THE CIRCUIT COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

CASE NO.: CV326207

BONNIE PIKKEL, et al., JUDGE BRIAN J. CORRIGAN

Plaintiffs,

vs.

MERIDIA HEALTH SYSTEM, et al.,

Defendants.

* *

DEPOSITION OF:	ALLEN J. JONES, M.D.
DATE TAKEN:	MAY 4, 2001
TIME:	COMMENCED AT 2:15 P.M. CONCLUDED AT 5:30 P.M.
PLACE:	VOLUSIA REPORTING COMPANY 150 SOUTH PALMETTO AVENUE SUITE 101 DAYTONA BEACH, FLORIDA
REPORTED BY:	SHARON K. DINES COURT REPORTER AND NOTARY PUBLIC

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VOLUSIA REPORTING COMPANY
POST OFFICE BOX 1409
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APPEARANCES:

MARK W. RUF, ESQUIRE
Linton & Hirshman
Hoyt Block, Suite 300
700 West Saint Clair Avenue
Cleveland, Ohio 44113
(216) 771-5800

Attorney for Plaintiffs

ROBERT F. LINTON, JR., ESQUIRE (VIA TELEPHONE
Linton & Hirshman
Hoyt Block, Suite 300
700 West Saint Clair Avenue
Cleveland, Ohio 44113
(216) 771-5800

Attorney for Plaintiffs

JAMES MALONE, ESQUIRE (VIA TELEPHONE)
Reminger & Reminger
113 Saint Clair Avenue, Northeast
Suite 700
Cleveland, Ohio 44114-1273
(216) 687-1311

Attorney for Meridia Hillcrest Hospital

KENNETH A. TORGERSON, ESQUIRE
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
50 Public Square
Cleveland, Ohio 44113
(216) 687-3205

Attorney for Dr. Spaner
and Lakeland Emergency Associates

C O N T E N T S

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INDEX OF EXHIBITS

***REPORTER'S NOTE: Plaintiff's Exhibit Nos. 1 thru 5 were marked prior to the deposition.

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S T I P U L A T I O N S

It is hereby agreed and so stipulated by and between the parties hereto, through their respective counsel, that the reading and signing of the transcript are expressly reserved by the Deponent,

Page 4

PROCEEDINGS

THEREUPON,

ALLEN J. JONES, M.D.,

having been first duly sworn, was examined and testified upon his oath as follows:

DIRECT EXAMINATION

BY MR. RUF:

Q Doctor, could you please state your name and spell your name.

A Allen, A-L-L-E-N, middle initial J. Last name, Jones.

Q And what is your address?

A My home address is 1932 Southcreek Boulevard. That's one word. And that's Daytona Beach.

Q What is the Zip Code?

A The Zip is 32124.

MR. MALONE: Doctor, I'm sorry, but your voice is very faint.

THE WITNESS: okay. I will try to speak up. I'm sorry.

MR. MALONE: Thanks very much.

BY MR. RUF:

Q Doctor, what is your business address?

A The hospital address at which I practice is -- I'm drawing a blank. It's on Saxon Boulevard in Orange City.

Page 5

Florida Hospital Fish Memorial.

Q That's the name of the hospital?

A Yes. Florida Hospital Fish Memorial. It's part of the Florida Hospital system.

Q And do you work at any other hospitals down here?

A Yes, Florida Hospital, DeLand.

Q How do you spell that?

A D-E-L-A-N-D.

Q Doctor, my name is Mark Ruf. And I, along with Bob Linton, represent the plaintiffs in this case, Bonnie Pikkel and her husband.

If at any time I ask you a question and you do not understand my question, please tell me. If you give me an answer to a question, I will assume that you have understood the question. Okay?

A Correct.

Q Also, this deposition will go a lot faster if you give direct answers to my questions. If you give me evasive answers, I'm going to wind up re-asking the questions and the deposition is going to take a lot longer.

So will you give me direct answers to my questions?

A I will do my best.

Q When were you first contacted and asked to be an expert witness in this case?

Page 6

A I believe it was 1998 or 1999.

Q Do you have a cover letter that shows the date when you were first contacted?

A There's a letter here from May of 1999.

Q Okay. Has that been marked as an Exhibit, Doctor?

A Yes, it has. It's labeled Exhibit 1.

Q And what is the date of that letter and who is it from?

A The letter is dated May 3rd, 1999. It's from Marilyn Miller Crisafi.

Q Were you first contacted by telephone or by correspondence?

A I believe by telephone.

Q Do you know how much prior to May 3rd, 1999, you were contacted by telephone?

A No. I have no idea.

Q Who were you contacted by, by telephone?

A I believe Ms. Crisafi called me at the hospital.

Q Do you remember the discussion that you had with her?

A Not specifically. She -- I believe she mentioned the case and asked if I would review it, and I said I would.

Q Did you discuss any of the facts with her during this initial phone conversation?

A No.

Page 7

Q Did you give her any kind of preliminary opinion during this phone conversation?

A No.

Q And sometime following this phone conversation, you were sent Plaintiffs Exhibit 1; is that correct?

A Correct.

Q And there were a number of enclosures listed in that letter, correct?

A Correct.

Q After reviewing Plaintiffs Exhibit 1 and the enclosures, did you form your initial opinions in this case?

A Yes, I did. I believe those were set forth in my report.

Q And what's the date of your report?

A I don't have a copy of the original report.

Q Okay. I have a faxed copy dated September 17th, 1999.

A That would --

Q To the best of your recollection, is that the first date on which you wrote a report?

A Yes.

Q Did you write any drafts of this report?

A No.

Q Do you have copies of any drafts in the report?

A No, I do not.

Page 8

Q At the time you formed your opinion stated in your report of September 17th, 1999, were the materials that you had available those listed in Plaintiffs Exhibit 1?

A I would assume they were. I have no reason --

MR. TORGERSON: Go ahead. It's a little vague. Are you asking him if he saw anything else between then?

MR. RUF: Yes.

BY MR. RUF:

Q I'm asking, did you base your opinions listed in your report of September 17th, 1999, solely based upon the attachments to Exhibit 1?

A As opposed to other material that was supplied to me?

Q Yes. Were there any other materials that you reviewed before writing your report, other than those listed in Exhibit 1?

A That's been almost three years. I believe I attempted to look through some of the textbooks in emergency medicine and looked at some articles. Unfortunately, I don't have those articles. We discarded many things in the move to Florida, so...

Q Did you discard anything recently?

A No.

Q Did you discard anything before this deposition?

Page 9

A No.

Q What medical or emergency room textbooks did you review?

A I believe Rosen's textbook and Tintinalli.

Q Are those two ER textbooks, textbooks that you regularly refer to?

A I suppose that would be fair to say. They are the most widely used.

Q Those are the two most widely used textbooks by ER physicians?

A Let me rephrase that. They are two widely used. I wouldn't say the most widely used. I don't know what would be the most widely used. But they are in common use.

Q Do you consider the information listed in Rosen's and Tintinalli accurate and reliable?

MR. TORGERSON objection. But you may answer.

THE WITNESS: I couldn't specify everything in there, that everything in there is accurate. I've not read them cover to cover,

BY MR. RUF:

Q But you rely on these textbooks in your own emergency room practice, correct?

MR. TORGERSON: objection. You may answer.

THE WITNESS: On occasion, on rare occasions. Normally, we don't have the luxury of time to look

Page 10

things up.

BY MR. RUF:

Q Are those the two most widely recognized authorities in ER medicine?

A I couldn't say that.

Q Who are the authorities in ER medicine?

A I think there are many. I don't *think* there's any one bible.

Q Well, could you list some of these many?

A The two I just mentioned. I don't recall the lead authors. The one -- there's a textbook by Ann Harwood Nuss, N-U-S-S. Although, I'm not familiar with that one. It's a fairly new text. And there are several others now.

Q Did you consult Rosen's and Tintinallis to look for their writings on cauda equina syndrome?

A I believe I attempted to. There's very little about it in there.

Q In reading those two texts, did you find anything in those sections to be inaccurate or unreliable?

MR. TORGERSON objection. If you know, Of course, everything is if you know. I will just note an objection.

THE WITNESS: To be inaccurate? Not that I was aware of.

BY MR. RUF:

Page 11

Q But you consulted those two textbooks before you wrote your report of September 17, 1999, correct?

A Yes.

Q And those two texts were texts you reviewed, along with the materials listed in Exhibit 1, correct?

A That's correct.

Q Other than the sections on cauda equina, did you review any other sections out of Rosen's or Tintinallis?

A No.

Q What were the articles that you reviewed?

A Again, I have no recollection, as I don't have the articles any longer.

Q Do you remember what the subject matter of the articles was?

A I believe there was one or two on cauda equina after chiropractic manipulation.

Q Were any of the articles on surgical outcomes for cauda equina syndrome?

A Not specifically, as I recall.

Q To the best of your recollection, the articles all related to herniated disks or cauda quina syndrome found in chiropractic manipulation?

A No. There was one or two articles on that. Most of them were -- I was looking more for articles of a general nature on low back pain, with specific reference to cauda

Page 12

equina syndrome.
Q Okay. I'm handing you Exhibit 4. Is that one of the articles that you reviewed?
A Yes.
Q And other than Exhibit 4, you can't tell me the specific articles you have reviewed for this case; is that correct?
A That is correct.
MR. LINTON: For the record, Mark, could you identify -- this is Bob Linton. Identify what Exhibit 4 is.
BY MR. RUF:
Q Doctor, could you, please, identify what Exhibit 4 is and where it came from?
A This, I believe, is a chapter from a series called Medical Clinics of North America. It's -- I believe it comes out quarterly. And it's -- I believe it's a chapter on low back pain. It's under the heading of "Common Medical Problems in Ambulatory Care."
Q Did you review Exhibit 4 before Writing your report of September 17th, 1999?
A I can't recall.
Q But that is an article that's in your file, and at some point during your involvement as an expert, you've reviewed and considered Exhibit 4, correct?

Page 13

A That's correct.
Q Can you tell me all of the depositions that you have reviewed up to the current date in order to form your opinions in this case?
A To recite them or to read them?
Q Just list the depositions you've reviewed, whose depositions.
A The depositions of Dr. Spaner, Dr. Villarosa, and Dr. Bell. Let's see, Ms. Pikkel and Dr. Yates, Dr. Zannetti, Dr. Englehard, and Dr. Blumenkopf.
Q Have you reviewed any medical records in this case?
A Yes.
Q What medical records?
A I'm trying to be accurate. Whatever we have here.
Q Is Exhibit 5 one of the reports?
A That's a report of Dr. Mentari.
Q Who is Dr. Mentari?
A It appears he is a physician who practices physical medicine and rehabilitation at the Cleveland Clinic.
Q And you have also reviewed the report of Scott Shapiro, M.D. of March 27, 2001?
A Yes.
Q Any other medical reports you have reviewed?

Page 14

A None that come immediately to mind.
Q What are all the medical records that you have reviewed in this case?
A There was a report from Dr. Kondray, K-O-N-D-R-A-Y, who is a urologist; Dr. Petroff, who is patient's family doctor; Dr. Siegenthaler, the chiropractor; their ER records from Hillcrest.
Q Are those ER records from 9/4 and 9/5 of 96?
A That's correct.
And I believe there's hospital admission in there also.
Q Okay.
A And then there's an admission, 9/27 and 9/28 to Hillcrest. And there's also records of Dr. Hahn, H-A-H-N, from the Cleveland Clinic.
Q Okay. You have also reviewed plaintiffs' first amended complaint; is that correct?
A I'm not sure if I read that or not.
Q Okay. But that is in your file?
A It's in the file.
Q You don't know whether or not you have reviewed it?
A Correct.
Q And the only correspondence that you have in your possession from the law firm of Weston, Fallon, Paisley &

Page 1

Howley are Plaintiffs' Exhibits 1, 2, and 3?
A I probably have other letters at home. But if they are, they are merely cover letters saying, Enclosed find whatever.
Q Did you review all of the materials we just listed in order to form your opinions in this case?
A Yes.
Q Is there anything that you have reviewed in order to form your opinions in this case that we have not covered?
A I think we have covered everything exhaustively.
Q To the best of your recollection, have you discarded anything you have reviewed in order to form your opinions in this case?
A As I said, I think some of the articles may have gotten lost in the move.
Q Okay. Under the local rule for the Cuyahoga Court of Common Pleas, all of your opinions need to be listed in your report in order to testify on those issues at trial. I'm assuming that you complied with the local rule and listed all of your opinions in your report of September 17, 1999.
MR. TORGERSON objection.
BY MR. RUF:
Q Is that correct?
MR. TORGERSON Objection. I'm not sure what the

local rule is. This doctor is unaware of it, since he is neither a lawyer nor in Cuyahoga County. And wher he was, was not a lawyer.

And his report is time driven. So you want to make certain he understands the implications of what opinions he gave on that date. That's the only thing I would say.

BY MR. RUF:

Q Doctor, can you answer my question?

A I'm not sure how to answer that.

Q Doctor, did you list all your opinions in your report of September 17, 1999?

