STATE OF OHIO)
)
COUNTY OF CUYAHOGA)

COURT OF COMMON PLEAS

JANICE KANE, E/O RICHARD ALLAN RABIN,

Plaintiff,

vs. No. 401658

MARSHALL LEED, et al., Judge Jones

Defendants.

- - -

DEPOSITION OF BRUCE DAVID JANIAK, M.D.

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

REPORTER: Kim M. McKinney, RPR
Notary Public

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APPEARANCES:

(Via Telephone Participation)
On behalf of the Plaintiff:
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(216)

On behalf of the Defendant:

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

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EXAMINATION

BY MR. FINELLI:

(Via telephone participation)

Q. Dr. Janiak, correct?

A. Correct.

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

A. Correct.

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

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

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

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

A. Okay.

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

A. I would think so.

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

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

(Court Reporter marked Plaintiff's Exhibit 1.)

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

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

A. I'll try.

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

A. Yes.

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

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

A. Yes.

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

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

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

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

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

A. Absolutely.

Q. Okay. Are you still on hospital committees?

A. Yes.

Q. Okay. Are you on the executive committee?

A. Yes.
Q. Credentialling committee?
A. Re.
Q. Budget committee?
A. Yes.
Q. Any other committees?
A. Medical -- or actually it's a quality steering committee, which is the general quality committee for the institution.
Q. Roughly how many times do these committees meet on a monthly basis?
A. Executive is once a month. Quality steering is no more than every other month. Credentials is every month. Oh, and budget, that's probably twice a year.
Q. Okay. What is the purpose of the quality steering committee?
A. It reviews departmental performance as measured against the department's own quality initiatives. For instance, if -- if the orthopedic surgery department is interested in having a postoperative knee surgery infection rate of below one percent, then we would review their actual statistics and -- and see how they're doing and then make recommendations, of course, if they are not meeting

their own goals.

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

A. Correct.

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

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

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

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

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

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

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

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

A. None.

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

A. Yes.

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

A. Yes.

Q. Physicians are all employees of that corporation?

A. Yes.

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

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

Q. Okay. You've expanded.
A. Yes, we have in the last six months.
Q. Of those 20 full time, are they all emergency room physicians?
A. Well, yes. Two are pediatric emergency specialists, but they're all emergency specialists.
Q. Okay. Are you still working Tuesday mornings 7:00 to noon and every third Thursday of the month?
A. No, that's changed because of my increased staff.
Q. Okay. Tell me your work schedule.
A. There isn't any, unless you want to know what it was two weeks ago. The last two weekends I worked. And I'm scheduled to work four out of the next seven days from 4:00 to midnight. And then I'm working 14 shifts in -- in January and February, March, April, May and June, as of right now.
Q. Are the shifts made every month?
A. Well, they're actually scheduled into perpetuity. Anyone on my schedule would know what their scheduled to do three years from now if they care to calculate it out.
Q. Okay. Are you listed as a physician on those blocks of shifts that are made monthly?

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

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

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

A. Well --

Q. -- and the quality health care?

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

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

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

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

A. Correct.

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

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

it.

Q. And why is that important to document appropriately?

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

Q. And what does document appropriately mean?

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

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

A. No.

Q. Have you published any articles on neurogenic bladder?

A. No.

Q. Published any articles on bladder dysfunction?

A. No.

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

A. Yes. It should be on the --

Q. Okay.

A. -- pages --
Q. I have it.
A. -- 7 and 8. Okay.
Q. Doctor, have you reviewed any articles dealing with the issues in this case prior or after authoring your report of June 18th, '01?
A. Boy, I cannot believe I -- in doing this for 20-something years I haven't read an article about spinal cord injury prior to this, but I don't remember when. I mean, it would be -- could be eight or ten years ago.
Q. All right. Let me -- let me clean that up a little bit. Have you reviewed any articles dealing with the issues in this case --
A. No.
Q. -- prior or after authoring your first report of June 18th, '01 for purposes of -- of rendering an opinion in this case?
A. I have not.
Q. And my -- my copy's a little fuzzy. Is the date June 18th, '01, your report?
A. I have no idea without looking it up. Let me look in my folder. That's correct.
Q. Okay. And same question with regards to articles. Have you reviewed my medical literature for

purposes of rendering an opinion in this case?

