

#654

THE STATE of OHIO,

: SS:

COUNTY of LUCAS.

IN THE COURT OF COMMON PLEAS

THOMAS G. BALDWIN,
 plaintiff,

vs.

: Case No. 96 2365

MARK E. REARDON, M.D.,
et al.,
 defendants.

Deposition of ROGER A. TRUE, M.D., a
defendant herein, called by the plaintiff for the
purpose of cross-examination pursuant to the Ohio
Rules of Civil Procedure, taken before Kris
Adorjan, a Notary Public within and for the State
of Ohio, at the offices of Jacobson, Maynard,
Tuschman & Kalur, 333 North Summit Street, Toledo,
Ohio, on THURSDAY, JANUARY 16TH, 1997 commencing at
2:04 p.m. pursuant to notice.

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I N D E XWITNESS:ROGER A. TRUE, M.D.PAGE

Cross - examination by Mrs. Garson

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DR. TRUE DEPOSITION EXHIBITSMARKED

1 - Dr. True's curriculum vitae

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2 - discharge summary

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(Dr. True Deposition Exhibit 1
marked for identification.)

ROGER A. TRUE, M.D.

of lawful age, a defendant herein, called by the
plaintiff for the purpose of cross-examination
pursuant to the Ohio Rules of Civil Procedure,
being first duly sworn, as hereinafter certified,
was examined and testified as follows:

CROSS-EXAMINATION

BY MRS. GARSON:

Q. Would you please state your name for the
record?

A. Roger A. True, T-r-u-e.

Q. Dr. True, my name is Ann Garson. I am here
today to take your deposition with regard to the
case of Thomas Baldwin.

My purpose today is not to trick
you or to cause any confusion. My purpose is to
try to understand the facts of the case as they
have **been** recorded in **your** notes; and to ask **for** a
clarification on the entries that you have made in
your chart.

1 If I ask a question that makes no
2 sense either grammatically or medically, let me
3 know, stop and just say break that down, or let me
4 know where it doesn't make sense, and I will
5 attempt to clarify my question.

6 If at any time you need to take a
7 break or you want to have a conference with your
8 attorney, that is entirely acceptable to me; and I
9 think that is probably it.

10 I am sure your attorney has given
11 you the ground rules in terms of making your
12 answers verbal so the court reporter can get
13 everything down.

14 I have your CV here. I don't want
15 to go through it too painstakingly so we can save
16 some time. Let me just make sure that I understand
17 basically some of your history.

18 Currently you are employed where?

19 A. Bedford Medical Arts, PC.

20 Q. What is PC?

21 A. Professional corporation, actually the PC was
22 just recently dropped.

23 Q. That is located where?

24 A. At the address there, 3175 Smith Road.

25 Q. In Lambertville, Michigan?

1 A. Correct.

2 Q. What do you do there?

3 A. Family practice physician.

4 Q. Prior to November of 1993 you were in a
5 different location; is that correct?

6 A. Right next door.

7 Q. Down the hall?

8 A. No, a different building.

9 Q. Was that a different kind of practice?

10 A. Still family practice, a private practice.

11 Q. So you still currently have a practice
12 operating at those offices?

13 A. Just at the one, Bedford Medical Arts.

14 Q. Just at the one?

15 A. The same practice, just moved.

16 Q. Prior to that you were employed where?

17 A. Prior to that I was a resident at Flower
18 Hospital.

19 Q. When you did your residency training at
20 Flower Hospital that was in family practice?

21 A. Correct.

22 Q. Have you had any other specialty training
23 other than family practice?

24 A. No.

- 25 Q. Are you Board certified in family practice?

1 A. Yes.
2 Q. I see, okay, there it is, that was in 1983?
3 A. Initially and recertified in 1990.
4 Q. Well, what is your current relationship with
5 Flower Memorial Hospital?
6 A. I am on the medical staff there.
7 Q. What does that entail?
8 MR. BODIE: Ann, are you
9 asking whether he is an employee at Flower?
10 MRS. GARSON: Right.
11 A. I am not an employee at Flower, just on the
12 medical staff there.
13 Q. Was your relationship with Flower Memorial
14 Hospital any different from 1990 through '92, or
15 was it the same then?
16 A. The same.
17 Q. I see you have active privileges at the
18 Toledo Hospital and Saint Vincent Medical Center,
19 courtesy privileges; is that accurate?
20 A. Correct.
21 Q. Is there anything on there that is missing
22 from your CV or is this the most current, updated?
23 A. I don't think there is anything missing, this
24 is the most current updated one.
25 Q. Has your medical license ever been suspended

1 or revoked?

2 A. No, it has not.

3 Q. Have you ever been the defendant in a medical
4 malpractice lawsuit before?

5 A. No, I have not.

6 Q. Did you review any documents in preparation
7 for today's deposition?

8 A. The patient's chart.

9 Q. Which chart is that?

10 A. The office chart that I kept **of** the patient.

11 Q. Your office chart of the patient?

12 A. Correct.

13 Q. As part of that chart does that include
14 Dr. Reardon's records?

15 A. No, I do not believe.

16 Q. Let me **go** back a little bit, let me make sure
17 I understand this.

18 In February of 1992 you were
19 practicing at the 6588 Secor address in
20 Lambertville, Michigan?

21 A. That is correct.

22 Q. Was Dr. Reardon practicing there with you as
2.3 well?

24 A. No.

25 Q. **He** had left the practice prior to that **time?**

1 A. We have never been associated in practice.

2 Q. Then I misunderstood.

3 You have never been associated in
4 any practice with Dr. Reardon?

5 A. I don't ever recall meeting Dr. Reardon.

6 Q. When did you first see **Mr.** Baldwin?

7 A. Let me look at my chart.

8 According to the chart the first
9 time I saw Mr. Baldwin, February 18th, 1992.

10 Q. When you first saw him what information or
11 what knowledge did you have about his prior medical
12 treatment?

13 A. The information solicited from him, his
14 history.

15 Q. Did you seek to obtain any of his prior
16 medical records?

17 A. Routinely when patients come to the office we
18 ask them if they have any records that are
19 appropriate they can send for, since the patient's
20 information is privileged information we cannot
21 obtain it ourselves, and we routinely ask that.

22 Q. If you felt something was relevant you could
23 ask the patient to **sign** a release so you **could**.
24 obtain records, couldn't you?

25 A. Correct.

1 Q. Were any of his prior medical records
2 obtained?

3 A. The only record we obtained pertaining prior
4 to his visit of February was an emergency room
5 visit that I alluded to in my note.

6 Q. That would have been the February 16th visit
7 at Flower Memorial Hospital?

8 A. Correct.

9 Q. I am going to back up a little bit.

10 Doctor, do you consider yourself
11 qualified to diagnose an appendicitis?

12 A. Yes.

13 Q. Can you tell me some of the signs and
14 symptoms that usually present with a case of
15 appendicitis?

16 A. Some of the signs and symptoms of acute
17 appendicitis include fever, pain, usually
18 initiating in the periumbilical radiating to the
19 right lower quadrant; along with that is nausea,
20 vomiting, there may be diarrhea, those are the
21 usual symptoms that occur with it.

22 Q. What role, if any, does the symptom of
23 constipation play in that constellation?

24 A. Extremely variable.

25 Q. Sometimes it's there, sometimes it's not; is

1 that what you mean?

2 A. It's true with all the symptoms I just
3 reviewed.

4 Q. Same question with regard to rebound
5 tenderness, is that within the constellation of
6 symptoms that indicate --

7 A. Actually rebound tenderness is a solicited
8 sign rather than a symptom, but that is a finding
9 that is compatible but not exclusive to acute
10 appendicitis.

11 Q. We have just gone through some of the
12 symptoms.

13 Let me ask you, what are some **of**
14 the physical findings that might be consistent with
15 appendicitis?

16 A. Rebound tenderness, the patient may or may
17 not have a positive psoas sign or obturator sign,
18 the patient may have pain on rectal examination,
19 the patient frequently is feverish.