MR. TORGERSON: That he had as of that date?

MR. RUF: yes.

THE WITNESS: As of that time, yes.

BY MR. RUF:

Q Did you issue any supplemental reports after September 17, 1999?

A I don't believe so.

THE WITNESS: Mr. Torgerson, did we?

MR. TORGERSON: I don't believe so, no. No.

For the record, the only report I have from Dr. Jones is a report of September 17, 1999. However, he has received information to review as recently as May 1st. And I intend to send him Dr. Shapiro's

deposition taken yesterday when it is typed.

BY MR. RUF:

Q Doctor, the only report you have issued in this case is a report of September 17th, 1999; is that correct?

A That's correct.

Q Have you spoken with anyone to form opinions in this case?

A No.

Q I assume that you have spoken with Mr. Torgerson and Ms. Crisafi.

A Yes.

Q Do you remember any of your conversations with them?

A With Ms. Crisafi, there was very little interaction. I think she was pregnant at the time and taking a leave of absence right afterwards. So there was essentially no interaction, other than her telling me about the case -- or telling me that she would send it to me to review. The other conversations have been with Mr. Torgerson. And, basically, most of those have consisted of telling me that he would be sending me depositions or additional infomation as he got them.

Q Were you told any facts by Ms. Crisafi or Mr. Torgerson that you relied on in order to form your opinions in this case?

A Other than a description of the case itself, no.

Q And I assume you met with Mr. Torgerson to prepare for this deposition today?

A We discussed it just prior, yes.

Q How much time did you spend with Mr. Torgerson?

A Discussing the case itself? Probably a half hour, 45 minutes.

Q Do you agree that Bonnie Pikkel had cauda equina syndrome?

MR. TORGERSON Point of time? Objection, vague.

BY MR. RUF:

Q Do you agree Bonnie Pikkel had cauda equina syndrome on September 4th 1996?

A That was the date of her initial ER presentation.

Q Correct.

A No, she did not.

Q When did she first have cauda equina syndrome?

MR. TORGERSON: objection. Presumes facts not in evidence.

THE WITNESS: That, I can't answer.

BY MR. RUF:

Q In your opinion, did she ever have cauda equina Syndrome?

A It appears she did. She had developed the symptoms by the next day.

Q So in your opinion, she did have cauda equina syndrome on 9/5/96?

MR. TORGERSON: objection.

THE WITNESS: she had -- she, apparently, exhibited many of the symptoms -- more of the symptoms the following day; reporting the numbness and had the continued urinary retention.

BY MR. RUF:

Q Okay. My specific question is: In your opinion, did she have cauda equina syndrome only 9/5/96 at the time of the second ER presentation?

MR. TORGERSON objection. But, please, answer.

THE WITNESS: Yes.

BY MR. RUF:

Q Do you have an opinion, based on reasonable medical probabilty, as to when she first suffered from cauda equina syndrome?

A No. No way of knowing that.

Q You would be speculating on that issue? You have no opinion on that?

A When she -- she did not have it on the 4th.

Q In your opinion, what was her diagnosis on September 4th at the time of the initial ER presentation?

A She had acute urinary retention.

Q Does any other diagnosis fit that clinical

Page 20

picture?
A Many things can cause urinary retention; urinary tract infection, obstruction, stone, plus neurologic problems. But she had -- I mean, to be reasonable, she had none of the other manifestations. She had back pain that was resolved. She reported some numbness of something that was resolved, The only symptoms she had at that time was numbness.
Q Doctor --
A Excuse me. Strike that. Was urinary retention.
Q Doctor, my question is: What other diagnoses fit her clinical picture on 9/4/96, other than cauda equina syndrome?
MR. TORGERSON: objection. Asked and answered. But go ahead and answer it again.
THE WITNESS: I think we are approaching it backwards. It's not how --
BY MR. RUF:
Q Doctor, please, answer my question.
MR. TORGERSON: He is trying to answer your question. Don't interrupt him.
MR. RUF: I'm not asking about syinptoms. I'm asking about diagnoses.
MR. TORGERSON: He hasn't answered. Don't interrupt him.

Page 22

manipulation?
MR. TORGERSON Note objection to the form of the question. But go ahead and answer if you can.
THE WITNESS: That would seem to be the case. But, I can't say for sure. I would say, probably.
BY MR. RUF:
Q Doctor, based upon reasonable medical probability, do you have an opinion as to whether or not the cauda equina syndrome was the direct result of chiropractic manipulation?
A Again, probably, is the best I can answer.
Q Well, Doctor, in your report of September 17, 1999, you wrote, "Unfortunately in this case, the cauda equina syndrome appears to be a direct result of the chiropractic manipulation." Is that correct?
A I will take your word for that. And, again, it said "appears to be."
Q So based upon your report, it appears the cauda equina syndrome began 9/3/96; is that correct?
MR. TORGERSON objection.
THE WITNESS: The wheels possibly -- if that were the result -- if that were the cause of it, rather, the wheels were set in motion. But, again, she did not have cauda equina syndrome on the 4th.
BY MR. RUF:
Q You do state though, the cauda equina syndrome

Page 2

Please proceed with your answer, Doctor.
THE WITNESS: Are you asking me what other conditions could be associated with urinary retention? That's the only way I can answer that.
BY MR. RUF:
Q Doctor, what would your differential diagnosis have been on 9/4/96 at the time of her initial presentation to the ER, from the time she presented up until the time she discharged?
MR. TORGERSON 9/4?
BY MR. RUF:
Q 9/4/96.
A Well, as I said, she could have a Urinary tract infection. She could have some type of mechanical obstruction. She could have -- be passing a stone. She could have obstruction by tumor, or it could be a neurologic problem.
Q Doctor, would you agree that the cauda equina syndrome was a direct result of chiropractic manipulation?
A That, I cannot answer. There is a time relation. There's a temporal relationship there. It began after chiropractic manipulation. But whether it was the cause of that...
Q So you are not able to state whether the cauda equina syndrome was the direct result of the chiropractic

Page 2

appears to be the direct result of the chiropractic manipulation, correct?
A Correct.
Q Do you know the extent of compression of the cauda equina either 913 or 9/4 of '96?
A Do I know the extent?
Q Yes.
A No.
Q Do you have an opinion, based on reasonable medical probability, as to whether or not there was compression of the cauda equina either on 9/3/96 or 9/4/96?
A There appears to be some -- to have been some nerve irritation. If she had actual compression, she would have had the other symptoms to go along with that.
Again, a syndrome is a constellation of symptoms or signs. She should have had the back pain, the leg numbness, the perineal numbness, plus the urinary incontinence. You can't take one symptom alone and call it the entire syndrome.
Q Doctor, my question is: Do you have an opinion, based on reasonable medical probability, as to whether or not there was compression of the cauda equina on 9/3/96?
MR. TORGERSON Objection. Asked and answered.
BY MR. TORGERSON
Q My specific question is: Do you have an opinion

Page 24

whether there was compression?
A Again, I don't believe there was, because -- at that time. Because if there were compression, she would have had the other symptoms.
Q Do you have an opinion, based on reasonable medical probability, as to whether or not she had compression of the cauda equina on 9/4/96?
A Tell me if I'm wrong. But I seem to be answering the same question.
Q Doctor, my question is: Do you have an opinion as to whether or not there was compression?
A I thought that's what you were talking about.
Q I first asked 9/3/96. That's the date of the chiropractic manipulation.
A Okay.
Q Now, I'm asking you about 9/4/96.
A I'm sorry. I thought we were only speaking of the ER visit.
Again, she -- those symptoms appeared to have resolved. The answer to the last question I was speaking of was in reference to 9/4. So at the time -- on the visit of 9/4, I don't believe she had compression. She had irritation of the nerves.
Q Doctor, do you agree that if there's compression on the nerves exiting the base of the lumbar spine, that a

Page 25

patient will have symptoms as a result of that compression?
MR. TORGERSON: I'm just going to ask it be read back, because I missed the first part of that, if that's okay. I'm not objecting to it. I'm just asking that it be read back.
MR. RUF: Please, read the question back.
(WHEREUPON, the last question was read by the court reporter.)
THE WITNESS: If there is compression of the nerves?
BY MR. RUF:
Q Yes.
A Then one would expect the person to have syinptoins.
Q Why is that?
A Well, compression implies that the nerves are compromised.
Q And when the nerves are compromised, that results in a physical manifestation, correct?
A Usually, yes.
Q So, Doctor, you disagree with Dr. Bell that Bonnie Pikkel had cauda equina syndrome on September 4, 1996, the date of her initial presentation to the ER?
A Yes, I do.
Q And you disagree with Dr. Blumenkopf that Bonnie Pikkel had cauda quina syndrome September 4th, 1996, the

Page 26

initial date of presentation to the ER?
A On September 4th, yes. She did not have cauda equina syndrome.
Q And you disagree with Dr. Shapiro, that Bonnie Pikkel had cauda equina syndrome on September 4th, 1996, the initial presentation to the ER?
A Yes, I do. And Dr. Yates, as well, if that's what he said.
Q So any physician that would have the opinion that based upon reasonable medical probability, she was suffering from cauda equina syndrome on September 4th, 1996, you would disagree with that opinion?
MR. TORGERSON: Well, objection. That's misleading, when it suggests that the physicians all feel that way. But, if you can answer the question, go ahead.
THE WITNESS: I would like to amplify on that in saying she had one of the symptoins of cauda equina syndrome. She had urinary retention. She did not have cauda equina syndrome. It has nothing to do with the physicians who said otherwise.
BY MR. RUF:
Q Would you agree that urinary retention is a classic symptoin of cauda equina syndrome?
MR. TORGERSON: objection as to the use of the

Page 27

word "classic."
BY MR. RUF:
Q Go ahead. You can answer the question.
A It's one symptom.
Q What are the classic symptoins of cauda equina syndrome?
MR. TORGERSON: objection to the use of the word "classic."
THE WITNESS: They almost virtually always have back pain, numbness down one or both legs, saddle anesthesia, and urinary retention.
BY MR. RUF:
Q What about bowel abnormalities?
A They can have either incontinence or constipation.
Q Would incontinence or constipation be a classic symptom of cauda equina Syndrome?
MR. TORGERSON: objection to the term "classic."
THE WITNESS: I have a problem with that also.
BY MR. RUF:
Q Well, Doctor, you're telling me there are no classic symptoms for cauda equina syndrome?
MR. TORGERSON: objection to the word "classic."
BY MR. RUF:
Q Please, answer the question.
A They -- that group of symptoms is

Page 28

characteristically seen in cauda equina syndrome.
Q So would you say those are typical or characteristic symptoms of cauda equina syndrome?
A Together, as a group.
Q Would you say that those are all well recognized symptoms of cauda equina syndrome?
A Taken together as a group, not individually.
Q We'll get to that in a minute.
Would you agree that all of those symptoms are listed in the medical textbooks and medical literature as being symptoms of cauda equina syndrome?
MR. TORGERSON: objection. Go ahead.
THE WITNESS: That's a fair statement, yes.
BY MR. RUF:
Q Do you agree that Bonnie Pikkel's incontinence -- I'm sorry. Strike that.
Doctor, do you agree that Bonnie Pikkel's urinary retention on 9/4/96 was caused by compression on the nerve roots that supply the bladder?
A In retrospect, probably. I don't *think* there was a way to diagnose that at the time or reasonably assume that at the time.
Q And that compression on the nerve roots was caused by the herniated disk in Bonnie Pikkel's lumbar spine, correct?

Page 29

A If indeed she had compression, it was caused by a herniated disk.
Q Doctor, do you agree there's no evidence of any trauma to Bonnie Pikkel's lumbar spine from after the chiropractic manipulation on **9/3** up until the second ER visit of **9/5/96?**
A I have no way of knowing that.
Q Do you have any evidence that there was any trauma to her lumbar spine during that time period?
A No, no.
Q So given that's the case, you can say with reasonable medical probability that the herniation was caused at the time of the chiropractic manipulation, correct?
MR. TORGERSON: objection. But, you can answer it if you can.
THE WITNESS: Given the time and Course of events, that's a reasonable assumption.
BY MR. RUF:
Q Doctor, do you agree that cauda equina syndrome should be diagnosed in an emergent fashion?
A Cauda equina syndrome? Yes, it should.
Q Why should it be diagnosed in an emergent fashion?
A The treatment is surgical decompression.
Q Would you **agree** that cauda equina syndrome is an

Page 3C

emergency?
A Yes.
Q Would you agree it's an emergency because the longer the nerve --
A Can I rephrase that? Urgency with -- as opposed to right this minute. It's generally accepted that it needs to be treated within several hours.
Q Well, Doctor, would you agree that this condition is a true emergency?
MR. TORGERSON Note an objection. But, go ahead,
THE WITNESS: yes, using the term loosely.
BY MR. RUF:
Q Well, Doctor, that's what you wrote in your report, didn't you? "This condition is a true emergency."
A Yes.
Q And would you agree, it's a true emergency because the longer the nerves are compressed by the cauda equina syndrome, the more likely it is that a patient will have permanent neurological deficits?
A That's true.
Q **So** would you agree that the sooner decompression surgery is done the better the chances of recovery are for the patient?
A Yes.
Q Doctor, could you tell me the number of

Page 31

neurosurgeries on the spine you have performed?
MR. TORGERSON: objection. Go ahead.
THE WITNESS: I'm not a neurosurgeon. I have not operated on any spines.
BY MR. RUF:
Q So the answer would be zero?
A That would be zero.
Q **So** I would, also, assume that you have performed zero surgeries on the spine for cauda equina Syndrome?
MR. TORGERSON: objection. You may answer.
THE WITNESS: That's correct.
BY MR. RUF:
Q Have you ever assisted in a neurosurgery on the spine?
A Yes.
Q When was the last time you assisted in a neurosurgery on the spine?
A **As** a medical student.
Q Which was what year?
A 1978.
Q So from 1978 until the present time, you have not assisted on any neurosurgeries on the spine?
A That's correct.
Q When was the last time you participated in a surgery of any kind?