A. No, I have not.

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

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

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

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

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

A. I do not.

Q. Do you know Dr. Gail Gallen?

A. Gail who?

Q. Gallen.

A. Gallen, no, I don't.

Q. Okay. How about Dr. Michael Jastremski?

A. No.

Q. Dr. Sam Kiehl?

A. Yes.

Q. And how do you know Dr. Kiehl?

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

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

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

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

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

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

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

A. Do not.

Q. Doctor, are you there?

A. Yes.

Q. Okay. Did you hear my last question?

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

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

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

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

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

A. No.

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

A. Yes.

Q. Okay.

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

Janice Kane. I think that's it.

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

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

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

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

A. I do.

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

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

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

A. Say that again.

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

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

for you if you want.

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

A. Yes.

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

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

MR. FINELLI: That's fine.

MR. SHROGE: Okay.

MR. FINELLI: That's fine.

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

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

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

A. Sure.

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

attorney?

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

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

A. No, sir.

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

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

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

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

Q. Per year?

A. Correct.

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

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

Q. Fair enough. Doctor, when was your last

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trial testimony?

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

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

A. Live.

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

A. Yes.

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

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

MR. FINELLI: Mike?

MR. SHROGE: Yeah.

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

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

MR. FINELLI: Okay.

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

MR. FINELLI: Okay.

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

A. 11th of May of this year.

Q. 11th of May this year?

A. Yes.

Q. Who contacted you?

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

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

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

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

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

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

years, is that roughly the same, or changed?

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

Q. And what is it the last three years?

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

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

A. Boy, I --

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

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

MR. MARGOLIS: Retrievable by some means.

MR. SHROGE: Objection.

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

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

A. Yes.

Q. How many times?
A. I would imagine five or six.
Q. Last time being when, other than this case?
A. I think there's another case within the last couple of months or a year.
Q. What's the allegations in that case?
A. I wouldn't have any idea.
Q. Okay. Any work with Reminger & Reminger other than Mr. Walters?
A. Yes.
Q. Roughly how many times?
A. Probably a total of 20, maybe 25.
Q. Have you been an expert -- medical expert on any other case with issues similar to this case?
A. I do remember a case of a patient who had a -- had a traumatic spinal cord injury who had a preexisting ankylosing spondylitis; that was one.
I remember a case of a missed cervical spine fracture and a paraplegia in a patient who had a cardiac arrest; that was up in Michigan. And I believe I spoke for the defense in both of those cases. Both of those are probably over five years old.
Q. Did any of those cases involve any autonomic neuropathy of organs?
A. Those two did not. I'm -- I'm still

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

Q. Sure.

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

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

A. Yes.

Q. Who would they be?

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

Q. Not to me.

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

Q. Yes.

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

reviewed three or four cases for her in total.

Q. Okay.

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

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

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

Q. Same question relative to the Akron area?

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

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

A. Yes.

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

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

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

A. Correct.

Q. And the number of years in existence for

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Janiak Consulting?

A. Wow, 15, 20.

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

A. Yes.

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

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

Q. And that would be gross?

A. Yes.

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

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

Q. Okay. Does Janiak Consulting advertise its services?

A. No.

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

A. No.

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

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

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

A. Say, 15, 12 to 15.

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

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

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

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

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

A. Well, yeah, actually there's a -- there's a couple new books out that my new doctors have brought in called Five-Minute_Consults. But I can't remember the name of the auth -- the editor or the publisher.

But that's the name, Five-Minute_Consults. I think there's one for peds and one for adult medical.

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

Q. And -- and the text we just mentioned and these Five-Minute_Consults, would those be the types of texts you would refer to if you wanted to brush up on spinal cord injuries or neurogenic bladders?