20 Q. What is McBurney's point?

21 A. The area in the right lower quadrant, that is
22 **a** frequent sign of the place where pain is
23 initiated with, ~~the right lower quadrant:~~ **symptoms .**

24 Q. Is it synonymous with right lower quadrant
25 pain **or is** it something different?

4 The point is just an anatomical point, so the
point itself is not synonymous with pain, just the
location where pain is sometimes solicited.

Q Is it in the right lower quadrant?

A. Correct.

Q This obturator's sign and the Moos sign, and
the pain at McBurney's point, these are findings?

A. Correct.

Q What does that mean?

A Those symptoms indicate --

MR BOHLE: What does that
mean? What does 'findings' mean or --

Q What does findings mean? In other words, the
patient doesn't come in and say I have an obturator
sign.

4 Those are things obtained through examination
of the patient.

Q. Moving their body a certain way or palpating
a certain way?

A Correct.

Q That role, if any, does an increased white
blood count play in the constellation of physical
findings or laboratory findings for diagnosing
appendicitis?

A. Elevated white blood cell count would be

1 consistent with acute appendicitis.

2 Q. Why is that?

3 A. The elevated white blood cell count is an
4 indication **of** some type of underlying infection,
5 either viral or bacterial. **So** if there is an
6 infection of the appendix or inflammation, there
7 may or may not be an elevation.

8 Q. **Do** you know what retrocecal appendicitis is?

9 A. Yes.

10 Q. Can you tell me what that is?

11 A. When the appendix is located in a less than
12 usual position, although not rare, the appendix is
13 then behind the cecum for the first portion of the
14 lower intestines, and if the appendix is inflamed
15 and is positioned behind the cecum then it's
16 retrocecal appendicitis.

17 Q. If a person has appendicitis and the appendix
18 is in the retrocecal position -- did I correctly
19 state that? You can have appendicitis and the
20 appendix is in the retrocecal position, it's behind
21 the cecum?

22 A. You may have that situation.

23 Q. Can that change **any of the symptoms or**
24 physical findings?

25 A. The symptoms and the findings for retrocecal

1 appendicitis are more variable than for
2 appendicitis that is not retrocecal.

3 Q. In which aspects would it be more variable?

4 A. In essentially all of the findings, but
5 especially in the signs we talked about earlier.

6 Q. I would like to go through each one.

7 For example, is it true that the
8 finding of abdominal pain might be more diffuse as
9 opposed to always a very pointed right lower
10 quadrant pain; is that one example of the variable
11 symptoms if it's a retrocecal --

12 MR. BODIE: As to

13 retrocecal only, versus just in general any type of
14 abdominal pain or abdominal findings?

15 MRS. GARSON: Right.

16 A. In all situations appendicitis symptoms are
17 variable, so there is never something true for all
18 appendicitis.

19 Notoriously in retrocecal
20 appendicitis the variability is increased as
21 opposed to nonretrocecal appendicitis, including
22 findings of right lower quadrant pain.

23 Q. Let me make sure I understand, and correct me
24 if I am wrong, I am not trying to put words in your
25 mouth.

The signs and symptoms of appendicitis include a list of various symptoms and findings. You don't necessarily have to have all of them in order to make the diagnosis of appendicitis or to have appendicitis, but there are certain ones you look for and some may be present or may not, correct?

MR. BODIE: Objection.
form. Doctor, if you can answer.

THE WITNESS: I don't understand

MR. BODIE: If you understand the question you should answer. I am going that for the record

A. Can you restate the question? I forgot it.

Q. I can understand, that was very poorly stated.

If you take an x-ray and see someone has a broken bone, that is a diagnostic film and you can see what the problems are; but appendicitis isn't really like that, correct?

A. Neither of those things are like that actually. There is nothing quite that clearcut and objective.

Q. A person presents with certain signs and

1 symptoms, and when the diagnosis of appendicitis is
2 suspected some of those signs and symptoms are
3 variable. correct?

4 A. All of them have variable, and while
5 compatible with appendicitis they are also
6 compatible with other diagnoses.

7 Q Right, and I was simply trying to understand
8 more clearly what you meant with retrocal
9 appendicitis that those signs and symptoms might be
10 more variable.

11 When you say "more variable," what
12 does that mean?

13 A. That the findings may vary from the list you
14 referred to, even more often than in nonretrocal
15 appendicitis.

16 Q. When you say "vary," does that mean more of
17 them may be present, more of them may be absent?

18 A. That they may be present or absent, in
19 increased or reduced amounts, correct

20 Q Is there any aspect of variability that you
21 mean other than presence or absence; or is that
22 what you mean by variability?

23 A. That's what I am referring to.

24 Q. Are there certain methods or tests which you
25 consider valuable in diagnosing appendicitis?

1 A. The first method that is valuable is
2 soliciting a history of the patient of his acute
3 symptoms, and then performing a physical
4 examination.

5 &- What would that physical exam involve?

6 A. It would involve an abdominal examination,
7 depending on the findings of the history; and the
8 examination of the abdomen may involve other areas
9 of exam based off the previous findings.

10 Q. What's involved in an abdominal examination?

11 A. Observation, auscultation, and palpation,
12 possibly depending on previous findings, percussion
13 of the abdomen.

14 Q. If a person presents with some of the signs
15 and symptoms of appendicitis, is a psoas sign
16 and/or an obturator sign helpful or is that
17 included in your physical exam?

18 MR. BODIE: Objection,
19 form. Go ahead.

20 A. Those exams would be extensions of an
21 abdominal exam, that would be precipitated based
22 off of findings in the initial exam.

23 Q. **So we have a history of: physical exam and: the**
24 **physical exam involves an abdominal exam, correct?**

25 A. Correct.

1 Q. Are there any other kinds of diagnostic tests
2 that are helpful in diagnosing or ruling out
3 appendicitis?

4 A. For evaluating or possibly ruling out **of**
5 appendicitis the use **of** a **CBC** is usually quite
6 helpful.

7 Q. Is that all?

8 A. In addition to the physical exam and history
9 that is most often all that is necessary to get an
10 appropriate diagnosis.

11 Q. Does a normal or abnormal CBC in and of
12 itself necessarily rule out appendicitis?

13 A. It neither rules in or rules out
14 appendicitis.

15 Q. Is that another one of the variable findings
16 that might be present?

17 A. Correct.

18 Q. What role, if any, do x-rays play in the
19 diagnosis or the ruling out of appendicitis?

20 A. Essentially none.

21 Q. **So** it's not diagnostic at all, or only is
22 there a percentage, does it have a diagnostic
23 accuracy **or** inaccuracy?

24 MR. BODIE: Objection. **I**
25 think that is unfair to ask the Doctor, **He** is not

1 a radiologist in that regard about the accuracy in
2 that regard.

3 Doctor, if you understand what she
4 is asking you, and you are able to answer that,
5 please go ahead.

6 A. I would not utilize that, x-rays are not
7 utilized in diagnoses of acute appendicitis.

8 Q. What about CAT scans, are those diagnostic or
9 helpful in the diagnosis in ruling out
10 appendicitis?

11 A. I have never used a CAT scan for the
12 diagnosis of appendicitis.

13 Q. I heard your answer and I am just going to
14 ask it again.

15 Are you saying to me it's
16 nondiagnostic, it's not useful? I heard you say
17 you have not used a CAT scan to diagnose or rule
18 out appendicitis. My question is: Is a CAT scan
19 useful?

20 A. A CAT scan is not a useful diagnostic tool
21 for acute appendicitis.

22 Q. Why is that?

23 A. Because it **has** a tremendously **high** false
24 negative findings rate.

25 Q. Do you know what that is, just **approximately**;

1 when you say "tremendously," are you saying
2 30 percent?

3 A. No.

4 Q. Are you saying 80 percent?

5 A. No, I couldn't give you a percentage. It's
6 tremendously high enough that it's not a useful
7 test for the diagnosis of appendicitis.