Page 3

A Probably, around that time.
Q Around 19 --
A I'm sorry. That would be 1979, 1980, during my residency.
Q You are not board certified in neurosurgery; is that correct?
A Correct.
Q You are not board certified in orthopedics, correct?
A That's correct.
Q Have you done a fellowship in orthopedics or neurosurgery?
A No.
Q Do you have any training after residency in neurosurgery or orthopedics?
A No.
Q What are the neurosurgical texts you have studied?
A I have not studied any neurosurgical texts.
Q What are the orthopedic texts you have studied?
A I have not studied any orthopedic texts. That's not my area of --
Q Do you regularly -- Do you regularly review any neurosurgical literature?
A No.
Q Do you regularly review any orthopedic literature?

Page 33

A No.
Q Have you ever published on cauda equina Syndrome?
A No, I have not.
Q Have you ever published on herniated disks?
A No.
Q Have you ever lectured on either cauda equina syndrome or on herniated disks?
A No.
Q Would you agree that you are not an expert in neurosurgery?
A Yes.
Q Would you agree you are not an expert in spinal surgery?
A Yes.
Q So would you agree that you have no expertise in surgery outcomes for cauda equina surgery?
MR. TORGERSON: objection.
THE WITNESS: I'm sorry. Please rephrase the question or repeat it.
BY MR. RUF:
Q Doctor, are you an expert in surgical outcomes for cauda equina surgery?
MR. TORGERSON objection.
THEWITNESS: NO.
BY MR. RUF:

Page 34

Q As an ER doctor, if a patient requires spinal surgery, would the appropriate referral be to a neurosurgeon?
A Or an orthopedic surgeon.
Q And you refer to a neurosurgeon or orthopedic surgeon when the standard of care requires it, correct?
A Yes.
Q For what spinal conditions does the standard of care require a neurosurgical consult?
A What spinal conditions --
Q Yes.
A -- would require -- are you saying in an emergent consult?
Q Yes. Why don't we limit it to emergent situations.
A Uh-huh. Okay. If one suspected cauda equina syndrome, that would be a reason to call. I'm trying to think of -- an acute paralysis, a tumor acutely compressing the spine. Someone who came in and said, A half hour ago I lost feeling in both legs. And they've got a tumor coinpromising the spine. That sort of thing.
Q If an ER doctor has cauda equina syndrome on his differential, would the standard of care require a neurosurgical consult?
A If that's what he felt was going on? Again, we're

Page 3

speaking specifically of this case. And that's not what appeared to be going on. I think he would have been laughed out of the hospital if he had called a neurosurgeon for urinary retention.
Q Doctor, would you agree that Bonnie Pikkel's urinary retention on 9/4/96 was either being caused by a bladder problem or some type of neurologic deficit?
MR. TORGERSON: objection. Asked and answered. But, go on. You may answer.
THE WITNESS: Technically.
BY MR. RUF
Q I'm sorry, Doctor, I missed --
A I think we agreed to that before.
Q What were the bladder conditions that could you have caused Bonnie Pikkel's urinary retention on 9/4/96?
A Most commonly, urinary tract infection, a stone. Or she could just have some irritation of the bladder causing the urethra to go into spasm.
Q How would you rule out a urinary tract infection?
A Doing a urinalysis. And sometimes a culture. It might not show up right away on the initial urinalysis.
Q Dr. Spaner performed a urinalysis on 9/4/96, correct?
A Yes, I believe, he did.
Q And that Urinalysis was normal, or negative,

Page 36

correct?
A I don't recall. I would have to look that up.
Q If you need to, refer to your records.
A (Perusing documents.) It's got a notation by Dr. Spaner, "UA negative."
Q So that's urinalysis negative, correct?
A Yes.
Q How would you rule out a stone?
A You could do an intravenous pyelogram or a CAT scan.
Q Is there any evidence Dr. Spanner was considering a stone as part of his differential on 9/4/96?
A I'm trying to read his abbreviations here.
Other than the fact that he notes no back pain. That could also be a symptom of a kidney stone.
Q That brings me to another question. What would be the signs or symptoms of a stone?
A Back pain, blood in the Urine, pain. People with kidney stones are usually in pretty severe pain.
Q So could you rule out a stone, based upon Bonnie Pikkel's history and physical on 9/4/96?
A Not completely. But, reasonably.
Q So you could reasonably rule out a stone as causing her problems on 9/4/96, correct?
A Yes.

Page 37

Q What about irritation? How would you rule out irritation?
A There is no way.
Q Well, how do you make a definitive diagnosis of irritation?
A Even looking. Even doing a pelvic exam, there's not always redness or swelling. Or, you know, you can have bladder spasm for who knows what.
Q Did Bonnie Pikkel have any signs or symptoms of irritation on 9/4/96?
A Not that she mentioned.
Q So could you reasonably rule out irritation as the diagnosis on 9/4/96 for Bonnie Pikkel?
A There's nothing to suggest that. So, I guess, that's a safe -- a safe assumption.
Q So would you agree on 9/4/96, you could rule out the potential bladder causes for the urinary retention?
A Not entirely.
Q Well, we just did that, didn't we doctor?
A Well, like I said. I said, reasonably. You know, it...
Q And would you agree Dr. Spaner probably ruled out bladder cause on 9/4/96 and that's why he sent the patient home?
MR. TORGERSON: objection.

Page 38

THE WITNESS: I don't think the two events would necessarily be related. If there was some bladder cause, it wouldn't dictate other treatment. I mean, other than what was done.
BY MR. RUF:
Q Dr. Spaner does not list any bladder abnormality as the diagnosis in his ER record of 9/4/96, correct?
A Correct.
Q If he thought she had a significant condition of the bladder, he would have had to admit or get a consult, correct?
MR. TORGERSON: objection.
THE WITNESS: Not necessarily.
BY MR. RUF:
Q Well, if she had had a Urinary tract infection, a stone or irritation, are those things he could treat?
A Yes.
Q He didn't provide any treatment for Urinary tract infection, a stone, or a irritation, correct?
A Well, I believe he did. I believe he put the catheter in and prescribed an antibiotic, if I'm not mistaken. And he put her on Cipro.
Q What would that be treatment for? Which of those conditions?
A That would be treatment for a Urinary tract

Page 39

infection.
Q But you said we could reasonably rule out Urinary tract infection, based upon the negative urinalysis, correct?
MR. TORGERSON: objection, asked and answered.
THE WITNESS: That's also frequently prescribed because of the Foley catheter to prevent infection.
BY MR. RUF:
Q Well, that was going to be my next question, Doctor.
Wasn't the real reason he prescribed the antibiotic, is to prevent infection because of the insertion of the Foley catheter?
A I'm not sure of that. Because it appears that he prescribed it for seven days. That would be a bit much to prevent infection. That would be more consistent with treating a presumptive urinary tract infection, pending the outcome of cultures.
Q Is there any evidence in Dr. Spaner's record of 9/4/96 or his deposition that his diagnosis was urinary tract infection?
A Other than the antibiotic prescribed, not that I'm aware of.
Q Urinary tract infection is not listed anywhere on the ER record, nor does he talk about Urinary tract

infection in his deposition, correct?
MR. TORGERSON: objection. Asked and answered. In fact, just asked and just answered.
BY THE WITNESS:
Q Is that correct, Doctor?
A I don't see anything on the ER records to that effect. And I will take your word for the deposition. I don't recall the specifics of that.
Q So wouldn't you say it's more probable than not that the antibiotic was prescribed to prevent infection as a result of the use of the Foley catheter?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: I still think he could have been -- that could have been in the back of his mind, because of the duration of the antibiotic he used for seven days.
BY MR. RUF:
Q So do you disagree that the antibiotic was prescribed to prevent an infection as a result of the use of the Foley catheter?
MR. TORGERSON: Disagree with what or whom? You The record?
BY MR. RUF:
Q Please answer the question.
MR. TORGERSON: Note an objection. There's a lack

A Tumor, hemorrhage into the spinal cord, things wouldn't, you know, realistically -- we're not realistically considering here.
Q Would you agree that hemorrhage or tumor were not part of the differential on 9/4/96?
MR. TORGERSON: objection. Of Dr. Spaner's differential or of the differential?
Objection for vagueness.
THE WITNESS: Yeah. I --
BY MR. RUF:
Q Okay, Doctor --
A Again, are you asking --
Q If Bonnie Pikkel present to you on 9/4/96, would hemorrhage or a tumor be part of your differential diagnosis?
A In 1996?
Q September 4.
A It's hard to say. Now, since I've been involved with the case, there's cauda equina behind every tree. But, seriously, I mean, that sort of is one of the things going through your mind with -- and most of these things, you would rule out as sort of as they, you know, filter down.
Q Did she have any signs or symptoms of hemorrhage or tumor of the lumbar spine on 9/4/96?
A No. She had no pain. She had no other paralysis.

of foundation.
MR. RUF: Fine, object.
BY MR. RUF:
Q Please answer the question.
MR. TORGERSON: I want to inake sure that the grounds for my objection is in the record. Lack of foundation.
THE WITNESS: I'm not trying to be cagey. I'm trying to be accurate. I'm assuming that it was because of the catheter. But, I cannot exclude the possibility that it was to treat a possible urinary tract infection.
More reasonable than not, it was for the catheter. But, I can't exclude other reasons.
BY MR. RUF:
Q So, Doctor, wouldn't you agree it's more probable than not that Bonnie Pikkel's -- a neurologic deficit was causing Bonnie Pikkel's urinary retention on 9/4/96?
A In retrospect, that appears to be the case.
Q And what type of neurologic deficits could cause the urinary retention she was having on 9/4/96?
A Well, obviously, cauda equina syndrome comes to mind, since that's what we are here for. Other types of acute spinal cord injuries.
Q What other types of acute spinal cord injuries?

She had none of these other --
Q So you could reasonably exclude hemorrhage or tumor of the lumbar spine as part of the differential, correct?
A Yes. In the same way that you could exclude cauda equina.
Q Well, you said cauda equina was part of the differential on 9/4/96, correct?
A Right. So were these other things. What I'm saying is, they filter through your mind in terms of possibilities.
Q If a spinal condition is on your differential diagnosis, does the standard of care require an ER doctor to perform the appropriate diagnostic test to rule out a spinal condition?
A By saying "the appropriate diagnostic test," are you saying imaging, MRI, CAT scan, whatever?
Q Well, I'm just saying this as a general proposition.
MR. TORGERSON would you repeat --
MRRUF: SUE.
MR. TORGERSON Did you understand that?
MR. RUF: could you read back the question, please.
MR. TORGERSON The question being asked?