A. Actually, probably not. I will probably refer to either -- probably look in the literature for -- for that. Because the approach of spinal cord injuries changes -- is changing a fair amount. So I'd probably look in the Journal_of_Trauma if I were looking for something like that.

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

A. Yes.

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

A. I don't believe so.

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

A. Exactly.

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

A. That is correct.

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

A. I would say almost certainly.

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

MR. SHROGE: Objection.

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

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

A. Yes.

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

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

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

A. No.

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

A. No.

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

A. Yes.

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

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

Q. Okay.

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

Q. Okay.

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

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

Q. Okay. But you have no certainty?

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

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

A. No.

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

MR. SHROGE: Objection.

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

Q. It's not ProNational, is it?

MR. SHROGE: Objection.

A. I don't know.

Q. Okay.

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

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

MR.SHROGE: Objection.

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

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

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

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

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

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

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

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

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

Q. Okay.

A. I would say somewhere around five.

Q. Fair enough. Anyone else other than

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

A. No.

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

A. No.

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

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

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

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

Q. Okay. Prior to authoring your report?

A. Correct.

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

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

Q. Okay.

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

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

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

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

A. Sure, 26, 38 and 41.

Q. Okay. Anything else on Barkoukis?

A. No.

Q. How about Dr. Ferrini?

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

Q. Okay. I'm listening.

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

Q. Okay.

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

Q. All right. How about Dr. Gordon?

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

Q. All right. How about Dr. Sawhny?

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

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

A. No references.

Q. Okay. He's clean, huh?

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

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

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

Q. I might have missed that.

A. Okay.

Q. Any references on that?

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

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

A. You are correct.

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

A. No, I requested nothing.

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

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

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

A. Oh, no.

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

A. It's okay. No.

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

MR. SHROGE: Objection.

A. No idea.

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

A. Sure.

Q. Are you familiar with -- and this is basically referencing diabetes mellitus. Are you familiar with the lipoides classification of patients with neuropathic voiding dysfunction?

A. No.

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

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

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

A. Sounds right.

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

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

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

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

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

A. That sounds right.

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

A. No idea.

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

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

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

MR. SHROGE: Okay.

A. And could you please read it again?

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

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

Q. Why not?

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

Q. So you could have symptomatology without objective findings?

A. Right.

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

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

Q. Okay.

A. But it's not necessarily progressive in

every patient.

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

A. I don't know.

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

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

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

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

Q. Is it symmetrical or asymmetrical?

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

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

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

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

A. Yes.

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

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

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

A. Usually nothing.

Q. So they have normal motor strength?

A. Yeah. Usually they do, yeah.

Q. Okay. Usually they have normal motor tone?

A. Correct.

Q. They do not have muscle atrophy?

A. Not usually.

Q. How about sensory findings?

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

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

Q. Okay. How about pain sensation?

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

Q. Okay. How about temperature?

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

Q. How about reflexes?

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

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

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

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

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

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

proximal?

A. Yes, could be.

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

A. They're usually symmetrical.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. SHROGE: Okay.

MR. FINELLI: All right.

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

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

A. No.

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

A. On the 23rd?

Q. Yes.

A. I would say no.

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

A. No.

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

A. No.

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

A. I would say no.

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

A. Well, certainly not in this record.

Q. Okay.

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

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

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

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

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

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

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

rate problems or gastrointestinal function.

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

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

Q. Diabetic autonomic neuropathies effect what organs or systems?

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

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

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

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

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

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

A. I would say no.

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

autonomic neuropathy?

A. Not that I'm aware of.

Q. On the 23rd?

A. Right.

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

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

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

A. Not that I could see.

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

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

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

A. Yes.

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

level of the lesion from a period of time?