8 Q. Same question with regard to ultrasounds: Is
9 an ultrasound a useful tool in diagnosing or ruling
10 out appendicitis?

11 A. Ultrasound is not a useful tool in diagnosing
12 acute appendicitis.

13 Q. Can you tell me why?

14 A. Again, it does not have effective diagnostic
15 value.

16 MR. BODIE: As to
17 appendicitis?

18 THE WITNESS: As to
19 appendicitis, correct.

20 Q. What about barium enema?

21 A. Again, radiographic procedures are not useful
22 in the diagnosis of acute appendicitis.

23 Q. So let me make- sure I understand then before:
24 we go on, the methods and procedures that you would
25 use or the tests to diagnose or rule out

1 appendicitis involve a history, and a thorough
2 physical exam, and a CBC?

3 A. Yes.

4 Q. How did you come to see Mr. Baldwin in
5 February of 1992; do you know?

6 A. He made an appointment, came to our office.

7 Q. You don't know if he was referred there --

8 A. I do not know.

9 Q. -- how he made it there?

10 I understand that when you first
11 saw Mr. Baldwin you did not have and did not review
12 any of his prior medical records?

13 A. When I first saw Mr. Baldwin I did not have
14 any **of** his prior medical records.

15 Q. With the exception we talked about, at some
16 point you did have the emergency room visit from
17 two days prior to his first visit with you?

18 A. I did not have that at the time I first saw
19 him.

20 Q. Let me make this clear.

21 What if any records **of**
22 Mr. Baldwin's have you reviewed prior to
23 **February 16th of 1992, if any?**

24 A. At the time I saw him?

25 Q. **No, right now.**

1 A. The only thing I reviewed of Mr. Baldwin's
2 was in the chart, since I have seen him, not prior.

3 Q. In your office chart.

4 You haven't seen Dr. Reardon's
5 records?

6 A. No.

7 Q. You haven't seen any prior emergency **room**
8 records?

9 A. No.

10 Q. I thought I understood you to say your only
11 knowledge of **Mr.** Baldwin's prior medical history is
12 what he told you on his first visit with you at
13 that time?

14 A. On 2-18-92 prior past medical history
15 information, what he related to me.

16 Q. What is that information? Perhaps you can
17 read the handwritten portion of your note **so** that I
18 can know what it says.

19 A. Did you want me to read the handwritten
20 portion or answer your question?

21 Q. Maybe my question would be answered if you
22 read this handwritten portion.

23 A. **It** reads "Stomach problems, **constipation**,
24 cold symptoms, fever, congestion, started Thursday
25 with abdominal pain, seen in emergency room, Flower

1 Memorial Hospital; Sunday, some nausea, vomiting,
2 and diarrhea; no bowel movement since a while, last
3 bowel movement yesterday, normal, severe cramps;
4 upper GI and lower GI passed last time one year
5 ago; Bentyl, 20 milligrams, t.i.d."

6 Q- Did you have any other medical information
7 from Mr. Baldwin, other than at that time?

8 A. I had my examination.

9 Q. Did you conduct a physical exam at that time?

10 A. Yes, I did.

11 Q. What did your physical exam involve?

12 A. Physical examination involved an abdominal
13 examination.

14 Q. What did the abdominal examination involve?

15 A. Palpation and auscultation of his abdomen.

16 Q. Is that in your note? I have read your note,
17 I didn't see that.

18 A. **No**, that is not there in the note.

19 Q. What else did your physical exam include?

20 A. Nothing else **I** recollect.

21 MR. BODIE: Ann, so I am
22 clear, **do** you mean "him" in person or in general,
23 because there **is a** notation **they took** his **weight**,
24 blood pressure.

25 MRS. GARSON: I actually am

1 talking a out aside from the weight and blood
 2 pressure. I am talking about the actual physical
 3 exam Dr. True conducted.

4 Q. You are saying it involes observation and
 5 auscultation?

6 A. And palpation of his abdomen.

7 Q. What were his findings at that time?

8 A. His abdomen was benign and asymptomatic. He
 9 was having --

10 Q. Where does it say it was benign and
 11 asymptomatic in the note?

12 A. It does not

13 Q. Is there any reason why it doesn't say that?

14 A. You use all the chart positive findings.

15 Q. Patient has symptoms of FBD?

16 A. Functional bowel disease

17 Q. Can you define that for me?

18 A. Function bowel disease is a symptomatic
 19 disease of the GI tract that is unaccompanied with
 20 anatomical abnormalities

21 Q. You are saying hat he had no symptoms at the
 22 time you examined him, correct?

23 MR. BODIE: That's not what

24 he said.

25 A. No.

1 Q. I thought you said that.

2 Tell me what symptoms did he have
3 when he came to visit you.

4 A. At the time he was in our office he was
5 asymptomatic at that time.

6 Q. The exam, that was when you palpated him, and
7 he did not feel pain; is that what you are saying?

8 A. That was also true.

9 Q. Because if he did you would have charted a
10 positive finding?

11 A. Correct.

12 Q. Did you at that time make a diagnosis?

13 A. Yes.

14 Q. Was functional bowel disease your diagnosis?

15 A. Functional bowel disease was the diagnosis at
16 that visit, correct.

17 Q. Tell me why you made that diagnosis.

18 A. Because of his history and physical findings
19 that I had solicited from the patient, specifically
20 his association with the symptoms, with his
21 lifestyle, the stress he was under, and the relief
22 he obtained from his symptoms, and from his
23 examination.

24 Q. What was the relief he obtained from his
25 symptoms?

1 A. He said he obtained relief from his emergency
2 room visit that he had prior to coming into the
3 office.

4 Q. I don't see that in the notes either; am I
5 missing it?

6 A. No, it's not written expressly in the notes.

7 Q. Is it written implicitly in the notes? I am
8 trying to understand, **do** you have an independent
9 recollection of that?

10 A. He was asymptomatic at this time. He was
11 symptomatic when in the emergency room, therefore
12 his symptoms were resolved.

13 Q. Functional bowel disease, what **is** the cause
14 of it?

15 A. We do not know the cause **of** functional bowel
16 disease.

17 Q. What is the pathology of it, if you will?

18 A. There is no actual pathology. There is no
19 anatomical abnormality **of** the bowel, it's a
20 collection of symptoms usually associated by the
21 patient with stress and anxiety, and the symptoms
22 vary with the stress and anxiety.

23 Q. **You are** not saying there **was** nothing, **that**
24 there was no problem there?

25 A. **No.**

1 Q. What kind of treatment did you recommend?

2 A. I used Bentyf, 20 milligrams, t.i.d., and
3 Xanax, 0.5 milligrams.

4 Q. What was the purpose of that?

5 A. The Xanax was to help relieve the anxiety and
6 the stress that the patient related with his
7 symptoms. The Bentlyl was to relieve the cramping
8 resulting in his abdominal pain, and that he also
9 related with this episode.

10 Q. Now, I see in your chart you have the Flower
11 Memorial Hospital chart, or some pages from
12 February 16th of 1992?

13 A. Correct.

14 Q. Do you have any knowledge when you obtained
15 that or when that became a part of your record?

16 A. No, I do not.

17 Q. There is no date on it or anything?

18 A. Right.

19 Q. At some point though that became a part of
20 your chart, correct?

21 A. At some point, correct.

22 Q. Do you know how that would happen?

23 A. The emergency room would send us this
24 material.

25 Q. When these records come in do you review

1 them?

2 A. Yes.

3 Q. Do you recall reviewing this document?

4 MR. BODIE: Meaning what by
5 "this document"?

6 MRS. GARSON: This document.

7 Q. I am talking about the records from Flower
8 Memorial Hospital from February 16th of '92. I
9 think it's just two pages.

10 A. I do not recall reviewing them specifically.

11 Q. Based upon your practice in the way that you
12 cared for your patients in their charts, do you
13 believe you would have reviewed it?

