not told by Ferrini that Rabin was in the ER on 7-20  
2 complaining of neck pain and diagnosed with severe  
3 radiculopathy, contrasted with Dr. Ferrini's testimony  
4 that he did tell Dr. Barkoukis the diagnosis of severe  
5 cervical radiculopathy made on 7-20 by Dr. Gordon?

6 MR. SHROGE: Objection.

7 A. Well, obviously there's two different  
8 memories of the conversation. Once again, it's an old  
9 conversation. But I can't imagine how it would be  
10 relevant whether he did or didn't.

11 So I would imagine both of them did not  
12 consider it to be really important information for this  
13 patient at this time. So once again, I'm not surprised  
14 there was a discrepancy in memory.

15 Q. Doctor, have we covered all of the opinions  
16 that you have in this case based on your report of June  
17 18th, 2001?

18 A. I think so .

19 Q. Okay. Do you have any other opinions that  
20 we have not discussed based on this case?

21 A. No, I don't believe so.

22 MR. FINELLI: All right. Doctor, I  
23 want to thank you very much. I have no  
24 further questions.

25 (Court Reporter marked Plaintiff's

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1                   Exhibit 2.)

2                               (A discussion was had off the  
3                   record.)

4                               (Deposition concluded and witness  
5                   excused at 4:15 p.m.)

6                               (Signature reserved.)

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C E R T I F I C A T E

I, Kim M. McKinney, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given was by me reduced to stenotype in the presence of said witness and afterwards transcribed; that the foregoing is a true and correct transcription of the testimony so given as aforesaid.

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

I do further certify that I am not a relative, employee or attorney of any party, or otherwise interested in the event of this action; that I am not a relative or employee of an attorney of any of the parties in this action; that I am not financially interested in this action, nor am I or the court reporting firm with which I am affiliated under a contract as defined in the applicable civil rule.

IN WITNESS WHEREOF, I Have hereunto set my



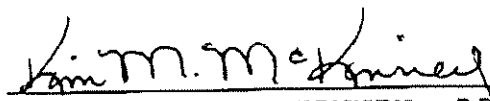
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1 hand and affixed my seal of office at Toledo, Ohio on this  
2 12th day of December, 2001.

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4   
5 KIM M. MCKINNEY, RPR  
6 Notary Public  
7 in and for the State of Ohio

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10 My Commission expires November 4, 2006.  
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SIGNATURE\_PAGE

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Date of Deposition: December 4, 2001

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Errata sheet(s) enclosed? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

\_\_\_\_\_  
Bruce David Janiak, M.D.                      Date

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2

3                   I, Kim M. McKinney, a Notary Public in and  
4 for the State of Ohio, duly commissioned and qualified, do  
5 hereby certify that the within-named witness was by me  
6 first duly sworn to tell the truth, the whole truth and  
7 nothing but the truth in the cause aforesaid; that the  
8 testimony then given was by me reduced to stenotype in the  
9 presence of said witness and afterwards transcribed; that  
10 the foregoing is a true and correct transcription of the  
11 testimony so given as aforesaid.

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

15                   I do further certify that I am not a  
16 relative, employee or attorney of any party, or otherwise  
17 interested in the event of this action; that I am not a  
18 relative or employee of an attorney of any of the parties  
19 in this action; that I am not financially interested in  
20 this action, nor am I or the court reporting firm with  
21 which I am affiliated under a contract as defined in the  
22 applicable civil rule.

23

24                   IN WITNESS WHEREOF, I Have hereunto set my

25

1 hand and affixed my seal of office at Toledo, Ohio on this  
2 12th day of December, 2001.

3

4

KIM M. MCKINNEY, RPR

5

Notary Public

in and for the State of Ohio

6

My Commission expires November 4, 2006.

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