IN THE COURT OF COMMON PLEAS

RICHLAND COUNTY, OHIO

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CHRISTOPHER TOON, et al., *

Plaintiffs, *

vs. * Case No. 00-482-H

BHAT & PADIVAL, M.D.s, INC., et al., *

Defendants. *

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New Haven, CT

February 10, 2003

8:34 a.m.

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DEPOSITION OF ALBERT CARL WEIHL, M.D.

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APPEARANCES:

FOR THE PLAINTIFFS:

FRIEDMAN DOMIANO & SMITH
BY: THOMAS CONWAY, ESQ.
1370 Ontario Street, Suite 600
Cleveland, OH 44113

FOR THE DEFENDANTS:

HAMMOND & SEWARDS
BY: JAMES M. McGOVERN, ESQ.
556 East Town Street
Columbus, Ohio 43215

Deposition of **ALBERT CARL WEIHL, M.D.**, the Witness, taken on behalf of the Defendants herein, for the purpose of discovery and for use as evidence in this cause, pending in the Court of Common Pleas, Richland County, Ohio, pursuant to Notice, before Lynne Stein, Licensed Shorthand Reporter, No. 00110, a Notary Public within and for the State of Connecticut, at the offices of Department of Emergency Medicine at 464 Congress Avenue, New Haven, Connecticut, on the 10th day of February, 2003, at 8:34 a.m., at which time counsel appeared as hereinbefore set forth . . .

MR. McGOVERN: Will you mark this, please.

(Whereupon, the Curriculum Vitae was marked as Defendant's Exhibit 1 for identification.)

Thereupon:

ALBERT CARL WEIHL, M.D., whose business address is Suite 260, 464 Congress Avenue, New Haven, Connecticut 06519, being first duly sworn, as hereinafter certified, was examined and testified as follows:

DIRECT EXAMINATION BY MR. McGOVERN:

Q Hi, Doctor. My name is Jim McGovern. We met earlier.

I want to just go through a few ground rules for your deposition.

Have you ever been deposed before?

A Approximately 150 times.

Q Then you probably know the ground rules, but I'll go through a few of them with you.

It helps if only you or I talk at the same time. Okay?

A Good.

Q And that you give affirmative or negative answers rather than shaking your head or saying um-hum or uhn-uhn. Okay?

A Yes.

Q If you don't understand one of my questions, I'd ask that you have me rephrase it or ask it a different way. If you do answer a question, I want to be able to rely on that answer as something that's true and accurate and something that you plan to testify at trial. Okay?

A Okay.

Q If at any time you want to take a break, please feel free to ask me that. But keep in mind that you have -- I understand that you need to be finished by 10:30, 10:45. So we'll try to keep things moving as best we can.

A Right. I need to work in the emergency department until 8 o'clock tonight.

Q We have marked as Deposition Exhibit Number 1 what appears to be a copy of your curriculum vitae. Is that correct?

A That's correct.

Q Is this a true and accurate and up-to-date description of your training, education, and experience as a physician?

A It is.

Q When is the last time you revised your CV?

A 9/16/02.

Q Do you have any Board certifications?

A Yes.

Q In what?

A Emergency medicine, internal medicine, and endocrinology and metabolism.

Q When did you graduate from medical school?

A 1971.

Q What clinical experience do you have working in either an emergency room setting or an urgent care setting?

A I worked in emergency departments full time or part time for 30 years. I've worked in urgent care settings part time from 1978 to 1999.

Q How do you differentiate between urgent care and emergency room?

A Urgent care settings are usually not hospital based, although in our emergency department we have an urgent care section in the emergency department, where we triage lower acuity patients. Often they're not hospital based. They're often freestanding, affiliated with office-based rather than hospital-based practice.

Q Tell me again what type of urgent care center you worked in up until -- I think you said 1999?

A Correct.

Q Where was that located?

A Basically there were two settings. One from '78 to '87, when I was working at a large office-based group practice of internal medicine where we had an urgent care department which the internists covered as part of their rotation evenings, nights, and weekends. That was part of my regular responsibilities during the '78 to '87 time frame that I worked there.

Also worked at the Shoreline Clinic, which is a freestanding urgent care facility affiliated with Middlesex Hospital. Middlesex Hospital is in Middletown, Connecticut. The Shoreline Clinic is in Essex, Connecticut. It's a freestanding facility. It is not physically connected to the hospital. If a patient presented there, if they needed to be hospitalized they would be transferred to the Middlesex Hospital or another hospital, depending on the patient's preference. I worked there from '82 into the '90s.

Q Was it a consistent amount of time you spent there from week to week or month to month?

A It probably was 20 to 40 hours a month. It varied from month to month. That was the range, obviously down to a low of zero if I was away for a month.

Q Why did you stop working in the urgent care

setting?

A They asked me to transition to their emergency department in the hospital in Middletown, so I began working in the primary hospital emergency department.

Q What are some of the differences, if any, that you have noticed in your experience working in an urgent care center versus an emergency room?