14 A. Yes.

15 Q. You did not change your treatment for
16 Mr. Baldwin or do anything differently after this
17 arrived in your office?

18 A. That is correct.

19 Q. Let's see, I assume at that time -- I
20 shouldn't assume anything.

21 Was appendicitis within your
22 differential at that time?

23 MR. BODIE:. At what time,,
24 Ann?

25 Q. I am sorry. As of February 18th, 1992?

1 A. As of February 18th, 1992 acute appendicitis
2 would not have been a differential, the symptoms
3 the patient came in with.

4 Q. Let me ask you something, what is the
5 definition of mesenteric adenitis?

6 A. Adenitis is an inflammatory response of
7 lymphoid tissue, mesentery adenitis is the same
8 response in the lymphoid tissue in the mesenteries.

9 Q. What are some of the presenting signs or
10 symptoms consistent with mesenteric adenitis?

11 A. Fever, abdominal pain, nausea, vomiting,
12 diarrhea, localized or generalized tenderness.

13 Q. Is that it?

14 A. Those would be some of the signs and
15 symptoms.

16 Q. On February 18th of '92 did you consider
17 mesenteric adenitis as a differential diagnosis?

18 A. That would not be compatible with what I saw
19 at that time.

20 Q. How do you clinically distinguish between
21 mesenteric adenitis and appendicitis?

22 A. Presence of rebound tenderness would be
23 helpful., but not **diagnostic.** The **type of white**
24 blood cell count elevation that may be present
25 would **be** helpful, but not diagnostic.

1 Presence of abnormal rectal exam
 2 might be helpful, but again not diagnostic, and the
 3 patient's history of initial perianal iliac pain
 4 that migrates to the right lower quadrant after a
 5 period of time would be helpful

6 Q That would be more indicative of
 7 appendicitis?

8 A. That would be more indicative of acute
 9 appendicitis

10 Q. By the way, have you reviewed Dr. Pearson's
 11 deposition prior to today?

12 A. I haven't read his deposition.

13 Q You saw Mr. Pearson again, let's see, when
 14 was it, August 30 of 1992?

15 A. Correct.

16 Q What were his presenting complaints as of
 17 that visit?

18 A. He stated that he felt fine at that time,
 19 that he had had GI symptoms prior to this visit

20 X He stated he had taken himself off
 21 of the pentyl and Zantac X He stated he was there
 22 essentially to get refills of those medications

23 Q. At that visit you were aware he had been to
 24 the emergency room prior, correct?

25 A. Correct

1 Q. Do you know whether or not at the time of
2 that visit you had his emergency room records as a
3 part **of** your chart?

4 A. I do not know for sure if they were part of
5 his chart at that time or not.

6 Q. Eventually did the emergency room records
7 **from** July 25th of 1992 become a part **of** your chart?

8 A. Yes.

9 Q. Can you tell from your records when they
10 became a part of your chart?

11 A. No, I cannot.

12 Q. Again, do you know whether or not you
13 reviewed those records once they came in?

14 A. As per my customary practice I would have
15 used those records as part of the chart.

16 Q. In those records, if you reviewed them, you
17 are aware that -- my copies are **so** bad, I believe
18 that he had -- no, I have my typed ones, they are
19 okay.

20 Actually, do you know what his
21 blood count, white blood count was in the
22 July 25th hospitalization?

23 A. I have ~~the~~ emergency room report that has
24 some of that material here, yes.

25 Q. What was that?

1 A. It states the white blood count was 6,000.

2 Q. What were the findings of his physical exam?

3 A. The emergency room record reads: "On physical
4 exam is tender in the right lower quadrant without
5 rebound, guarding or rigidity, bowel sounds active,
6 rectal exam shows no tenderness, stool negative for
7 blood."

8 Q. Is this picture consistent with appendicitis,
9 those physical findings?

10 A. These physical findings do not express a
11 picture of acute appendicitis.

12 Q. Why is that?

13 A. There is a lack of enough findings or
14 symptoms consistent with appendicitis to make the
15 correlation.

16 Q. Well, let me ask you this then: How many
17 findings do you need in order to make the
18 correlation?

19 A. It's not just a matter of quantity but also
20 quality of the findings. **So** there may be a small
21 number of findings, if they are quite significant
22 they may very well confirm a high suspicion for the
23 **diagnosis. So it's not really quantity,, it's more**
24 overall exam.

25 Q. Right lower quadrant pain was present, that

1 you stated as one of the indicators for
2 appendicitis, correct?

3 A. No, I stated that was one finding, one
4 symptom that is compatible with appendicitis.

5 Q. I don't mean to misstate you.

6 He also had some nausea, correct?

7 A. The record states he had some nausea, but no
8 vomiting.

9 Q. Are there any other physical findings or
10 symptoms in that chart that are consistent with
11 appendicitis?

12 A. There are no other findings or symptoms
13 listed in this chart that would add to the
14 diagnosis of acute appendicitis.

15 Q. This hospital chart was from July 25th
16 of '92?

17 A. Correct

18 Q. Obviously it didn't become a part of your
19 chart on that day, but at some point thereafter.
20 correct?

21 A. Correct.

22 Q. But no doubt by the time this was a part of
23 your record you would have already reviewed the
24 February 16th hospital records?

25 A. Most probably, yes.

1 Q. That makes sense they would have been in your
2 chart by then?

3 A. Yes.

4 Q. I would like to look at the February 16th
5 typewritten page of the Flower Memorial Hospital
6 record, that is a part of your chart.

7 I am trying to go here kind of
8 fast, so instead of you reading the whole thing in
9 that visit, the history he gave or what was
10 included in that history was right lower quadrant
11 pain for two days, with some nausea and vomiting;
12 is that correct?

13 A. Yes.

14 Q. He always had tenderness noted in the right
15 lower quadrant on physical exam.

16 A. The report reads there is some tenderness
17 noted in the right lower quadrant.

18 Q. Right.

19 A. No specific point tenderness.

20 Q. Are those symptoms that we **just** described,
21 are those consistent with appendicitis?

22 A. The symptoms could be but the lack of point
23 tenderness would not be consistent..

24 Q. Are you saying there is always point
25 **tenderness?**

1 A. I am not saying always, as we mentioned
2 earlier there is never always symptoms.

3 Q. Especially if it was a retrocecal
4 appendicitis?

5 A. With retrocecal appendicitis symptoms are
6 even more variable.

7 Q. What was his blood count, his white blood
8 count, on that admission or that emergency room
9 visit?

10 A. His white blood count was 5,100.

11 Q. **Did** you make any note **or** was it of any
12 concern to you that the white blood count had gone
13 up from the February emergency room visit to the
14 July visit?

15 A. The blood counts are not appreciably
16 different. Both blood counts, total white blood
17 cell count numbers are within normal limits, so
18 there was no increase in terms of pathological
19 changes in the white blood cell count, total white
20 count.

21 Q. I appreciate what you are saying, but as a
22 more general statement, just because a white blood
23 count remains within normal ~~limits~~ **doesn't** mean **a**
24 change of the white blood count is not necessarily
25 significant; isn't that true?

1 MR. BODIE: Objection. In
2 any situation or in this situation?

3 Q. In a situation where a person may have an
4 infection.

5 MR. BODIE: Objection,
6 form. **Go** ahead.

7 A. An increase in the white blood cell count, in
8 total white count, while the numbers are remaining
9 within normal limits --

10 Q. Right.

11 A. -- that would not indicate pathology.

12 Q. As long as it's within normal limits?

13 A. That is true most of the time, yes.

14 Q. **So** we were on your August, 1992 visit, what
15 were your physical findings, if any, on that visit?

16 A. Patient had no abnormal physical findings at
17 that visit.

18 Q. Did you have any physical findings for him?

19 MR. BODIE: Other than what
20 is noted?

21 MRS. GARSON: Yes.

22 A. No abnormal ones, no.

23 Q. Going back **to the July, 1992 record, in the**
24 history it indicates that this gentleman had
25 complaints of right lower quadrant abdominal pain

1 off and on over the past year or **so**, and has been
2 worked up in the past with no definite diagnosis
3 found?