Page 44

THE WITNESS: yeah. Let me --
MR. TORGERSON: we are going to read it back.
(WHEREUPON, the last question was read by the court reporter.)
THE WITNESS: If there's some latitude there, meaning diagnostic tests include part of -- include the physical exam. Or are you specifically referring to tests outside of the physical exam?
MR. TORGERSON: YOU can answer. Without definition, answer it as you feel it ought to be answered, Doctor.
If he's not defining and you are trying to guess at what he's meaning and he's not clarifying, then you should answer what you believe he's asking you.
BY MR. RUF:
Q Doctor, can you answer the question?
A I'm trying to do that.
Q Okay. Well, please, do that.
A Diagnostic tests, including -- if you include physical exam as a diagnostic tests, then, yes.
Q Would you agree that the acceptable standard of emergency room practice requires an ER doctor to perform radiologic tests when those tests are indicated?
A When they are indicated.
Q Is there a radiologic diagnostic test for ruling

Page 45

out cauda equina syndrome?
A The test of choice is an MRI.
Q Why is that the test of choice?
A Because cauda equina syndrome is a soft tissue injury. There's a bulging disk impinging on a nerve, both of which are soft tissue. And an MRI is much better at delineating soft tissue than CAT scan. And, certainly, x-rays would be of no value whatsoever.
Q The only way to actually know what's going on in a patient's spine is to do an MRI, correct?
MR. TORGERSON: objection. Please, answer.
THE WITNESS: Again, I'm not a radiologist. So I may be going on a limb here. But, yes, I guess that's --
BY MR. RUF:
Q I mean, as an ER doctor, you can't detennine for sure whether or not somebody has got a herniated disk simply from examination and history, can you?
MR. TORGERSON: Objection.
THE WITNESS: If I could expound on that a little bit. In a word, no. But, a herniated disk in itself is not a medical emergency. You see herniated disks all the time, or symptoms of suggesting a herniated disk. In other words, low back pain, pain down the leg. And what we tell them, we treat them with pain

Page 46

medication and have them follow-up in a week or two if it's not better.
BY MR. RUF:
Q Would you agree that a herniated disk that's causing neurologic deficit is an emergency?
A Not necessarily. If that neurologic deficit is pain down the leg, things like that.
Q What type of neurologic deficits resulting from a herniated disk would be a medical emergency?
A Come back to that good old cauda equina syndrome. The full blown syndrome of back pain, leg numbness, saddle anesthesia, bladder incontinence or retention.
Q Well, given that an MRI is the test of choice for ruling in or ruling out cauda quina syndrome, wouldn't the standard of care require an ER doctor to perform an MRI if cauda equina was on his differential?
MR. TORGERSON Objection.
THE WITNESS: No, no. I can't say that at all. In this case, she had urinary retention. You wouldn't be working there or any other ER very long, if you ordered MRIs on everyone with urinary retention, or everyone with back pain, or everyone with any one of those symptoms.
BY MR. RUF:
Q Well, you just said, though, you can't rule out

Page 47

cauda equina syndrome for sure, unless you perform an MRI, correct?
A Yeah. But--
MR. TORGERSON: objection. That's been asked and answered. If he just said it, why are you asking him again?
BY MR. RUF:
Q Please answer the question.
MR. TORGERSON: Don't answer the question.
BY MR. RUF:
Q Answer the question.
MR. RUF: If you instruct him not to answer, I'm going to move to exclude him. Because I'm not going to put up with these non-answers and these instructions not to answer. It's not appropriate. You said it yesterday on the record, it's inappropriate. And you are not going to do it.
MR. TORGERSON: well, was it inappropriate yesterday? I'll move to exclude Dr. Shapiro, then.
MR. RUF: That's the position you took yesterday.
MR. TORGERSON Well --
MR. RUF: Dr. --
MR. TORGERSON: Well, then we're taking the same position. But why don't you ask a new question rather than asking the same old question, or repeating what

Page 48

you believe he said.
MR. RUF: I don't think it was same question.
Please, read back the question.
MR. TORGERSON: You referred to what he said. And then you asked him to confirm what you said that he said. That's the same question.
BY MR. RUF:
Q Fine. Doctor, let me ask a new question.
Would you agree an MRI is the only way to definitively rule in or rule out cauda equina syndrome?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: Definitively rule it in or rule it out, yes.
BY MR. RUF:
Q And given that's the only way to definitively rule it in or rule it out, isn't it reasonable, under the circumstances, to do an MRI if cauda equina syndrome is in the differential?
MR. TORGERSON Objection. Asked and answered. But, please, answer again.
THE WITNESS: NO. It's not reasonable in this case.
BY MR. RUF:
Q So you think it's acceptable to go ahead and take the risk that it might be cauda equina syndrome without

Page 49

doing the definitive tests, correct?
MR. TORGERSON: Objection.
THE WITNESS: Without the other manifestations.
BY MR. RUF:
Q So one manifestation or more is not enough to warrant doing an MRI?
MR. TORGERSON objection. Asked and answered. Please, answer.
THE WITNESS: For example, if one of the other manifestations is back pain, that would be saying everyone with back pain should have an emergent MRI. That's crazy.
BY MR. RUF:
Q Well, not everyone with back pain has a differential diagnosis of cauda equina syndrome, do they?
MR. TORGERSON: objection. Please, answer.
THE WITNESS: That's true.
BY MR. RUF:
Q Was cauda equina syndrome part of the differential on 9/4/96, when Bonnie Pikkel presented to the emergency room?
MR. TORGERSON objection. Asked and answered.
I will, also, move to exclude all repetitive questions in this case. And I will ask for a Motion in Limine to preclude Counsel from doing it during the

Page 50

trial of this matter.
THE WITNESS: You are asking, was cauda equina in the differential?
BY MR. RUF:
Q Yes.
MR. TORGERSON: Same objection. You may answer.
THE WITNESS: Again, given the absence of the other symptoms, I don't think that was realistic.
BY MR. RUF:
Q Well, if Dr. Villarosa and Dr. Spaner testified cauda equina syndrome was part of the differential, you would disagree with that?
MR. TORGERSON objection. Objection as to the representation of what they testified to and its inischaracterization of use in this particular question.
THE WITNESS: Again, your differential at first is very large. It's very broad. You -- that goes into the thought process with any -- with back pain, with urinary retention, with any of those things. But, because of the absence of other symptoms, you sort of filter them out. So at first, is it in the differential? Yes, it is.
BY MR. RUF:
Q So if Dr. Spaner has testified that cauda equina syndrome was in the differential on 9/4/96, you would agree

Page 51

with that or disagree with it?
MR. TORGERSON: Agree that he testified to that or that it is? Objection, vague.
BY MR. RUF:
Q Please answer the question.
A As I said, it's in the differential initially.
Q Would you agree that a diagnosis is part of the differential until it's ruled out?
MR. TORGERSON I'll note an objection. But, if you can answer that question, you can.
THE WITNESS: It can be ruled out on the basis of additional history or physical findings or both.
BY MR. RUF:
Q I'm sorry, Doctor. I don't think you answered my specific question. My specific question --
MR. TORGERSON Ask another question. He answered that question.
MR. RUF: No, he didn't. I told him, I'm going to re-ask questions if he gives me evasive answers.
MR. TORGERSON That's fine. Just ask a question. But don't characterize his answer and --
MR. RUF: I'm not going to take evasive answers. I want a direct answer to my question.
MR. TORGERSON: The answers are not evasive. They're answers based on the difficulty of the

Page 52

questions posed, to the repetitive nature, and their vague and ambiguous use of different facts from different sources.

MR. RUF: stop interrupting and coaching the witness.

BY MR RUF:

Q Doctor --

MR. TORGERSON: I'm not coaching him. I'm addressing the inherent defective nature of the questions being posed and your inischaracterization of his answers as evasive when he can't answer what is an unclear question. And I want the record to reflect that.

BY MR. RUF:

Q Doctor, is a diagnosis part of the differential until it's ruled out?

MR. TORGERSON objection. Asked and answered.

THE WITNESS: yes.

BY MR. RUF:

Q Thank you, Doctor.

A I thought I answered that.

Q Does the standard of care require an emergency room physician to perfonn a thorough history and physical examination?

A A focused exam directed toward the complaint.

Page 53

Q So do you take issue with thorough history and physical examination as being the standard?

MR. TORGERSON: objection. He answered your question. You're now asking him if he's taking issue with your characterization?

THE WITNESS: Again, let me clarify that. When you say a "thorough exam," would you do an ENT exam or a cardiac exam, a thorough cardiac exam for urinary retention? Probably, not. You would focus on the abdomen --

BY MR. RUF:

Q If Dr. Spaner has testified the standard of care requires an ER doctor to perform a thorough history and physical exam, do you disagree with that?

A I'm *sorry.* I didn't hear the first of the sentence.

Q If Dr. Spaner has testified that the standard of care requires an ER doctor to perform a thorough history and physical exam, do you disagree with that?

MR. TORGERSON Objection. Objection to the characterization of what it is that Dr. Spaner may or may not have testified to.

THE WITNESS: Again, thorough, focused on the problem. Thorough, not focused on the entire body, I mean, you don't do that for everyone that --

Page 54

BY MR. RUF:

Q So you would agree with that, subject to the qualification of focused on the problem?

A Correct.

Q So the standard of care would require an ER doctor to perform a thorough history and physical examination, focused on the problem.

A With that proviso, yes.

Q Would you agree that a thorough history and physical examination is critical for making a diagnosis?

MR. TORGERSON: objection to the use of the word "critical." But, answer the question as you think he -- as you understand the term "critical."

THE WITNESS: It's helpful.

BY MR. RUF:

Q Wouldn't you say it's very important?

A It's very important, yes.

Q And would you agree that an ER physician can miss a diagnosis by failing to do a focused and thorough history and physical examination?

MR. TORGERSON: objection. You may answer if it's capable of being answered. You're asking him to speculate that that can be done under those circumstances?

BY MR. RUF:

Page 55

Q I'm saying, Doctor, based upon your experience, would you agree an ER physician can miss a diagnosis by failing to do a thorough and focused history and physical examination?

A Yes, yes. That's a safe assumption.

Q And that's one way in which an ER physician can deviate from acceptable medical practice, correct?

MR. TORGERSON: objection.

THE WITNESS: Yes.

BY MR. RUF:

Q Would with you agree that the standard of care requires an ER doctor to form a differential diagnosis for a patient?

A I don't know if that would be the standard of care. We sort of all do that, as a matter of course.

Q So would you agree that's a standard of practice, if you do it as a matter of course?

MR. TORGERSON I'll interpose an objection. You want him to characterize what it is?

BY MR. RUF:

Q Doctor, you are an expert in this case, correct?

A Yes.

Q You understand the issue here is whether or not Dr. Spaner deviated from acceptable medical practice, correct?

Page 56

A Yes.
Q And you know what acceptable medical practice is, correct?
A Yes.
Q So, Doctor, does the acceptable standard of medical practice require an ER doctor to form a differential diagnosis?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: Again, as I said, we do this as a matter of routine. I don't know -- again, I don't know that you could say that's standard of care. It's just common practice. It's not a --
BY MR. RUF:
Q How long have you been practicing ER medicine?
A Twenty -- twenty-one years. It's not -- you how, it's not a formal necessarily in every case. It's more of a mental thing.
Q Well, isn't that the methodology you are taught in medical school, residency and internship? That when a patient comes in, you take a history and physical examination and you form a differential diagnosis, correct?
A Correct.
Q And after you formed that differential diagnosis, you rule in or rule out certain conditions, based upon that history and physical examination, correct?

Page 57

A Correct.
Q And you may be able to reach a definitive diagnosisjust based on the history and physical examination, correct?
A You may, sure.
Q And you may not. You may not be able reach a definitive diagnosis, just based on the history and physical examination, correct?
A That's correct.
Q And at that point, you may conduct diagnostic tests to rule in or rule out diagnoses that are part of the differential, correct?
MR. TORGERSON objection. You may answer.
THE WITNESS: Correct.
BY MR. RUF:
Q And isn't that the inethodology that doctors go through in diagnosing conditions?
MR. TORGERSON: Objection. You may answer.
THE WITNESS: Yes.
BY MR. RUF:
Q And that's the methodology you are taught from the time of medical school, through internship and residency, and during practice?
MR. TORGERSON Have I missed something? Objection. Asked and answered.

Page 58

BY MR. RUF:
Q Is that correct, Doctor?
MR. TORGERSON objection. Asked and answered.
THE COURT REPORTER I'm sorry. I didn't get your answer, sir.
THE WITNESS: Yes. We seem to be answering the same question.
BY MR. RUF:
Q Do you agree that you cannot provide treatment to a patient without a diagnosis?
A Yes. At least a presumptive diagnosis or an impression. It may be a preliminary diagnosis.
Q And you would agree you can't treat cauda equina syndrome without diagnosing cauda equina Syndrome?
A That -- yes.
Q And would you agree that Bonnie Pikkel did not receive treatment for cauda equina syndrome from the presentation on 9/4/96 up until the ER visit of 9/5/96?
MR. TORGERSON: objection.
THE WITNESS: Did she receive treatment? No. The treatment is surgical. Obviously, she did not.
BY MR. RUF:
Q Blabber catheterization is not an effective treatment for cauda equina syndrome, is it, Doctor?
A No, it isn't.