A. As a general statement, no.

Q. Why not?

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

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

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

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

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

Q. Doctor, do you understand the question?
A. Forgot it now.
Q. Okay. Let me repeat it. Would you agree that the period immediately following spinal cord injury, that is characterized by the absence of any spontaneous reflex activity below the level of the lesion for a period of time?
A. I don't know.
Q. Okay. Would you agree that period is referred to as spinal shock?
A. Yes. When you have a -- if you have a patient that's had a spinal cord injury and there are no reflexes, I would agree that is frequently referred to as spinal shock. However, it usually is associated with hypotension unresponsive to fluid load.
Q. Okay. During any period of spinal shock there is hypotension unresponsive to fluid load?
A. No, I said usually.
Q. Usually, okay. Would you agree that a super sacral injury to the cord, above the -- above the sacrum, results in acute dysfunction of the bladder?
A. Boy, I -- that question is -- I don't even understand the question. Because the cord doesn't go down anywhere near the sacrum, so I don't know what -- I don't know what it means.

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

A. No.

Q. Why not?

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

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

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

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

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

Q. Okay. And in those instances where you

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

A. Oh, no, I don't.

Q. Why not?

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

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

A. Yes. Okay.

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

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

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

A. That's correct.

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

A. I would say that would be more likely than

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

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

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

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

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

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

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

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

secondary to spinal cord injury?

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

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

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

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

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

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

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

A. I couldn't tell you.

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

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

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

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

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

A. I can't.

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

A. I can't tell you.

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

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

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

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

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

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

Q. More likely positive, you said?

A. That's what I think, yeah.

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

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

Q. What about the injury do you need to know?
A. Well, once again, is it anterior, posterior cord, transection of the cord --
Q. If they --
A. -- penetrated injury of the --
Q. -- that progresses to neurogenic bladder?
A. Yeah. Remember, and I said I needed to know two things. I need to know that, plus I had to have the textbook to look up the pathways again.
Q. So without the textbook, you can't answer that?
A. That's correct.
Q. Okay.
A. Same answer -- same question and same answer.
Q. Okay. Fair enough. In spinal cord injury that progresses to neurogenic bladder, can you tell me what the motor exam of the extremities is?
A. Well, I would say in spinal cord injury, same answer to that as I said before, I can't tell you without the injury and the textbook.
Q. Okay. That's fair enough. Doctor, with spinal cord injury, you'd agree the primary mechanical injury to the spinal cord is either compression -- cord compression, or transection, laceration?

MR. SHROGE: Objection. Asked and answered.

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

Q. I think I said either compression or laceration.

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

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

A. Right. You either --

Q. -- compression or laceration?

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

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

A. Yes, I do.

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

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

your correct.

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

A. Right.

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

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

Q. Correct. Correct.

A. Okay.

Q. Just to that localized area?

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

Q. Okay. Secondary following the primary injury?

A. Right.

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

A. Sure.

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

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

MR. SHROGE: Objection.

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

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

A. Absolutely.

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

A. Right.

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

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

Q. How about in a devastating injury?

A. In a devastating --

MR. SHROGE: Objection.

A. In a devastating injury, which, by

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

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

THE WITNESS: Yeah.

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

THE WITNESS: Okay.

(Brief recess was had.)

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

A. Right.

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

A. Right. But it certainly would not be an

unheard of thing.

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

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

Q. It's in the Fairview --

MR. MARGOLIS: Admit.

Q. -- admit.

MR. MARGOLIS: 7-25?

THE WITNESS: 7-25 is the number?

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

MR. FINELLI: Is the admit date.

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

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

THE WITNESS: Okay. That will help a lot.

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

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

reports.

A. I got a myelogram.

Q. There you go.

A. Is that what you're talking about?

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

A. That's it.

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

MR. SHROGE: Objection.

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

A. Okay. That's fair.

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

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

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

A. From his diabetes.

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

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

Q. What would be needed for you to include

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

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

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

A. Right.

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

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

Q. Okay. Any other reason?

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

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

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

Q. Okay. Other than the grip strength?

A. I don't think so.

Q. How about his reflexes, were they diminished?

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

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

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

Q. Okay.

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

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

A. Right.

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

A. Right.

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

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

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

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

cord, sure.

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

A. You could compress it externally with -- with infection. You could compress it with blood. You could compress it with fluid. You could compress it with bony fragments. You could compress it with a herniated disc. You could compress it with a foreign body.