4 A. That's the way it reads, correct.

5 Q. How do you account for, if you do account for
6 it, the right lower quadrant pain that he had off
7 and on for over a year as accounted for in that
8 note?

9 MR. BODIE: Objection. I
10 think it's unfair to ask this doctor about
11 accounting for a period of time he didn't even **see**
12 or treat the patient. I think that is unfair.

13 Q. You had this record as part of your chart,
14 right?

15 A. Correct.

16 Q. You reviewed it when it came in?

17 A. Correct.

18 Q. Did it give you any concern as to
19 **Mr.** Baldwin's care and treatment, that he had right
20 lower quadrant pain off and on for a year?

21 A. It gave me no concern that he had any
22 problems in terms of abnormal or inappropriate care
23 **of treatment, no.**

24 Q. Well, that wasn't what I was asking about,
25 his prior treatment. I was just asking in terms **of**

1 your treatment of him.

2 A. It gave me no concern that there was any
3 problems in terms of inappropriateness of my
4 treatment either, no.

5 Q. The functional bowel disease that you
6 diagnosed, would that account for right lower
7 quadrant pain off and on for a period as long as a
8 year?

9 A. That can go on for much longer than that,
10 however, that was not necessarily directly related
11 to this emergency room visit.

12 Q. I understand, but I am asking whether the
13 functional bowel disease that you diagnosed, can
14 that account for right lower quadrant pain off and
15 **on** over a year, that specific pain?

16 A. Yes, it can and much longer.

17 Q. How is it that it is localized like that?

18 A. It wasn't localized, the note specifically
19 says there was no point tenderness.

20 He also included in the note he had
21 upper abdominal pain, **so** he did not have exclusive
22 right lower quadrant pain.

23 Q. However, **you do** feel that **the** functional
24 bowel disease could account for consistent right
25 lower quadrant pain?

1 A. Yes.

2 Q Did you do any further tests in August to
3 rule out or diagnose any other condition, other
4 than the functional bowel disease?

5 A The patient did not have an indication for
6 any further workup

7 Q Did functional bowel disease remain your
8 diagnosis as of August, 92?

9 A Because of his onset of upper abdominal pain
10 and the improvement with Zantac, it also included
11 severe gastritis as well

12 Q Now, you did not prescribe that Zantac, that
13 was prescribed by the emergency room or in the
14 emergency room?

15 A. I did not prescribe it initially

16 Q That did you know that prescription for him?

17 A. At that visit.

18 Q. The purpose of renewing that was for what
19 symptoms?

20 A. The symptoms from his severe gastritis, which
21 he said improved with the medication

22 Q Did you have any evidence or information in
23 your mind as of August of 1992 that Mr. Baldwin had
24 appendicitis?

25 A. That visit there was absolutely no indication

1 that he was suffering from acute appendicitis.

2 Q. Were there any indications that he might be
3 suffering from an abscess?

4 A. At that visit he was totally asymptomatic, in
5 his own words feeling fine.

6 Q. Well, let's back up.

7 What is the usual course for acute
8 appendicitis?

9 A. The usual course for acute appendicitis is
10 the initial symptoms that we discussed earlier,
11 followed by continuing unrelenting progression **of**
12 those symptoms, worsening, elevation of the white
13 blood cell count well above normal, persistence of
14 the fever, and the general malaise and nausea,
15 vomiting; and then at that point surgical
16 intervention if the patient has been evaluated, and
17 the symptoms have been persisting.

18 Untreated without surgery those
19 symptoms continue to progress to the point the
20 patient has peritoneal symptoms, ruptured viscera
21 resulting in widespread peritonitis, resulting in
22 possibly sepsis and even death, that is the usual
23 progression **of** acute appendicitis..

24 Q. That progression you talked about, in some
25 point in there, there **is** a rupture, correct?

1 A. That can be part of the progression, right.

2 Q. That course you just explained had a rupture
3 involved?

4 A. Correct, a ruptured viscera.

5 Q. It's that rupture that causes the sepsis?

6 A. No, the sepsis is when the bacteria enters
7 the blood stream, that can occur with or without
8 ruptured viscera.

9 Q. **Is** it unusual for there to be a relenting **of**
10 the symptoms subsequent, immediately subsequent to
11 the rupture?

12 A. I don't understand. Run that by me again.

13 Q. **You** explained the course of an appendicitis.
14 My question **to** you is: Is it unusual for in the
15 course whether there is a rupture, that subsequent
16 to the rupture there will be a brief relenting of
17 the symptoms?

18 A. The symptoms may wax and wane minimally, but
19 for progressing to a rupture, symptoms are usually
20 unrelenting and persistent.

21 Q. Are you aware that an appendicitis does not
22 necessarily have to completely rupture at all,
23 **correct?**

24 A. That is correct.

- 25 Q. An abscess **can** form?

1 A That is one possibility

2 Q Would the course of what you have just
3 explained be different when there is an abscess
4 that forms and not a complete rupture?

5 A Yes.

6 Q How would that course be different?

7 A Usually the severity of symptoms continues to
8 waxing and waning, with frequent often months
9 recurrences or persistence of symptoms.

10 Also, there is usually signs of
11 persistent infection; again, sepsis may or may not
12 be involved in that

13 Q Is it fair to say that altered course also
14 has variables just the same?

15 A. All disease has variables.

16 Q In your August 3rd, 1992 visit did you say
17 that you did a physical exam again, I
18 didn't see any notations of what you actually did
19 in your physical exam, and you said there were no
20 positive findings, so?

21 A. I said there were no abnormal findings

22 Q. Did you do a physical exam on that visit?

23 A. Yes.

24 Q. Do you know what you did?

25 A Examination for that visit would have

1 included palpation of his abdomen also, not just
2 lower abdomen, but also upper abdomen because of
3 his gastritis symptoms.

4 Q. That is not in there, right, I am not missing
5 anything?

6 A. No, there is no mention **of** any abdominal
7 findings, because there were none.

8 Q. Did Mr. Baldwin mention to you the right
9 quadrant pain that he reported to the emergency
10 room on July 25th?

11 A. At that time he reported no pain.

12 Q. But I am asking you whether he gave you the
13 history of right lower quadrant pain.

14 A. I **do** not have a note of any specific right
15 lower quadrant pain history.

16 Q. Did you see him only one more time?

17 A. In my office?

18 Q. Right.

19 A. Correct.

20 Q. That was on October 9th?

21 A. Correct.

22 Q. As of that visit were you aware that he had
23 had an emergency room visit from October 7th?

24 A. Yes.

25 Q. **Can** you read the handwritten report of **your**

1 note?

2 A. "205 pounds, stomach problems, Zantac worked,
3 out of pain medicine, pain right lower quadrant,
4 CBC, Zantac."

5 Q. At this point you knew that he was in the
6 emergency room, do you know whether you had the
7 emergency room record in your chart or not?

8 A. No, I do not know.

9 Q. Because it's not date stamped, right?

10 A. Correct.

11 Q. Can you read the first part of your typed
12 note?

13 A. To where?

14 Q. The first sentence.

15 A. "He needs refill on his Zantac, this has
16 helped his right middle and lower quadrant pain,
17 not sure why; his previous upper GI and gallbladder
18 were all negative."

19 Q. That's enough. I am not sure I understand
20 your note.

21 Can you explain what you meant when
22 you said "not sure why," does that relate to the
23 Zantac or the previous studies?