Page 59

Q Doctor, could you tell me what type of physical examination the standard of care would require for an ER physician for a patient suspected of having cauda equina syndrome?
A First of all, for suspecting cauda equina syndrome, as with most things, I think the history, by far, is more important. If she --
Q Why is the history far more important?
A As someone once said, If you give a patient enough time, they'll tell you what's wrong.
Does she have back pain? Does she have the numbness? Is pain going down the leg, along with the urinary retention? Then you would focus on the other things; the rectal exam, pin prick, things like that.
Q So what type of physical exam would the standard of care require if you suspected that a patient was suffering from cauda equina syndrome?
A Again, I think it's not so much the standard of care and the physical exam; it's the history. The history is more important. If the history eliminated these other things, I don't think there's any specific cookbook approach to a physical exam that would be, as you say, standard of care.
Q Would you take me through the physical exam that you would perform on a patient that you suspected was

Page 60

suffering from cauda equina syndrome?
A Again, you are assuming they had the other facts in the history; that someone came in and said they had back pain, they haven't been able to urinate for 12 hours. They have got saddle anesthesia. They have got pain down both legs. Are you -- is that taken into the --
Q Would you agree that if cauda equina syndrome is part of the differential, it's important to do the appropriate physical exam to help you rule in or rule out cauda equina syndrome?
MR. TORGERSON: objection. Asked and answered.
A Not if the history has eliminated these other things.
BY MR. RUF:
Q Well, Doctor, you --
MR. TORGERSON: wait a minute. Let him finish answering his question. You like to interrupt him to get onto something -- that you don't like his answer for. I *think* he ought to be given a full opportunity to answer your repetitive questions.
BY MR. RUF:
Q I'm sorry, Doctor. Did I interrupt your answer? Please -- if I interrupted, please, continue.
A She had no back -- she reported no back pain. Numbness in buttocks previously is now resolved. Both of

Page 61

those would lower my index of suspicion.
Q But that alone would not rule out cauda equina syndrome, would it?
A Well, without those symptoms, the cauda equina syndrome isn't there. Again, all she had was the urinary incontinence, with no back pain. I guess, I wouldn't be that excited --
Q Well --
MR. TORGERSON: wait a minute. You are interrupting him.
BY MR. RUF:
Q I'm sorry. Please continue.
THE WITNESS: Again, that's -- I think that's more important that the physical. I mean, people really don't like fingers inserted in their rectums without good reason. But, if she had these other symptoms --
BY MR. RUF:
Q Well, if somebody is having neurologic deficit, that would be a good reason to stick your finger in somebody's rectum, correct?
A If they're having these other symptoms together with that, yes.
Q Would you agree that you cannot rule out cauda equina syndrome just based on the history alone for Bonnie Pikkel?

Page 62

MR. TORGERSON objection. Asked and answered.
THE WITNESS: we're beating this to death.
But, again, the syndrome includes back pain, leg numbness, saddle anesthesia.
BY MR. RUF:
Q Okay. I'm sorry, Doctor. Let me rephrase the question.
Would you agree that you cannot rule out a massive herniated disk in Bonnie Pikkel's lumbar spine, based upon her history alone?
A You cannot rule it out? That's true. Again, up to 25 percent of people walking around totally asymptomatic have herniated disks.
Q So given that's the fact, Doctor, wouldn't it be important to perform a physical exam to help you to determine whether or not she was suffering from a massive herniated disk in her lumbar spine?
MR. TORGERSON objection. Go ahead and answer.
THE WITNESS: well, I think he did perform an exam.
BY MR. RUF:
Q Dr. Spaner did not use "the spine" once in his emergency room notes of 9/4/96, correct?
MR. TORGERSON: Did not use?
THE WITNESS: He didn't -- there's no evidence of

Page 63

a back examination. There's -- it's not recorded. I don't recall what he mentioned in his deposition. It's not in the ER sheet, correct.
He's saying, "Extremities within normal limits." One would assume that that included straight leg raising.
BY MR. RUF:
Q But under "Physical Exam," he doesn't say anything about her spine, correct?
A correct.
Q What types of things can you do in a physical exam to help you to determine whether or not a patient is suffering from a large herniated disk in the lumbar spine?
A Very little. Actually, it's more of the history of the pain. Pain in the back, pain going down the leg. There's --
Usually, one would percuss the spine. In other words, you would tap on it and find if there was any areas of tenderness. Sometimes there is, sometimes there isn't. It's a very subjective finding. Straight leg raising would imply some sciatic nerve impingement. When you straight leg raise, you stretch the sciatic nerve. Which if it's irritated --
MR. MALONE: could you speak a little louder, please?

Page 64

THE WITNESS: I'm sorry. I keep forgetting about you guys back there.
Do you want me to repeat that?
MR. MALONE: Please. I didn't hear any of that.
THE WITNESS: All right. I'm sorry. We were talking about a physical exam.
I was saying, one would percuss the spine, tap on it to look for any areas of tenderness. And straight leg raising, which would imply irritation of the sciatica nerve.
MR. MALONE: Thank you.
BY MR. RUF:
Q Would you agree that Dr. Villarosa met the acceptable of emergency room care on 9/5/96?
MR. TORGERSON: objection.
MR. RUF: It's the date of the second ER visit.
MR. TORGERSON But, go ahead and answer.
THE WITNESS: Yes.
BY MR. RUF:
Q Would you agree he demonstrated the acceptable standard of care on that date?
A Yes.
Q And do you agree he made the diagnosis of cauda equina syndrome?
THE WITNESS: That would appear to be the case, I don't recall his note. But, I'm -- since she had surgery that same day, I'm assuming that was the case.
BY MR. RUF:
Q Okay. If you need to take a look at his record and tell me how did Dr. Villarosa make the diagnosis of cauda equina Syndrome.
MR. TORGERSON DO you want him to read his deposition, as well? Or do you want to limit him to the emergency room record?
BY MR. RUF:
Q Well, Doctor, based upon everything you have reviewed, how did Dr. Villarosa make the diagnosis of cauda equina syndrome on 9/5/96?
MR. TORGERSON: If -- let me simply object. If you can do that, please, do it. And answer the question.
THE WITNESS: If I could just take a moment and look at the note here.
MR. RUF: Please, do.
MR. TORGERSON Is there more water outside? Does anybody else want inore water?
(WHEREUPON, there was a brief recess.)
MR. TORGERSON As I mentioned, Doctor, if you are going to respond to that question, make it clear on the record what record you are referring to in order to answer the question.
THE WITNESS: okay. I'm, at this the, only referring to Dr. Villarosa's note from 9/5.
And could you state your question again?
BY MR. RUF:
Q Sure. How did Dr. Villarosa make the diagnosis of cauda equina syndrome?
MR. TORGERSON Objection. But, please, answer.
THE WITNESS: well, the things he did, he, again, took a history and did an exam. And it looks like he did an MRI.
BY MR. RUF
Q In your opinion, did Dr. Villarosa do a thorough job with his history, physical exam and diagnostic testing?
A Yes.
Q Would you agree that Dr. Villarosa performed a perineal exam?
A That appears to be the case. He mentions total perineal numbness.
MR. TORGERSON: Was that --
BY MR. RUF:
Q And he also notes as a result of the perineal exam, no rectal tone, correct?
A That's correct.
Q And you agree that Dr. Villarosa ordered an MRI, correct?
A That's correct.
Q And the MRI was diagnostic of a massive herniated disk at L5-S1, correct?
A Correct.
Q Based on Dr. Villarosa's history, he took a history from Bonnie Pikkel of having no bowel movement for two days, correct?
A Yes.
Q And he, also, took a history of no -- or an inability to urinate for two days, correct?
A Well, urinary symptoins began the previous day, or before she came in. But, she had a catheter in at that time. So that wasn't -- that wasn't an issue when she was seen the second time.
Q Do you agree that it's an ER physician's job to ask specific questions of a patient, in order to get the important infomation the doctor needs to make a diagnosis?
A Yes.
Q Do you have any dispute with the information that Dr. Villarosa obtained in his history?
MR. TORGERSON objection. By saying "dispute," are you saying do I disagree with it?
BY MR. RUF:
Q Yeah. Do you disagree with anything that he

Page 68

obtained in his history?
MR. TORGERSON objection. Objection for vagueness.
BY MR. RUF:
Q Please answer the question.
A I wouldn't say an objection. But, there's -- one part of it is vague. That I don't know what line this is. The fifth line down, or something. It says, "Pain resolved. But then developed perineal numbness, which has persisted."
It's not clear when that perineal numbness developed. Because that, apparently, was not present the previous day.
Q So are you saying a more thorough history might have stated when the perineal numbness developed?
A More thorough. Just to clarify a point there. Obviously, he knew it -- apparently, knew what he meant. But it's not clear, to someone reading that, when -- how the events transpired.
Q Okay. Let's go to Dr. Spaner's notes of 9/4/96.
A Okay.
Q Okay. Would you disagree there's no mention of bowel habit in Dr. Spaner's record of 9/4/96?
A There's no evidence of --
Q Let me rephrase that question. Because I -- it really wasn't articulate enough.

Page 69

Would you agree that he has no mention of whether or not she's voluntarily able to have bowel movements in his note of 9/4/96?
MR. TORGERSON: Note an objection.
I will withdraw my objection.
THE WITNESS: There's no mention either way.
BY MR. RUF:
Q He doesn't say whether she's having problems having bowel movements or whether she's not having problems, correct?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: There's no mention either way. He doesn't address it in the note.
BY MR. RUF:
Q Does he address whether or not she had a pre-existing disk before 9/4/96?
A Well, she's known to have a history of chronic back pain.
Q Where is that in his record?
A Oh, I don't know if that's in his record. But, she'd been going to the chiropractor for years for back pain.
Q There's no mention of chronic back pain in Dr. Spaner's record of 9/4/96, correct?
A Correct. Indirectly, if one would infer that she

Page 70

was seen by her long-time chiropractor and adjusted, that would sort of imply a long-standing condition. Otherwise, why would one go to a chiropractor for a long time?
Q Well, it doesn't say whether she's having manipulation of her cervical spine, thoracic spine, or lumbar spine, correct?
A That's correct.
Q And all those areas could be manipulated by a chiropractor, correct?
A Unfortunately.
Q And no mention whether she has prior problems with her lumbar spine, thoracic spine, or cervical spine, correct?
A That's correct.
Q He doesn't list what her symptoms were before the manipulation, does he?
A No.
Q Does he list what her symptoms were immediately after the manipulation?
A "Unable to urinate for 26 hours. No fever, chills. No back pain. Numbness in buttocks previously is now resolved."
Q Does it list what her immediate symptoms were after the manipulation?
A No.

Page 71

Q Why don't we go back to Dr. Villarosa's note of 9/5/96. Dr. Villarosa does note that Bonnie Pikkel had lumbar back pain for years, correct?
A Yes. And this first line of the history of present illness. "Patient has had recurrent low back pain for years."
Q Okay. Let's go back to Dr. Spaner's note. Does he note whether Bonnie Pikkel had any difficulty walking either before or after the manipulation?
A I don't *think* there's any mention of walking, any difficulty walking.
Q Can difficulty with a patient's gait be a sign or symptom of cauda equina syndrome?
A Yes. But it can, also, be a symptom of plain old low back pain, strain and other non-emergent conditions.
Q Okay. Let's go back to Dr. Spaner's note of 9/4/96. Do you agree that he writes "47-year-old white female who was seen by her longtime chiropractor"?
A Yes.
Q Do you agree that information is incorrect?
A That specific information?
Q Yes.
A I guess that was the case. Because she was seen -- is it Siegenthaler was her longtime chiropractor? And she was seen by Dr. Zannetti. Do I have the names

Page 72

correct?
Q That's correct.
A It was his young associate.
Q Well, you have in your report that Dr. Siegenthalerhad died, correct?
A I believe that's -- okay. I didn't recall when he -- he had passed away at some point. I wasn't sure at what -- was that after this or before. I didn't recall.
Q And based upon your review of the records and the depositions, wasn't this the first time Dr. Zannetti manipulated Bonnie Pikkel?
A Yes, I believe that's in someone's note.
Q So would you agree that's inaccurate information in Dr. Spaner's history?
A Yes, in terms of that was not her longtime chiropractor.
Q Well, given that he has inaccurate information in his history, isn't it likely that he might have gotten other information wrong in the history?
A I don't *think* one can go leap from one to the -- necessarily to the other.
Q Well, you can't say one way or the other whether there's other information in here that's inaccurate or not, correct?
MR. TORGERSON objection. It depends on what it

Page 73

1s.
THE WITNESS: I mean, that's kind of a minor technicality. If someone says -- if she's 47. And he says "48-year-old white female." You can say, Yeah, that's inaccurate. So other things must be inaccurate. That's not a fair assumption.
BY MR. RUF:
Q Well, he did get some information wrong in his history, correct?
A Yes.
Q Does the standard of care require thorough medical documentation?
MR. TORGERSON: I'm going to note an objection. That's a little vague. But, if you can answer that vague question, you go right ahead, Doctor.
THE WITNESS: That's what we all want to do, ideally. I don't know if one could say that's the standard of care. Sometimes five years down the road, one wishes one had documented more thoroughly. But -
BY MR. RUF:
Q Why is that something you ideally want to do?
A For a lot of reasons; medical, legally.
Q Well, could you list the reasons for me?
A Medically, legally. If something happens later on. If -- mainly, if someone else -- if another physician

Page 74

picks up the chart, ideally, what you want to do is see a word picture on that chart of exactly what transpired. And you want to pick up a chart that I wrote and look at it and say, I know exactly what he did. I know exactly what he found. This is perfect. It's documented just perfectly. And then you go -- come along and note if there's any change. Ideally, that's what one would want.
Q So what you're striving for is to list all the information -- all the pertinent information you have taken in the history?
A Yes.
Q And you want to list everything you have done, as far as physical examination and diagnostic tests, correct?
A Ideally.
Q Because if a consultant comes in, or another doctor, and they need to see this patient, it's important for them to see the history that's already been obtained, what physical examination has been done and, also, the diagnostic tests that have been performed, correct?
A correct.
Q Do you agree that thorough medical documentation is something that every ER physician should strive for?
MR. TORGERSON Objection. Asked and answered.
THE WITNESS: Yes.
MR. TORGERSON: Did he say perfect or thorough?