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

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

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

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

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

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

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

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

MR. FINELLI: Yes.

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

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

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

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

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

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

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

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

MR. SHROGE: Objection. Go ahead.

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

And he has a -- findings consistent with a

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

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

A. Yes.

Q. Due to possibly disc herniation?

A. Sure.

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

A. I would not.

Q. Okay. Why not?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. SHROGE: Objection.

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

Q. All right. Similar to the reflexes?

MR. SHROGE: Objection.

A. Exactly.

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

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

MR. SHROGE: Objection. Asked and

answered.

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

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

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

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

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

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

A. It would not.

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

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

MR. FINELLI: No, on the 23rd.

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

A. Sure.

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

A. I understand. I would have --

MR. SHROGE: Objection.

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

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

A. Correct.

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

A. Yes. Correct. Correct. Exactly.

Q. Doctor, did Dr. Ferrini, after reviewing

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

A. I would say no.

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

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

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

A. Right.

Q. Why is that?

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

Q. And what did Dr. Ferrini find on his annual examination?

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

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

A. In general?

Q. On this case.

MR. SHROGE: On the 23rd?

MR. FINELLI: Yes.

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

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

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

Q. What is the importance of the physician to

document the clinical findings of the physical exam?

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

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

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

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

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

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

A. Well, he says so in his deposition.

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

A. Oh, sure.

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

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

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

A. Just his deposition testimony.

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

MR. FINELLI: You want me to repeat it?

MR. SHROGE: Yeah, if you can.

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

A. And I said just his deposition testimony.

Q. So your opinion in this case is based on

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

A. Well --

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

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

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

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

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

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

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

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

A. Absolutely not.

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

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

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

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

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

A. Yes, sir.

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

related to his spinal cord compression --

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

Q. -- at the time you sit here?

A. Yeah, I -- I -- I'm sure they were secondary to whatever was going on in his spinal cord. I don't know that he had actual cord compression right at that time. I -- I know that his disease process was what was causing the problem on the 20th. Whether there was actual cord compression or there was just a radiculopathy, that, I'm not sure.

Q. But as you sit here today, you would agree that Mr. Rabin had cervical spinal cord injury?

A. I think he had -- yeah. I think the MRI taken way back when he had his injury in July was positive.

MR. SHROGE: You mean April?

A. Or April, sorry.

Q. So that -- would you agree, as you sit there today, that the diagnosis and findings of Mr. Rabin on July 20th were related to the spinal cord injury?

MR. SHROGE: Objection. Asked and answered.

A. I think -- you know, the problem with that, I think they're related to process. And I'm not trying

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

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

Q. -- neurologic deficit to the extremity --

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

MR. FINELLI: Okay.

MR. SHROGE: Were you done, Doctor?

THE WITNESS: I think so.

MR. SHROGE: All right. Go head.

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

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

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

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

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

neurogenic bladder was secondary to his spinal cord injury?

MR. SHROGE: Objection. Asked and answered.

A. The answer would be no.

Q. Why not?

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

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

A. Boy, I --

MR. SHROGE: When --

A. There could be millions of different --

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

MR. FINELLI: Pardon?

MR. SHROGE: When? Facts when?

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

A. You asked me on the 23rd.

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

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

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

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

Q. Do you understand the question?

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

Q. Let me repeat the question without any editorials.

A. Go ahead.

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

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

Bladder?

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

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

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

A. Sure.

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

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

Q. Nothing else as far as neuropathy --

A. No.

Q. -- autonomic or peripheral?

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

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

MR. SHROGE: Objection.

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

Q. Have you ever diagnosed diabetic neurogenic bladder?

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

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

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

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

A. Did you say the incidence?

Q. Yes, if any?

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

Q. Why does there have to be an incidence?

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

Q. More probable than not that you can present

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

MR. SHROGE: Objection.

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

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

THE WITNESS: Sure.

(Brief recess was had.)

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

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

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

A. Got it.

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

quadriplegia?