24 A. That relates to the Zantac.

25 Q. So are you saying you are not sure why the

1 Zantac helped with the right lower quadrant pain?

2 A. I am saying I am not sure why this helped
3 with his right middle and right lower quadrant
4 pain.

5 Q. Why aren't you sure why?

6 A. That would be a less than typical response
7 with that medication.

8 Q. What was the purpose of prescribing Zantac to
9 Mr. Baldwin?

10 A. It was previously mentioned from his last
11 visit for his severe gastritis.

12 Q. Why would that be inconsistent with relieving
13 the right lower quadrant?

14 A. That would be possibly inconsistent with
15 right middle and lower quadrant pain relief, and
16 those are not generally symptoms exclusive to
17 gastritis.

18 Q. **So** the "not sure why" does not refer to the
19 upper **GI** and the gallbladder?

20 A. That is correct.

21 Q. The next part **of** your note you indicate or in
22 the last sentence, "May need more aggressive
23 therapy **like a** BE," **is** that; barium **enema**?

24 A. Yes.

25 Q. **Can** you explain to me why you wrote that?

1 A. At this time the patient presented to my
2 office three times with variable complaints of
3 abdominal discomfort. So at that time I discussed
4 with him that we should consider additional workup,
5 although he indicated to me he had extensive
6 abdominal workup.
7 Q. What would a barium enema tell you or what
8 would you use that for, as a tool to diagnose or
9 rule out?
10 A. A myriad of problems, it could be used
11 specifically looking into evaluate the anatomical
12 integrity of his large intestines or colon.
13 Q. Not for appendicitis, correct?
14 A. That is correct.
15 Q. When you say "May need more aggressive
16 therapy," is that contingent upon something else
17 happening?
18 A. His agreeing to it
19 Q. That's all?
20 A. That would have been the factor at that
21 point, yes.
22 Q. Did you discuss it with him or --
23 A. Yes, that's why the notation is there.
24 Q. Do you know by looking at your notes why he
25 agreed to it, or if you had an additional claim to

1 it?

2 MR. BODIE: Agreed to what,
3 the barium enema evaluation, and whatever the
4 findings were?

5 MRS. GARSON: Yes, I am
6 asking if his agreeing to more aggressive therapy
7 was the only prerequisite. I can't tell from the
8 note what happened.

9 A. It was not done.

10 Q. So are you saying that you discussed with
11 Mr. Baldwin that he may need more therapy?

12 A. Discussed with him that he may need the
13 barium enema, and that would be helpful in further
14 evaluating his symptoms.

15 Q. Then do you recall what he said?

16 A. Not specifically, but a barium enema was not
17 scheduled and not set up.

18 Q. Are you drawing a conclusion from that?

19 A. If he agreed it would have been set up.

20 MR. BODIE: Ann, in light
21 of the time frame from the 9th to the 10th and
22 everything else, I think the circumstances such
23 that Mr. Baldwin didn't have a chance to get back.
24 to him, given what happened thereafter.

25 MRS. GARSON: Maybe, by

1 looking at this note it doesn't say a lot of that.
2 I am trying to understand, I wasn't there.

3 MR. BODIE: Oh, sure, nor
4 was I.

5 MRS. GARSON: So I want to
6 make sure I understand.

7 Q. When you say "May need more aggressive
8 therapy," like a barium enema, what that implies,
9 you had a conversation with
10 Mr. Baldwin that he would need it, that it would
11 help in assessing his ongoing abdominal complaints,
12 correct?

13 A. That it may be helpful, yes.

14 Q. Because it was not set up, it just didn't
15 happen, correct?

16 A. Correct.

17 Q. Are you assuming that he refused it, do you
18 remember that he refused it?

19 A. I do not remember specifically, it's not
20 uncommon that the patients want to consider these
21 matters, think about them.

22 Q. Did you have any discussions that you recall
23 with Mr. Baldwin regarding appendicitis being a
24 possible diagnosis?

25 A. Not based off of this record, no.

1 Q. You don't recall it independent of this
2 record, correct?

3 A. No.

4 Q. Did you have any conversations with
5 Dr. Reardon about Mr. Baldwin's care at any point?

6 A. No.

7 Q. Have you had conversations with Dr. Husted
8 about Mr. Baldwin's care?

9 MR. BODIE: Since the
10 filing of the lawsuit or during the time he was
11 treating him?

12 MRS. GARSON: I will ask
13 both.

14 Q. First, have you spoken with Dr. Husted since
15 the filing of the lawsuit?

16 A. About this case?

17 Q. About this case.

18 A. No.

19 Q. Have you spoken with Dr. Husted with regard
20 to Mr. Baldwin during your care and treatment of
21 him?

22 A. Yes, but not at or prior to 10-9-92.

23 Q. I understand.

24 When you said that he "May need
25 more aggressive therapy," were you thinking that

1 Mr. Baldwin may have some medical condition that
2 had not been diagnosed?

3 A. As per my note I thought that the patient did
4 not have adequate explanation for his relief of
5 symptoms.

6 Q. Right.

7 A. And that was the reason I suggested the
8 barium enema.

9 Q. Did you have in your mind any possible
10 differentials that the barium enema could assist in
11 diagnosing?

12 A. Yes.

13 Q. What are some of those?

14 A. Those would include obstructive disease,
15 tumors, polyps, and inflammatory bowel disease.

16 Occasionally functional bowel
17 disease can be demonstrated due to decrease spasm,
18 or at least alluded to or if not confirmed.

19 Q. You never made a diagnosis of an ulcer; is
20 that true?

21 A. That is correct.

22 Q. Did you rule out an ulcer or did you consider
2.3 that a **possibility?**

24 A. Based off of his exams, his possibility for
25 ulcerative disease as opposed to gastritis was very

1 unlikely, so no further workup was indicated.

2 Q. Were the symptoms that Mr. Baldwin presented
3 to you consistent with peptic ulcer; if you know?

4 MR. BODIE: On what day,
5 Ann?

6 A. There are three different dates.

7 Q. Well, let's see, over the period of time that
8 you treated him, I guess. There is three dates, I
9 will ask you for each one.

10 In February?

11 A. There was not an indication for peptic ulcer
12 disease, no.

13 Q. In August?

14 A. **No**, only his gastritis.

15 Q. And October?

16 A. **No**.

17 Q. What would be the indications for peptic
18 ulcer?

19 A. Severe mid epigastric pain, possibly
20 associated with bleeding, usually triggered by
21 certain foods, but not exclusively; severe
22 epigastric tenderness on examination, with possible
23 radiation of ~~that~~ pain and to the chest;; **many** other
24 possible signs and findings; those would be the
25 most **common** ones.

1 Q Is right lower quadrant pain consistent with
2 peptic ulcer?

3 A While not a usual finding with peptic ulcer
4 disease, the presence of right lower quadrant pain
5 does not exclude the possibility, because pain may
6 be more generalized.

7 Q. It is certainly not a usual --

8 A. No

9 Q. Would you be offering any opinion with
10 regard to whether and whether surgery is indicated for
11 appendicitis?

12 A. Yes

13 Q. What symptoms and physical findings would
14 there be for surgery to be indicated?

15 MR. BODIE: I object.
16 is not a surgeon in that regard to make a surgical
17 decision. I think that is more for a surgeon; but
18 Doctor, if you have an opinion in that regard feel
19 free to expound.

20 A. I could give you my opinion as to when I
21 would consult a surgeon.

22 Q. That's fair.

23 A. That would vary from patient to patient,
24 depending on the quantity and quality of presenting
25 symptoms that we reviewed earlier on.

1 The alterations and variations and
2 abnormalities of the patient's blood count; but
3 generally it's with the unrelenting abdominal right
4 lower quadrant pain that is unrelieved with therapy
5 and continues to be unrelenting.

6 Fever is persistent, elevated white
7 counts exceeding the normal limits are persistent
8 and continuing to increase, or pain becomes
9 increasingly worse.

10 Q. Let me ask you this: What is the normal
11 blood count range?

12 A. It varies, depending on the test used by
13 hospital to hospital. For most facilities between
14 the area of 4,000, 5,000 on the lower portion, up
15 to 10 to 11,000 on the upper portion.