Page 7:

THE WITNESS: Thorough, I think, was his word.
MR. TORGERSON Okay.
THE WITNESS: It's an imperfect world.
BY MR. RUF:
Q Would you, also, agree that medical documentation is important, because as time goes on your memory fades?
A Oh, absolutely.
Q Do you know whether or not you were even working on 9/4/96?
A Not a clue.
Q Do you know how many patients you saw 9/4 of '96?
A Not a clue.
MR. TORGERSON: we'll stipulate that memory fades; my memory, perhaps, this doctor's memory. *All* memory fades.
BY MR. RUF:
Q Can you remember any diagnosis you made 9/4/96, if you even worked that day?
A Again, I don't remember if I worked that day. Nor do I remember any specific diagnosis.
Q Can you remember any diagnosis you made during the week of 9/4/96?
A It's safe to say back pain was one of them.
Q Are you just guessing? Or do you, specifically, recollect that?

Page 76

A No specific recollection. You just see so many back pains.
Q When you were working at Southwest General Hospital, approximately how many patients did you see during a shift?
A Between 25 and 40.
Q And you would agree, that given you would see 25 to 40 patients a night, that as time goes on, it's easy to get patients mixed up?
A If one doesn't write -- if one doesn't chart immediately. I can't keep them straight. Some people can.
Q Do you agree there's no differential diagnosis listed in Dr. Spaner's record?
A Yes.
Q Would you agree that no perineal exam is noted in Dr. Spaner's record?
A Yes. Other than what's -- there's no exam listed. But, it is mentioned in the history.
Q He doesn't say anything about rectal tone, one way or the other, correct?
A That's correct.
Q Do you agree that Dr. Spaner had no etiology for the urinary retention?
MR. TORGERSON: objection.
THE WITNESS: I have no way of knowing what was

Page 77

going through his mind at the time. There's nothing -- nothing on the chart that would reflect that.
BY MR. RUF:
Q What is an etiology?
A A cause, a source.
Q Does a standard of care require a doctor to determine an etiology for a patient's condition?
A Not necessarily.
Q What's the importance of determining an etiology for a patient's condition?
A Again, we're speaking in context of an emergency physician?
Q Yes.
A In the ER, we paint with a pretty broad brush.
First of all, is it a life threat? Does the patient need to be admitted, or can they go home? And does anything need to be done emergently?
I mean, seldom we frequently admit people with chest pain as the diagnosis. Are they having an attack? Who knows. It doesn't appear to be at the time. But they are admitted with chest pain or abdominal pain. Undetermined etiology. They get admitted to the hospital.
We eliminate -- or try our best to eliminate the immediate life threats. Is the chest pain -- are they having a heat attack right at this moment? Are they

Page 78

dissecting an aneurism? Are they -- do they have a blood clot in the lung, a pulmonary embolus? Is that abdominal pain due to an abdominal aorta aneurism? Appendicitis? Is it a vascular catastrophe?
Those are the things we try to eliminate emergently. And once we do that, with -- reasonably, they may still -- they still get admitted with that diagnosis of abdominal pain. We don't know what is going on. And they get admitted for further workup.
Q So you would agree the etiology is important in making the decision whether or not to admit a patient or discharge that patient home?
MR. TORGERSON Well, I'll object. But, please, answer.
THE WITNESS: Again, you frequently can't come up with a specific etiology. But, again, we -- the thinking inight go something like, I don't know what's going on, but I *think* it's something bad. She needs to be admitted. Or I don't know what's going on, but it can wait be to be worked up.
BY MR. RUF:
Q Well, if the etiology is a life-threating condition or a condition that could cause further or permanent damage to a patient, you're going to want to admit that patient to the hospital, correct?

Page 79

A Usually.
Q I mean, because you don't want to send a patient home that has a life-threatening condition or if that patient is going to suffer further injury because of a lack of treatment?
A fight.
However, again, getting back to this case, specifically. Symptoms improving usually implies a more benign process. She had numbness -- or she back pain that was resolved. It's getting better now. There's -- the alarm sort of goes off. You don't worry as much.
Q Well, do you agree that Dr. Spaner had no cause for Bonnie Pikkel's urinary retention?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: Again, I have no way of knowing wha was going through his mind. There's nothing apparent from the chart.
BY MR. RUF:
Q You mean there's no cause stated in the chart. That's just what you just said, correct?
MR. TORGERSON: objection. That's what he just said. That's the asked and answered objection that I've been making periodically.
BY MR. RUF:
Q In his deposition, does he list any cause or

etiology for the urinary retention?
MR. TORGERSON Are you asking the doctor if he recalls that he did?
MR. RUF: yes.
MR. TORGERSON DO you want him to review the deposition?
THE WITNESS: I, honestly, don't recall. I would have to review the deposition. I don't know.
BY MR. RUF:
Q Well, did you thoroughly review Dr. Spaner's deposition?
MR. TORGERSON: For preparation of your deposition today? Or at some point in the past?
BY MR. RUF:
Q In order to form your opinions in this case.
MR. TORGERSON You mean in 1999, when he wrote his report?
THE WITNESS: I reviewed it at the time. I didn't -- I have not looked at it recently. So I don't want to give an inaccurate answer.
BY MR. RUF:
Q So as we sit here today, you don't know what's in his deposition and what is not?
A That's, essentially, correct.
Q And that doesn't matter, for purposes of forming

Q Okay. So somebody in the ER, whether it's Dr. Spaner or the triage nurse, listed the date and time of Illness at 9/3/96 at 4 p.m., correct?
A That's what's indicated, yes.
Q Dr. Spaner ultimately signed the ER record, did he not?
A Uh-huh, yes.
Q And as an ER physician, if you disagree with something in the record, do you correct it?
A You certainly should.
Q Dr. Spaner, or whoever wrote date of injury, time of illness, did not change that, correct?
A There's no indication that -- no, there's no correction or change.
Q So would you agree that based upon the ER record, the manipulation was listed as the time of onset of the injury?
MR. TORGERSON: objection.
THE WITNESS: Assuming that's what time she had the manipulation and if she's stating that that's when the injury occurred. Obviously, you can't be doing two things at the same time. So...
BY MR. RUF:
Q Would you agree that cauda equina syndrome is a known complication of chiropractic manipulation of the

your opinion, as to whether or not he committed malpractice?
A I'm sorry?
MR. TORGERSON He's going to withdraw the question.
MR. RUF: That's fine. Strike that question.
MR. TORGERSON: He's withdrawing the question.
Could I just take a minute to get some water, so I don't go into convulsions here?
MR. RUF: certainly.
(WHEREUPON, there was a brief recess.)
MR. RUF: I forgot. What was the last question?
(WHEREUPON, the last question was read by the court reporter.)
BY MR. RUF:
Q All right. Would you take a look at Dr. Spaner's 914 record?
Would you agree that he lists the date and time of injury as 9/3/96 at 4 p.m.?
MR. TORGERSON: wait a minute. Just let me interpose an objection.
Are you representing that Dr. Spaner listed that there?
THE WITNESS: That would most likely have been done by the triage nurse.
BY MR. RUF:

lumbar spine?
MR. TORGERSON: Objection. Use of the word "known" vague and ambiguous. Go ahead and answer.
THE WITNESS: It is an extremely rare complication. It is recorded. I've seen estimates in -- as I recall, the articles I reviewed, one article estimated one in every 5 million manipulations. And one was, I *think*, ten or more million. I don't know where they got these figures.
BY MR. RUF:
Q Well, you Write in your report: "Cauda equina syndrome is a known coinplication of chiropractic manipulation of the lumbar spine."
A It's recorded, yeah.
Q Do you still stand by your representation in your reports?
A Yes.
Q What types of injury can be caused by chiropractic manipulation that can result in an inability to void?
MR. TORGERSON I'm just going to ask that be read back.
(WHEREUPON, the last question was read by the court reporter.)
THE WITNESS: cauda equina syndrome. I suppose one could have a herniated disk higher up above the

cauda equina. Or simply stretching, irritating the nerves.

BY MR. RUF:

Q And that's information you've obtained based upon your education and training as an ER doctor in your review of the literature?

A Basically, it's -- I'm basing that on my knowledge of spinal anatomy, along with what my understanding is done during chiropractic manipulation, which, I suppose, is pushing and stretching and adjusting. What they call adjusting the spine.

Q Would you agree it's important for a physician to stay current on the medical literature?

MR. TORGERSON: objection. When you say "the medical literature," are you referring to any specific medical literature or the world of medical literature?

BY MR. RUF:

Q Fine. Do you *think* it's important for a doctor to stay current on the medical literature in his or her field?

A Yes.

Q And during your years of practice, I assume that you reviewed ER literature?

A Yes.

Q And during your years of practice in reviewing ER literature, you came across reports of cauda equina syndrome

being caused by chiropractic manipulation?

A That was done in a literature search, I believe.

Q So would you agree for a patient with a 26-hour history of urinary retention following chiropractic manipulation, it would be reasonable to suspect -- or would be foreseeable that a patient inight have cauda equina syndrome?

MR. TORGERSON objection.

THE WITNESS: That would be one of the possibilities. Again, it would appear that that was considered, by the fact that the numbness in the buttocks is mentioned and, also, back pain. Both of which she did not have. So by indirect inference.

BY MR. RUF:

Q But based upon the known reports, it's foreseeable that somebody with a 26-hour history of urinary retention following chiropractic manipulation is suffering cauda equina syndrome.

MR. TORGERSON Objection to "foreseeable." Vagueness. You may answer.

THE WITNESS: By "foreseeable," I don't know if you mean very likely or it's possible. I guess that's using the two kind of synonoinous there. When you say "foreseeable," does that mean -- I'm not trying to split hairs. I'm just saying, by -- what do you mean

by "foreseeable"? Is it -- do you mean, is it likely that it would cause it, or is it possible? There's sort of different shades of...

BY MR. RUF:

Q Would you agree that Dr. Spaner has testified in his deposition that he has seen and evaluated people in the ER following chiropractic manipulation?

MR. TORGERSON objection. If you know what he has said in his deposition or can recall it now.

THE WITNESS: I don't know that. I don't recall specifically. If he said it, then that's what he said.

BY MR. RUF:

Q Well, if that's what he's testified to, then he was aware that spinal injury can be caused by chiropractic manipulation, correct?

MR. TORGERSON objection.

THE WITNESS: Again, it's assuming what he knew. And I...

BY MR. RUF:

Q I'm not sure I asked this. Bob told me I did not ask these questions. So I want to ask them, to make sure. Please apologize -- I apologize if I'm repeating questions I've already asked.

A Sure. No problem.

Q Did the acceptable standard of medical care

require Dr. Spaner to check for perineal sensation on 9/4/96?

A Not necessarily. It was mentioned in the history. One would assume that the person would know if they had perineal numbness or not.

Q Well, sometimes isn't it difficult, because of the nerve impingent, for a patient to determine whether or not they have a problem with perineal sensation?

MR. TORGERSON objection.

THE WITNESS: NO. I think that's a pretty sensitive area. If it's numb, you are going to know about it.

BY MR. RUF:

Q What's the reason for doing a pin prick test when you are testing for perineal sensation?

A To delineate -- delineate the area of involvement, the extent of the involvement.

Q And you are going to do a pin prick test, even if a patient tells you they've got numbness, because you want to delineate the area of involvement, correct?

A Right.

Q You're not just going to go by the history. You want to do your own examination of that area, correct?

MR. TORGERSON objection. I *think* you may be misconstruing an answer. But, note an objection.

Page 88

THE WITNESS: To -- basically, to delineate the dermatomes or the area supplied by the nerve, Rather than someone saying, It's numb down there. You want to know, where is it numb. So you would say, Do you feel this? Does it feel the same as that? That sort of thing.

BY MR. RUF:

Q Why is it important to check the areas of the dermatomes.

A If they do report numbness, basically, you want to know the areas involved and what that would help, or it may help. Again, that's a subjective thing. You know, numbness is a subjective finding. People may report different things.

But, it may help identify the level of injury of the -- you know, whether it's a L3-4, L4 -- you know, L5-S1 disc or in the sacral area.

Q What are the dermatomes for L5-S1?

A L5-S1, I believe, go down the outside of the leg, down to the -- is it the inside or the outside? Do they go down the outside of the leg to the toe, to the great toe?

Q Would you agree that dermatome for L5-S1 is the area immediately around and including the anus?

A L5-S1? No, I believe it's the lower sacral. Somewhere in there.

Page 89

Q Have you ever studied the dermatomes, or do you know for sure --

A Yeah. I don't commit them to memory. If I need to know them, I look it up.

Q So you would look up the dermatomes in some ER book or other medical text if you wanted to check those?

A Correct.

Q But in evaluating the dermatomes, it can provide insight into what level might be involved, correct?

A Correct. You might make a note. In other words, you do the exam, note what area's involved, and have that recorded. And then go back and look up what nerve -- what level is supplied by that area.