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

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

A. The April one.

Q. Okay.

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

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

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

A. -- whatever.

Q. Did he have a transection?

A. Well, it's a block.

Q. A block, not a transection?

A. Yeah.

Q. Okay. Is there a difference?

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

difference, but probably not a functional difference.

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

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

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

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

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

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

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

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

Q. Doesn't that depend upon the examiner?

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

Q. What is so obvious?

A. I'm sorry.

Q. What is so obvious?

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

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

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

At any rate, the answer to your other

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

Q. Okay.

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

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

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

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

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

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

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

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

Q. And you would possibly land on your head?

A. And break your neck.

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

A. Well, maybe you injure your cord then.

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

A. Right.

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

MR. SHROGE: Objection.

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

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

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

A. Yes, exactly.

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

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

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

A. Sure.

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

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

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

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

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

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

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

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

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

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

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

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

MR. SHROGE: Objection.

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

Q. Any procedural manual'?

A. No, not at all.

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

A. None.

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

MR. SHROGE: Objection.

A. Yes.

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

A. Yes.

MR. SHROGE: Objection.

Q. How many times?

A. Once.

Q. One time. And the disposition of that?
A. You know, I'd have to go look it up. I haven't heard from it for a couple of years. I think it's probably dropped.
Q. Okay. Doctor, does the standard of care include the duty to reduce the risk harm to the patient as far as reasonably possible?
A. Sure. You want to reduce risk of harm to the patient as long as you have a reasonable assessment of the likelihood of that -- of that risk.
Q. Does the patient deserve to have the standard of care provided to him or her that maximizes their chance of survival?
A. Well, I think the standard of care is what the average competent physician would do under the same or similar circumstances. And that -- that means that in order to meet that standard, you perform in a -- in an adequate, shall we say, average way. Now, that doesn't mean there isn't some other brilliant thing that couldn't be done. But by definition, if you don't do it, that doesn't mean you've committed malpractice.
Q. What if you do it negligently?
A. Then you would. If it's been found to be negligent, then that would be malpractice.
Q. Are you familiar with JCAHL?

A. Yes, indeed.

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

MR. SHROGE: Objection.

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

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

MR. SHROGE: Objection.

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

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

A. Never.

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

A. Never.

MR. FINELLI: Just give me a minute. I think we're done.

(Brief recess was had.)

Q. Doctor --

A. Yes, sir.
Q. -- one last question.
A. Sure.
Q. Six parts to one question. When you first evaluated this case, you did not have the benefit of the deposition materials, correct?
A. I can tell you exactly. I wrote my letter in June, so it appears that I read the depositions of Sawhny, Saul, Gordon, Ferrini, Barkoukis, and that's -- that's it.
Q. Doctor, how do you reconcile the discrepancies between the deposition testimony of Dr. Saul and the deposition testimony of Dr. Ferrini?
MR. SHROGE: Objection.
A. I -- I wouldn't know unless we -- unless you gave me specifics, as I don't remember those details.
Q. Okay. If you -- and I can give you the page and number if you like. But, basically, in Dr. Saul's deposition, he states he does not recall Ferrini telling him of urinary retention. And in Dr. Ferrini's testimony, he states he was told -- he told Dr. Saul of urinary retention?
A. Well, I think the record --
MR. SHROGE: Objection.

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

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

MR. SHROGE: Objection.

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

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

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

Q. Did Mr. Walters tell you that?

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

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

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

MR. SHROGE: Objection.

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

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

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

A. I think so .

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

A. No, I don't believe so.

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

(Court Reporter marked Plaintiff's

Exhibit 2.)

(A discussion was had off the record.)

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

(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

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

KIM M. MCKINNEY, RPR
Notary Public
in and for the State of Ohio

My Commission expires November 4, 2006.

SIGNATURE_PAGE

Date of Deposition: December 4, 2001

Errata sheet(s) enclosed? Yes_____ No_____ How many?____

_____

Bruce David Janiak, M.D. Date

- - -

Please return this signed signature page along with correction page(s) to:

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- - - - - - - - - - - -

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in and for the State of Ohio

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