16 Q. Does a white blood count within that range
17 rule out appendicitis?

18 MR. BODIE: In and of
19 itself?

20 Q. In and of itself?

21 A. No, there is no findings in and of itself
22 that would rule out appendicitis.

23 Q. Are **you** aware **of** the negative **exploration**
24 rates with regard to appendicitis?

25 A. Only vaguely.

1 Q. In what regard?

2 A. Could you be more specific in your question?

3 Q. In general is there a negative exploration
4 rate which is acceptable when we are talking about
5 diagnosing appendicitis?

6 MR BODIE: Objection. I
7 think that goes to the standard of care for a
8 general surgeon, with respect to you saying it's
9 acceptable.

10 Again, I think it's unfair.
11 Doctor, go ahead, if you know.

12 A. I am aware there is a level of explorations
13 for a possible abdominal pain etiology, uncertain
14 or negative findings do occur. I know that varies
15 depending on the surgeon and the facility. The
16 number I was taught back in medical school is
17 around 12 percent.

18 Q. I looked at the literature, it's actually
19 much higher for appendicitis

20 A. As I mentioned it depends on what facility
21 and the surgeon.

22 Q. Of course.

23 To what extent were you involved

24 with Mr. Baldwin's care after October 9th of 1992?

25 A. My recollection at that point on I was

involved only in terms of the inpatient care

Q You had no more office visits with him?

A. That is correct.

Q. He was an inpatient at Flower Memorial Hospital?

A. Correct

Q Do you know in general for what procedure he was there in October of '92?

A I would have to look at the chart to give you that.

MR. BOBIE: Hold off one second. Off the record

(Discussion had off the record)

A. On October 11th according to the record I have before me, the patient was admitted to Flower Hospital.

MR. BOBIE: Hold off one second.

(Interruption in the proceeding)

R. BOBIE: Go ahead.
Doctor. I am sorry

4 The admission of 10-11-92 at Flower Hospital.
 5 According to the records I have where he was
 6 admitted and taken to surgery by Dr Huston, with
 7 what he described as ill defined excruciating
 8 abdominal pain, with few symptoms, without clearcut
 9 peritoneal signs, patient underwent surgery.

10 Q What were you just referring to as far as the
 11 physical findings?

12 A. This was the history and physical dictated by
 13 Dr Huston, 10-11-92

14 Q The history of his present illness was
 15 multiple bouts of intermittent abdominal pain,
 16 correct?

17 A. That's how it reads.

18 Q. When it says with maximal tenderness in the
 19 right lower quadrant?

20 A. If you start in the middle of the sentence,
 21 it reads: "Xp described it as rather spasmodic,
 22 but now primarily maximal tenderness in the right
 23 lower quadrant."

24 Q. The patient denies any fever or chills and
 25 does not vomit secondary to pain and no
 26 emesis"?

27 A. Correct, that's how it reads

28 Q. Is this picture in your assessment consistent

1 with appendicitis?

2 A. With the limited information in that amount
3 of information there, this could be consistent with
4 appendicitis and several other abdominal problems,
5 yes.

6 Q. As a result of that, that history, and as a
7 result of the physical findings that Dr. Husted
8 made, **Dr.** Husted determined that he was going **to**
9 take him to the OR for an appendectomy; is that
10 correct?

11 MR. BODIE: Objection. I
12 think that is the question better posed to
13 Dr. Husted as to why he did that.

14 Q. The assessment plan on the next page states:
15 "The patient potentially with retrocecal
16 appendicitis, will take to the OR for
17 appendectomy"; is that how it reads?

18 A. That is **how** it reads.

19 Q. Eventually were you aware that Dr. Husted
20 diagnosed there was a chronic abscess formation?

21 A. What part of the record are you referring?

22 Q. **One** more.

23 **A.** It's not in his history and **physical, no.**

24 MR. BODIE: Are you looking
25 at the path report?

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MRS GARSON: What do I
have?

MR WODIE: What are you
looking at there, Ann?

MRS GARSON: It's a medical
record multipurpose form, discharge summary

MR. WODIE: I don't have a
copy of that here.

You are referring to a discharge
sheet.

(Dr True deposition Exhibit 2
marked for identification)

Q I have marked this as deposition Exhibit 2,
it is a portion -- well, it's a medical record
multipurpose form, discharge summary

MR. WODIE: Okay.

Q Do you see on that form that Dr Husted made
a diagnosis, one of the diagnoses was a chronic
abscess formation?

A. That's how it reads, yes

Q. Let me skip all of this and ask you: Do you
have any dispute or differing opinions regarding
Dr. Husted's diagnosis or Dr. Husted's treatment of

1 Mr. Baldwin?

2 MR. BODIE: Objection,
3 form.

4 Q. Do you have any criticism **of** the care
5 Dr. Husted rendered?

6 A. **No.**

7 Q. Do you have any dispute or differences in
8 terms of the diagnoses he made?

9 MR. BODIE: Objection,
10 form.

11 A. I have no basis for that, no.

12 Q. If Dr. Husted said that the diagnosis, based
13 on the surgery and the pathology, that there was a
14 chronic abscess, would you dispute that?

15 A. I would have no reason to at this point, no.

16 Q. Can you define chronic in the way you use
17 that term?

18 A. Chronic means not acute, that can go on for a
19 period of a day, several days, weeks, months,
20 years.

21 Q. In your opinion did Mr. Baldwin have an
22 appendicitis, did he have an appendicitis **on**
23 **August..9th when he Last. saw you in. your office?**

24 A. I saw him on August 9th, he had no symptoms
25 **of** acute appendicitis in my office.

1 Q. In your opinion did he have any signs or
2 symptoms of an abscess, an appendiceal abscess on
3 October 9th in your office?

4 A. When he was in my office on October 9th, 1992
5 he was without symptoms of any type.

6 Q. Let me ask you, aside from what his specific
7 symptoms were on August 9th, take --

8 MR. BODIE: October 9th.

9 Q. October 9th, 1992, take into consideration
10 your prior two office visits with him, and the
11 hospital records from February and July of '92 that
12 were a part of your record at that time; and let me
13 ask you, as of October 9th, 1992 did Mr. Baldwin
14 have signs and symptoms of an appendiceal abscess?

15 A. Based off of the three visits I had with him
16 and off the information that I had from the
17 emergency room visits, prior to those visits and
18 subsequent I had available, I had no findings of
19 any symptoms at that time.

20 So only in as much that the lack of
21 symptoms is compatible with any disease, was there
22 compatibility with any disease state.

23 Q. **Is it your opinion or do** you have any opinion
24 as to whether the chronic abscess diagnosed by
25 Dr. **Husted** began before or after October 9th

1 of 1992?

2 A. I do not know when the chronic abscess
3 discussed by Dr. Husted began, and I have really no
4 way of pinpointing that date.

5 Q. Well, when you say you don't know, I can only
6 assume that it's entirely possible it began while
7 he was under your care and/or prior to that,
8 correct?

9 MR. BODIE: Objection.

10 A. I can only repeat and say I have no idea when
11 that was there, there was no way to tell.

12 Q. It's not your testimony then that this
13 abscess was formed after October 9th, correct?

14 A. My testimony is we do not know when this
15 abscess was, and I already stated that two,
16 three times.

17 Q. Dr. Husted diagnosed that ruptured of course,
18 what is your testimony in terms of when that
19 rupture occurred, if you have an opinion?

20 A. There is no way to tell, anyone's
21 guesstimation would be that, a guess.

22 Q. Is there any period of time that you feel
23 comfortable absolutely ruling out when that rupture
24 occurred?

25 A. There is no way at any time to decide when

1 the rupture occurred.

2 Q. Why is that? I don't mean pinpointing it to
3 a precise second in time, I am talking about based
4 on --

5 A. But --

6 MR. BODIE: Let her finish
7 the question.

8 Q. I am not asking you to be God and say you
9 knew the exact second when it happened, because of
10 course we don't; but in terms of clinical signs and
11 symptoms, and based upon your records and the
12 records you have in your file, are you able to rule
13 out at any point when that rupture would have
14 happened?