Q Do you agree that L4-L5 provides motor function to the legs?

A It -- yes.

Q Do you agree that L5-S1 does not provide motor function to the legs?

A I would have to look that up. You are catching me off guard here, as far as specific anatomy.

Q So if you had cauda equina Syndrome involving L5-S1, you may not have leg weakness or motor problems with the legs, correct?

MR. TORGERSON: objection. You may answer.

THE WITNESS: well, then it wouldn't be a cauda equina syndrome. That's usually implied at a lower level. You would usually have a sciatica at L5-S1.

Page 90

BY MR. RUF:

Q Would you agree that cauda equina syndrome can involve different levels of the lumbar spine?

A Within a small area.

Q What is that area?

A I would have to look that up.

Q Okay. So you don't know for sure?

A Offhand. I mean, it's the -- I believe it's the sacral. The fifth lumbar through the -- down into the sacral nerves.

Q **So** if you can have cauda equina syndrome just involving certain levels of the spine, you are going to see different symptomatology, depending on which level is involved, correct?

A True.

Q And that's why you have a whole list of symptoms. Because some of those may or may not be involved, depending on the level of the spine that's involved with the cauda equina Syndrome, correct?

A Right. But, again, the syndrome implies that group of symptoms, including the back pain, the perineal numbness. That's generally accepted that those comprise the syndrome.

Page 91

In other words, I guess, an analogy could be someone is having a heart attack. They've got chest pain, typically -- or frequently going down the arm. They are sweaty. They are short of breath. The corollary that someone having arm pain is having a heart attack is not true. They have got one symptom of that. But, not the chest pain. You know what I mean?

Q Okay. But the point is, you can have varying symptoms depending on what levels of the lumbar and sacral spine that are involved, correct?

MR. TORGERSON Objection. Asked and answered. But, go ahead and answer.

THE WITNESS: Yeah. I answered that. I mean, within a small area. Again, you're catching me a little off guard there.

BY MR. RUF:

Q Did the standard of care on **9/4/96,** require Dr. Spaner to perform a rectal exam?

A Not necessarily.

Q Well isn't the loss of rectal tone **a** sign or symptom of cauda equina syndrome?

A That's one of them, yeah.

Q So wouldn't you want to check -- wouldn't it be reasonable to check for rectal tone, if that's a sign or symptom of cauda equina syndrome?

Page 92

MR. TORGERSON: objection. You may answer.
THE WITNESS: It would have been good if he did. But to not do it is -- In this case, without the other symptoms, I don't *think* he deviated from the standard of care by not doing a rectal exam.
BY MR. RUF:
Q Well, if he did a rectal exam that might have provided him with some important information that he didn't have, correct?
MR. TORGERSON: objection.
THE WITNESS: possibly. I mean, there's no way to know, since it wasn't done.
BY MR. RUF:
Q I mean, the loss or absence of rectal tone would be an important determination if cauda equina was on your differential diagnosis, correct?
A True.
Q Because that's one of the signs or symptoms. And you want to check the signs or symptoms in determining whether or not a patient has that syndrome, correct?
MR. TORGERSON: objection. Asked and answered many times.
THE WITNESS: That would give you additional information, yeah. But, again, to not -- to not do it is not, I don't *think* in this case, a deviation.

Page 93

You don't do a rectal exam on everyone that comes in with low back pain.
BY MR. RUF:
Q Well, if you are evaluating a patient for cauda equina syndrome, doesn't the standard of care require you, as an ER doctor, to check for those signs or symptoms of cauda equina syndrome?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: Not if they -- if, in your mind, they've been ruled out by the history. Which, in this case, I believe, they had been.
BY MR. RUF:
Q I want to give you a hypothetical, Doctor. And I would like you to answer my question.
I want you to assume that Bonnie Pikkel had perineal numbness on 9/4/96.
A Okay. Assume that she had. And that it was reported?
Q And that it was reported. And the remaining clinical picture remains the same as reported in the ER record. Do you understand?
A Okay.
Q The only fact we are changing in the ER record is that Bonnie Pikkel has perineal numbness. If she reported that she had perineal numbness, would the standard of care require Dr. Spaner to check for perineal sensation?
MR. TORGERSON: objection to the hypothetical. But, you may answer.
THE WITNESS: If she reported perineal numbness, then it's -- yes, he should have.
BY MR. RUF:
Q If Bonnie Pikkel reported perineal numbness, would the standard of care have required him to check for rectal tone?
MR. TORGERSON: same objection to the hypothetical, based on the additional fact. But, go ahead and answer.
THE WITNESS: what's the saying? Assuming facts not in evidence. But, yes.
BY MR. RUF:
Q You are aware that Bonnie Pikkel has testified in her deposition that she had perineal numbness from the time of the manip -- let's strike that. Let me re-ask that.
You're aware that Bonnie Pikkel has testified that from some point after the manipulation on 9/3/96 up until 9/5/96, she had no feeling in her pelvic area.
A That's what she -- I'm aware that's what she testified. However, in the record here, which is contemporaneous to her visit, he had no reason to indicate otherwise. He made -- the record was made at the time of

Page 95

the visit. He would have no reason to alter the facts when he reported, "Numbness in buttocks previously, now resolved."
Q Well, Doctor, if the massive herniated disk occurred around 9/3/96 at four o'clock, wouldn't that be consistent with continued numbness from that time up through 9/5?
MR. TORGERSON: Objection.
THE WITNESS: would it be consistent? Well, I suppose it's like saying chest pain is consistent with a heart attack. But not everyone has chest pain.
BY MR. RUF
Q But you've already said if you've got compression, you're going to have symptomatology, correct?
MR. TORGERSON objection. If he has said that, and I believe he did, he said it in response to a question. So by asking it again, it's a question that's been asked and answered. That's the basis of my objection.
BY MR. RUF:
Q Correct, Doctor?
A If you have compression you're going to have symptomatology more than likely. But, again, there are no absolutes in medicine. You know, you see some horrendous things like that. And they say, Look at this spine. I

Page 96

can't believe she didn't have any pain, or didn't whatever.
Q So if Bonnie Pikkel had perineal numbness on 9/4/95, that would be consistent with a massive herniated disk occurring at the time of manipulation, correct?
MR. TORGERSON objection.
THE WITNESS: 9/4/96? You said '95. But --
BY MR. RUF:
Q I'm sorry.
A If she had perineal numbness, and given the sequence of events, that would be consistent with a disk herniation.
Q Now, Dr. Spaner does note that she previously had numbness in her buttocks, correct?
A Uh-huh.
Q You need to give a verbal answer.
A Yes. I'm sorry.
Q Given that's a fact, wouldn't it be reasonable to check her buttocks with a pin prick test to see whether or not she's still got the numbness?
MR. TORGERSON: objection. You may answer.
THE WITNESS: Not necessarily. Because if -- she reported it was there. Then she reported it resolved. Again, that would lower one's index of suspicion. Transient or temporary symptoms, it's -- they seem to be getting better. She had pain that's gone. She had

Page 9

numbness that's gone.
BY MR. RUF:
Q Well, if she's got compression of the nerves in the lumbar spine, that could affect the sensation in the buttocks area, correct?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: Again, if she had it she would know it. She knew it before, Why would she not know it now?
BY MR. RUF:
Q Well, given that she had either current or previous numbness in the buttocks, wouldn't it be prudent to check for rectal tone?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: Not necessarily, given that her symptoms had abated.
BY MR. RUF:
Q Given that Bonnie Pikkel had a 26-hour history of urinary retention and the fact that it's well known -- strike that. Let me re-ask that.
Given that Bonnie Pikkel had a 26-hour history of urinary retention, and cauda equina syndrome is a known complication of chiropractic manipulation, wouldn't that have put cauda equina syndrome on the top of the differential on 9/4/96?

Page 98

MR. TORGERSON: objection. Asked and answered. I'm also objecting to the use of the word "known." We've already established that.
MR. RUF: Those are his words.
MR. TORGERSON: well, in any event --
BY MR. RUF:
Q Please, answer the question.
A It would be in the differential. I don't necessarily -- at the top of the differential.
Q What was at the top of the differential?
A I don't know what he -- what his thought process was at that time.
Q What would be at the top of your differential?
A In what type of symptoms?
Q With the presentation Bonnie Pikkel had.
MR. TORGERSON: well, I'm going to note an objection. Because you hypothetically adjusted whatever presentation you previously established. So it's now difficult to tell what you believe her presentation was.
BY MR. RUF:
Q Okay. Let's go back.
Based upon the medical record of 9/4/96, what would be at the top of the differential for Bonnie Pikkel?
A In all fairness, knowing what I know now about

Page 9

this and about this case, it's -- my judgment has to be colored by the facts in this case and by what I know about the case. You know, I would have to say, Oh, gosh. If I saw someone like this, I would have to say cauda equina syndrome. Since I've been involved with this case, I've suspected a lot more cauda equina syndromes. Never saw one. But, looked for them.
Q Is it your opinion that the acceptable standard of medical practice only requires an ER doctor to make a diagnosis if there is a classic presentation of a condition?
MR. TORGERSON objection to the word "classic."
THE WITNESS: I'm not sure where you are going with that. Would you be more specific?
BY MR. RUF:
Q Sure. Let me ask some other questions. Maybe that will help you out.
Do you agree that the human body is complicated?
A Yes.
Q And do you agree that diseases and conditions are manifested different ways in different people?
A Yes.
Q And that doctors are trained to make diagnoses based on differing clinical pictures?
A Yes.
Q And that's part of a doctor's skill as a

Page 100

professional?
A Otherwise, you could send a trained monkey in with a checklist.
Q Right. That's part of the reason why you go through four years of medical school, you go through internship, residency and training, and get board certification, correct?
A Yes.
Q It's because you want to be trained so you can make a difficult diagnosis as well as an easy diagnosis, correct?
MR. TORGERSON I will object. But, please feel free to ask these questions as long as you want.
THE WITNESS: It's somewhat vague in form. But, in an ideal world, yes.
BY MR. RUF:
Q Would you agree the standard --
A I'm *sorry*. I said in an ideal world you would want to diagnose everyone correctly no matter what, no matter how bizarre or atypical a presentation.
Q And would you agree the standard of care requires an ER doctor to use his education and training to make a diagnosis on a patient?
MR. TORGERSON I'll object. But, go ahead and answer.

Page 101

THE WITNESS: Yes. How else can one answer that one?
BY MR. RUF:
Q So would you agree if a doctor decides that a presentation is too difficult and he says, I can't make the diagnosis, and he sends the patient home, that would be a deviation from acceptable medical practice?
A Not necessarily, no. That's -- I won't --
MR. TORGERSON: objection.
BY MR. RUF:
Q You *think* that would be acceptable medical practice?
MR. TORGERSON objection.
THE WITNESS: sure. In many cases it is.
BY MR. RUF:
Q That's the standard you are using in this case to judge Dr. Spaner's conduct?
MR. TORGERSON objection. We haven't established what standard it is you are referring to.
BY MR. RUF:
Q Please, answer the question, Doctor.
A Was it acceptable in this case? Given her presentation, her only symptom was urinary retention. Yes. He told her to follow up with her doctor the next day.
Q Okay. Under what factual scenario would have been

Page 102

a deviation from acceptable medical practice to send Bonnie Pikkel home?
MR. TORGERSON: Objection. You're asking him to create a factual scenario in answer to your question, where had those facts he creates been here, even though they are not?
MR. RUF: Yes. I want to see under what circumstances he would think malpractice was committed.
MR. TORGERSON: objection. You may answer.
THE WITNESS: Malpractice is a legal definition. But, I think if the other -- if the other symptoms of cauda equina were there and he felt that was what was going on and still sent the patient home, then that would be a prima facie case. In other words, it would be like diagnosing a heart attack and sending someone home.
BY MR. RUF:
Q Okay. What other symptoms would she have had to have had in order for it to be a deviation from acceptable medical practice to send her home?
MR. TORGERSON: I will object. You may answer.
THE WITNESS: I think continuing back pain, continuing saddle anesthesia. ***Or*** perineal numbness, whatever you want to call it. You know, along with the urinary retention. They would also -- I would also

Page 103

expect them to have numbness in the legs. You know, the full-blown syndrome.
BY MR. RUF:
Q What's the number of cauda equina cases you have diagnosed?
A I have suspected any number. I shouldn't say any number. Probably, fifteen or twenty over the years,
Q Have you ever reached the definitive diagnosis of cauda equina syndrome?
A No.
Q If you've suspected cauda equina syndrome, have you called in either a neurosurgical or orthopedic consult?
MR. TORGERSON On any occasion in those fifteen or twenty?
MR. RUF: Yes.
THE WITNESS: As I recall -- first of all, I think it would actually be much less than fifteen or twenty. But, I don't recall how few less. But --
BY MR. RUF
Q Would it have been less than ten?
A Around ten, perhaps. Maybe, less than ten. You know, because it's an exceedingly rare condition. I've done MRIs to rule -- they've all been ruled out.
Q So all the cases that you've suspected a patient has had cauda equina syndrome you have done an MRI and ruled

Page 104

that out as a condition?
A Yes. They've all had severe back pain, I *think.* You know, along with the other symptoms. They reported urinary retention and things like that.
Q So as an ER doctor, you have actually never been presented with a case of cauda equina syndrome?
A Not that I can recall.
Q Do you know Dr. Spaner?
A No, I don't. Never met him.
Q ***So*** you know Dr. Villarosa?
A No.
Q Do you know anyone at Lakeland Emergency?
A No.
Q Have you ever worked for Lakeland Emergency?
A No.
Q Have you ever worked for Meridia?
A No.
Q Hillcrest Hospital?
A No.
Q Cleveland Clinic?
A No.
Q Do you know a Dr. Bell?
A No, not at all.
Q Before this case, were you ever an expert for Marilyn Miller Crisafi?

Page 105

A No.
Q Before this case were you ever an expert for Ken Torgerson?
A Yes.
Q How many times were you an expert for Ken Torgerson?
A One.
Q What type of case was that?
A That was a stroke involving Medina.
Q And you were an expert on behalf of the defense?
A Yes.
Q Was that a case that was filed in Medina?
A I don't recall.
MR. TORGERSON: I do. But, I can't testify. And I'm not telling Mark.
THE WITNESS: I don't recall the venue. I think it was -- I don't recall.
BY MR. RUF:
Q Did you give a deposition in that case?
A Yes.
Q Do you know, approximately, what year that was?
A That would, I believe, have been in '99.
Q Do you know the name of the case?
A Stehler, S-T-E-H-L-E-R, I believe.
Q Did you have to testify at trial in that case?

Page 106

A No. It was dismissed with -- dismissed without prejudice, I believe.
Q How many other cases have you served as a medical expert?
A I've reviewed, probably -- six or eight would be my best guess.
Q Did any of the other six to eight cases involve cauda equina syndrome?
A No.
Q Did any of the other six to eight cases involve a herniated disk?
A No.
Q You seem to be hesitating.
A No. I'm trying to -- I don't want to give an untruthful answer. And I -- no.
Q Were some of those six to eight cases for Weston Hurd law firm, or lawyers in that law firm?
A There were -- let's see. Stehler, this one. There was another -- one other case that was a head injury.
Q Was that with the Weston Hurd firm?
A Yes. Yeah, that was your question, right?
Q I'm sorry. So how many cases for the Weston Hurd firm?
A Let's see. Stehler, Moton. I believe, three.
Q And you said one case was named Moton?

Page 107

A Either Moton or Melton. I -- There was -- it came in under Moton, M-O-T-O-N. But then they said there was a mistake in the name.
Q Do you know if that was a Cleveland case?
A Yeah. That was Cleveland.
Q How long ago was that?
A Oh, that was finally settled. It was coining to trial, I was never even deposed on it. I just sent a report. It was settled late last year.
Q Did you testify -- you testified in a deposition, correct?
A No. I was never even deposed on that. I just did a report on that. And the defendant settled. It was originally filed, I think, as Moton v. St. Vincent Charity Hospital, et al.
Q Were any of the other six to eight cases as an expert for the Jacobson Maynard law firm?
A Uh-huh, yes.
Q How many cases?
A One or two. Two that I can recall. But, I can't give you the particulars on that. One was an eye case that I went to trial on. It was a case against an ER physician at Kaiser. And the other one was -- I don't recall the -- I don't recall the plaintiff in that case. That was settled prior to the trial.

Page 108

Q Have you ever reviewed a case on behalf of a plaintiff?
A Sure.
Q How many cases?
A Four or five.
Q Have you ever formerly rendered the opinion that a doctor committed malpractice?
A Yes.
Q Did you ever write a report saying that a doctor coinmitted malpractice?
A Yes. In fact, I've got one coming up to that effect.
Q How many cases have you done that in?
A Trying to think. Boy, it's been such a smattering over the years. I just -- I would have to say, just a rough guess, two or three. And these were cases that I sent a report in and that was the end of it. I never heard -- never was deposed. Or nothing, apparently, came of it. At least, I never heard any more from it.
Q Were those emergency room cases?
A Yes. They were all ER cases.
Q Were any of those cases -- did any of those cases involve the failure to diagnose a condition?
A Again, the others were so long ago, I can't recall the particulars. The one -- there was one from Pittsburgh

Page 109

alleging failure to diagnose a stroke.
And I've got one currently going that is going to trial in Texas. It's really not an ER case. It was against a VA hospital. Failure to diagnose pneumonia. That, apparently, is coining to trial soon. I just got a letter last week from the plaintiff's counsel.
Q In the case with the stroke, why did you believe there was malpractice for the failure to diagnose --
A No. That one, I did not.
Do you want a capsule synopsis of the events?
MR. TORGERSON He'll ask you if he wants one.
Don't encourage him.
BY MR. RUF:
Q If you've formerly rendered the opinion that a doctor has committed malpractice in a failure to diagnose case, I just want to know why you felt that way in the case.
A In the case of -- the current one in Texas, they -- a gentleman had pneumonia that required extensive treatment and surgery for drainage of an abscess that should have been diagnosed with a simple chest x-ray, and it wasn't.
I feel like in these cases, I have got to look at myself in the mirror. And I should be able to sit across from someone and say, You screwed up. And do it in good conscience. Not as a hired gun.

Page 110

Q Are you board certified in ER medicine?
A Yes.
Q When were you board certified?
A Originally, in 1989. I was recertified in 1999.
Q What is your charge per hour?
A We haven't really discussed that. I don't know. I haven't really done enough to go on specific charges.
Q Do you know what you have charged the Weston Hurd firm to date on this case?
A No, I sure don't. I think it's -- it's around five or six hundred to prepare a report. Unless there's something long and drawn out that -- or more than a usual report. Because, you know, work can expand the time -- or to fill the time allotted to it. So it's easy to milk those. I would rather just -- you know, just a have a flat fee.
Q Do you know how much time you spent total on this case?
A At this point, in reviewing everything?
Q Yes.
A Gosh, probably ten, twelve hours.
Q And you said you don't know what rate you're charging?
A No, I honestly don't.
Q Do you have a different charge for the deposition

Page 111

today than you've had to this point?
A Yeah. Again, I haven't -- we haven't worked out any particulars on that. Obviously, I don't do it enough to make a living off of it.
Q Why did you leave Southwest General?
A I was there 19 years. We wanted to, basically, move to a sunnier climate and get away from Cleveland weather. My wife was wanting -- wanted to more than I did. And the group had changed. The group was bought out by a national group.
Q Was it for performance reasons at all?
A No. Oh, no. They wanted me to stay.
Q Has any hospital ever disciplined you or --
A No.
Q -- pulled your privileges?
A No.
Q Or taken any action against your privileges?
A No.
Q Has your license ever be subject to disciplinary action?
A No.
Q Have you ever been a defendant in a malpractice suit?
A Named as a defendant?
Q Yes.

Page 112

A Yes.
Q What happened in that case?
A Well, there were several. They've all been dropped.
Q How many lawsuits have you been in?
A Six or seven.
Q Did any of those cases involve the failure to diagnose the condition of the spine?
A No.
Q Were those all Cleveland cases?
A Yes.
Q Do you agree the failure to diagnose cauda equina syndrome because of an inadequate examination is malpractice?
MR. TORGERSON: objection. Asked and answered.
THE WITNESS: That's a broad statement. To fail to diagnose it if the symptoms are there? Given that -- is this a hypothetical?
BY MR. RUF:
Q Well, I'm asking you: Do you agree the failure to diagnose cauda equina syndrome because of an inadequate examination is a grounds for malpractice?
MR. TORGERSON: objection as to the terminology of "inadequate examination" and what it constitutes. Lack of definition, vagueness. And is a matter of judgment.

Page 113

BY MR. RUF
Q Well, if Dr. Spaner has testified to that, do you disagree with that statement?
MR. TORGERSON: objection as to what Dr. Spaner testified to.
BY MR. RUF:
Q Please, answer the question, Doctor.
MR. TORGERSON: If you can refer him to something which would support your characterization as you have phrased it, I would prefer that you do that.
BY MR. RUF:
Q Fine. Dr. Spaner's deposition, page 42. I asked the following question.
MR. TORGERSON: Give me a chance to catch up with you, now that you have notified us of this page. Because we can look at it as long as you -- as well as you.
BY MR. RUF:
Q Here. I will read it and then give it to you.
My question was: "Do you agree the failure to diagnose cauda equina syndrome because of inadequate examination is malpractice?"
The answer on page 43, line 4: "I would say that malpractice by definition would be departure of standard care. Then the answer would be yes." (Tenders.)

Page 114

MR. TORGERSON: Wait a minute. You can look at it there.
THE WITNESS: okay.
MR. TORGERSON Just read the surrounding area.
THE WITNESS: Yeah. It's taken out of --
MR. TORGERSON Then we'll have the question read back.
BY MR. RUF:
Q Do you agree or disagree with that testimony, Doctor?
MR. TORGERSON: Note an objection.
THE WITNESS: Failure to diagnose cauda equina syndrome because of and inadequate examination? The examination, according to history and physical --
BY MR. RUF:
Q I'm *sorry*. An inadequate exam. You said --
A Right.
Q -- an adequate.
A No. I said an inadequate. I'm *sorry*. Inadequate -- yes -- examination. Meaning, examination encompassing the history and physical? I would agree with that.
Q And you would agree it's malpractice, because the failure to diagnose cauda equina syndrome because of an inadequate exam should not occur?

Page 115

MR. TORGERSON objection.
Could you read that question back?
BY MR. RUF:
Q I'll re-ask it. The failure to diagnose cauda equina syndrome because of an inadequate examination is malpractice because the failure to diagnose cauda equina syndrome -- never mind. Strike it.
I'll just end the deposition. That's fine. I will let you off the hook on the last question.
MR. TORGERSON Thank you. You are a swell guy for doing that.
MR. RUF: Any questions, Jim?
MR. MALONE: I've got a couple of hours, Doc. Are you all right? Just kidding.
THE WITNESS: I'm hanging in there.
MR. MALONE: NO questions for the witness.
MR. TORGERSON we're both catheterized. So you go ahead and ask your questions.
MR. MALONE: I have no questions.
MR. TORGERSON Thank you, Jim.
MR. RUF: Do you want to read or waive?
MR. TORGERSON we're going to read it.
MR. RUF: okay. That's fine,
(WHEREUPON, the deposition was concluded at 5:30 p.m.)

REPORTER'S DEPOSITION CERTIFICATE

STATE OF FLORIDA)
COUNTY OF VOLUSIA)

I, SHARON K. DINES, Court Reporter, certify that I was authorized to and did stenographically report the foregoing deposition of ALLEN J. JONES, M.D.; that a review of the transcript was expressly waived; and that the transcript is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

Dated this 8th day of May, 2001.

SHARON K. DINES, Court Reporter
& Notary Public
(Signature valid only if signed in blue *ink.*)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF **VOLUSJA**)

I, the undersigned authority, certify that ALLEN J. JONES, M.D. personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 8th day of May, 2001.

Sharon K. Dines, Court Reporter
Notary Public - State of Florida
My Commission No.: DD007485
Expires: May 18,2005
(Signature valid only if signed in blue *ink.*)

Sharon K Dines
My Commission DD007485
Expires May 18, 2005

DEPOSITION OF: ALLEN J. **JONES,** MD.; 5/4/01
STYLE: PIKKEL, et. al vs. MERIDIA HEALTH **SYSTEM,** et al.

ERRATA SHEET

PAGE & LINE NUMBER	CORRECTION AND REASON THEREFORE

I have read my deposition in this matter and entered any changes in form or substance as reflected above.

DATED:_____ **SIGNED:**_____

May 8,2001

Volusia Reporting Company
150 South Palmetto Avenue
Suite 101
Daytona Beach, Florida 32114
Telephone (386)255-2150
Facsimile (386)258-1171

Allen J. Jones, M.D.
1932 Southcreek Boulevard
Daytona Beach, Florida 32124

In Re: PIKKEL, et al. vs. MERIDIA HEALTH***SYSTEM,*** et al.

Dear Dr. Jones:

Attached is the mini-transcript copy of your deposition, which was taken in the above-styled cause on May 4,2001, and which is being sent to you for the purpose of reading and signing.

PLEASE DO NOT MARK ON THE **ORIGINAL.** TRANSCRIPT. Any corrections you may desire to make in your testimony should be TYPEWRITTEN OR PRINTED on the attached Deponent's Errata Sheet, giving the page number, line number and desired correction. Please return the Deponent's Errata Sheet to our office.

Due to the expedited circumstances, please return the Errata Sheet with your signature to our office as soon as reasonably possible.

Should you have any questions regarding this matter, please call the number indicated above.

Sincerely,

Sharon K. Dines,
Court Reporter

cc: Mark W. Ruf, Esquire
Robert F. Linton, Esquire
James Malone, Esquire
Kenneth A. Torgerson, Esquire