15 A. There is no way to determine when that
16 rupture would have happened.

17 Q. Is that in this case or is that in any case?

18 A. The only way to diagnose the moment when a
19 rupture happens is by seeing it, everything else
20 would be a diagnosis of estimation and suspicion.

21 Q. The estimation and the suspicion is based on
22 clinical symptoms and physical findings?

23 A. That he did **not** have **as** 10-9-92, according to
24 my prior discussion.

25 Q. To what degree were you involved in his care

1 while he was hospitalized in October of '92?

2 A. Can you be more specific?

3 Q. Yes.

4 You saw him on an inpatient basis?

5 A. Yes.

6 Q. What was the purpose of your seeing him?

7 A. To follow along for any medical problems,
8 that would be appropriate for family practitioners
9 to address in this situation.

10 Q. Can we go through this? You had noticed
11 several places that your signature appeared. I
12 would like you to read those notes for me.

13 A. Certainly.

14 Q. I think you said there were four of them?

15 MR. BODIE: That we saw
16 when we were flipping through.

17 A. The first one in October, here is a notation
18 from 10-21-92, it reads: "Overall doing well, no
19 nausea, no bowel movement yet, flatus is going."

20 MR. BODIE: Let the record
21 reflect this is the Flower Memorial Hospital
22 progress note, and it appears to be identified by
23 Dr. True with a zero with a squiggly line in it.

24 A. The notation from "10-22-92, BM yesterday, up
25 okay, discharge if okay with surgery, continue

1 Zantac, no antibiotics, dressing/surgery.

2 "10-12-92, patient status post
3 appendectomy, with question mark, appendiceal mass,
4 pathology pending, start incentive spirometry,
5 increase I.V. fluids."

6 MR. BODIE: That's about
7 the middle of the page on that note on 10-12?

8 THE WITNESS: Correct.

9 MR. BODIE: Thank you.

10 A. "10-13-92, patient continues febrile,
11 vomiting some, path report pending, using PCA."

12 Q. What is PCA?

13 A. Patient control analgesia.

14 "10-14-92, sodium 135,
15 potassium 3.9, chloride" -- I am having difficulty
16 reading the Xerox copy. I believe it's "82; saline
17 change, KCL.

18 "10-15-92, temperature down, feels
19 better."

20 I am unable to read this date
21 because of the xerox copy.

22 MR. BODIE: 10-17 -- I
23 believe it's 10-16?

24 A. I am unable to read that for sure above
25 "appreciated," and "continue I.V."

I cannot read the next word, it's
in a black line from the Xerox, "overall, better
yet.

"10-17-92, apparently wound drained
of much material, attempts" -- I cannot read the
next word. "Lower grade, will continue antibiotic
therapy.

"10-18-92, doing well, feels much
better, voiding.

"10-19-92, vital signs good
including temperature, overall better yet, **blood**
cultures in sensitivity, no growth.

"10-20-92, n.p.o., Augmentin,
without fever, change to p.o., Zantac, doing well,"

That's all of the progress notes I
have.

MRS. GARSON: That's fine,
that's okay.

Q. Do you recall having any conversations with
Dr. Husted during this admission regarding
Mr. Baldwin?

A. It is customary for me to converse with him
about a case. We have in the hospital, but I do
not recall any specific conversations.

Q. Do you recall any general conversations at

1 all that discuss the nature of the abscess or the
2 rupture?

3 A. I don't understand what you mean by "nature
4 of the abscess"

5 Q. The chronicity of it?

6 A. No.

7 Q Did you ever discuss with Dr Huston any of
8 the cases rendered by Dr Reardon?

9 A No

10 MRS GARSON: I don't think I
11 have anything further for you. Thank you very
12 much

13 -----

14
15 (proposition concluded; signature not waived)

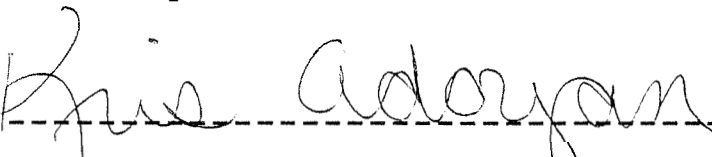
16
17 -----

1 The State of Ohio,
2 County of Cuyahoga.

CERTIFICATE:

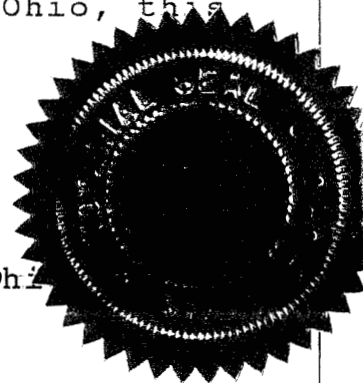
3 I, Kris A. Adorjan, Notary Public within and
4 for the State of Ohio, do hereby certify that the
5 within named witness, ROGER A. TRUE, M.D., was by
6 me first duly sworn to testify the truth in the
7 cause aforesaid; that the testimony then given was
8 reduced by me to stenotypy in the presence of said
9 witness, subsequently transcribed onto a computer
10 under my direction, and that the foregoing is a
11 true and correct transcript of the testimony so
12 given as aforesaid. I do further certify that this
13 deposition was taken at the time and place as
14 specified in the foregoing caption, and that I am
15 not a relative, counsel or attorney of either
16 party, or otherwise interested in the outcome of
17 this action.

18 IN WITNESS WHEREOF, I have hereunto set my hand and
19 affixed my seal of office at Cleveland, Ohio, this
20 20TH day of JANUARY, 1997.

21  --
22

23 Kris A. Adorjan Notary- Public/State of Ohio

24 Commission expiration: 12-14-97.



Look-See Concordance Report

UNIQUE WORDS : 1,055

TOTAL OCCURRENCES: 3,614

NOISE WORDS: 384

TOTAL WORDS IN FILE: 10,317

SINGLE FILE CONCORDANCE

CASE SENSITIVE

COVER PAGES = 4

INCLUDES ALL TEXT OCCURRENCES

DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE

THRESHOLD: 50

NUMBER OF WORDS SURPASSING

OCCURRENCE THRESHOLD: 2

LIST OF THRESHOLD WORDS:

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symptoms [71]

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CURRICULUM VITAE
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EDUCATION

Undergraduate 1971 - 1974	Indiana University, A.B. Degree, Chemistry.
Post graduate 1974 - 1978	Indiana University School of Medicine, Indianapolis, Indiana, M. D. Degree, October 31, 1978.
1978 - 1981	Residency training November 1, 1978 through October 31, 1981, Flower Hospital, Family Practice Residency, Program Director, Roland Scherbarth, M.D.
1979 - 1981	Chief resident November 1, 1979 through October 31, 1981.
1983 & 1990	Board Certified in Family Practice by the American Board of Family Practice in 1983. Recertified in 1990. Status, Diplomat.
1981 - Present	Active - Family Practice, Private, offices located at:
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LICENSURE

February 13, 1981	State of Ohio State Medical Board
November 18, 1981	State of Michigan Department of Licensing and Regulation Michigan Board of Medicine

**DEPOSITION
EXHIBIT**

1-16-97
TRUE

HOSPITAL PRIVILEGES

Active	Flower Hospital - Family Practice
Active	The Toledo Hospital - Family Practice
Courtesy	St. Vincent Medical Center - Family Practice

PERSONAL

Born	Kay 23, 1953
Family Status	Married September 1981, wife Julia; son David, born January 1, 1986.
Affiliations	<p>Previous member Executive Committee at Flower Hospital.</p> <p>Previous Vice Chairman of the Department of Family Practice at Flower Hospital.</p> <p>Minister with Jehovah's Witnesses since January 1992.</p> <p>Acting Director of Flower Hospital's Bloodless Surgical and Medical Care Program.</p>