A The major difference is urgent care center does not accept ambulance traffic coming in. They're usually not equipped to handle trauma, heart attacks, seriously ill adults or children. Other than that, urgent care often sees walk-ins with lesser trauma, heart attack, asthma. But the major difference is most urgent care facilities do not accept incoming ambulance patients. They may send patients out by ambulance, but do not accept ambulance patients, who are more sick than a patient who comes in by private car, although that is not always the case.

Q In your experience, did you find any differences in the amount of patients who used urgent care as their primary care versus using the emergency room for that purpose?

A I don't think I could make a generalization about that. Patients use both our main emergency

department and urgent care facilities as their primary source of medical care if they don't have an ongoing physician relationship.

Q In the past year or two, how much time have you spent working in an emergency room setting, clinically?

A I average 24 hours a week in the emergency department. I worked there yesterday, I'm working today, I'm working on Wednesday; 9-hour shifts. So this week it will be 27 hours if I get out on time. But I average 24 hours a week in the emergency department. That's been the case for approximately the last 18 months.

Q What are your responsibilities when you're in the emergency room?

A I'm the senior physician in the emergency department. I'm supervising the care rendered to all the patients by residents, interns, students, and also seeing patients on my own. I am the attending senior physician in the emergency room.

Q You are both supervising the care being provided by the residents --

A Correct.

Q -- and you are actively seeing your own patients?

A Well, I'm actively seeing patients. Often they are seen in conjunction with other providers, usually students or residents. But I'm seeing all the patients.

Q Tell me about your experience in the last five years seeing and treating patients experiencing gastroenteritis.

A I'm not quite sure how to answer that. Gastroenteritis, or patients with potential gastroenteritis, is a presenting complaint to the emergency department that we see on a regular basis. The issue always, with a patient who is thought to or -- diagnosed with gastroenteritis is the possibility of other potentially much more severe and/or life-threatening conditions that they may have. That's something that needs to be considered in every patient presenting with abdominal complaints.

Q You've somewhat answered my question. But what -- in a given week, month, whatever time period that you find it most -- most able to talk in terms of, how many cases of gastroenteritis may you encounter in a typical year?

A I would have no way of making any remotely reasonable estimate of that.

Q Okay.

A It would be in the dozens, but whether it would be a hundred or more, I have -- I mean, it's not something that I would remotely keep track of.

Q But you have encountered patients who -- you didn't go so far in your last answer as to say that you've actually diagnosed patients as suffering from gastroenteritis. Is that something that you don't do?

A That is an infrequent diagnosis.

Q Why is that?

A Because if you send somebody home with that diagnosis, as one of the more famous physicians in emergency medicine says, it means you're probably going to get sued because you're probably going to miss an underlying condition.

If you want to discuss the features of gastroenteritis, we can get into that. I'm not sure how you want to pursue that.

Q In what situations have you diagnosed gastroenteritis in your career?

A In patients who have three features, nausea, vomiting, and diarrhea, and in the absence of one feature, which is in the absence of significant abdominal pain and tenderness. Patients with gastroenteritis generally do not have significant abdominal pain or abdominal tenderness. They tend to

have crampy feelings with nausea, vomiting, and diarrhea.

Q So what we need to talk about, then, is crampy versus significant abdominal pain. How do you, as a clinician, distinguish between the two?

A Crampy abdominal pain is episodic. In between the cramping episodes, patient usually feels relatively little or no pain. They also have minimal tenderness; tenderness being elicited by physical examination, pain being a symptom a patient verbalizes to you. So patients with gastroenteritis tend to have crampy pain that is episodic and minimal to no abdominal tenderness except perhaps during a period of acute abdominal cramping when they may have some tenderness which is then resolved.

Q Is this something that you've encountered in your experience as a physician, or is this something you can point me to, authoritative research that you -- authoritative research or writing that would support your point?

A This is something that I've encountered in my 30-plus years as physician experience.

Q Are you aware of any writings in that area that would be consistent with your experience as a practicing physician?

A If you're asking about authoritative sources, the answer is no.

Q Okay. How many times have you served as a paid consultant in medicolegal issues such as malpractice? I'm primarily concerned with reviews into whether there has been a deviation from the standard of care.

MR. CONWAY: Objection as to form.

A If you're asking how many times have I been hired or employed where I found my position to support the position of the attorneys?

Q That's not what I'm asking. I'm asking approximately how many times you've been asked to do reviews, whether you come to the conclusion that there's been a deviation or not. How many times have you been hired as a paid consultant?

A Between 700 and a thousand.

Q Over what period of time are we talking about?

A Since 1989, so 14-plus years.

Q The number, you said, was?

A 700 to a thousand.

Q That's from '89 to the present, correct?

A Correct.

Q What about the breakdown of plaintiffs

versus defense?

A Approximately, at the present time, 80 percent on behalf of plaintiffs and 20 percent on behalf of defendants.

Q Of those 700 to a thousand times, how many times have you actually reduced your opinions to writing in the form of an expert report like you did in this case?

A I have no idea.

Q How many times have you given a deposition like we're doing here today?

A Ballpark, 150 times.

Q How many times have you testified in court?

A Ballpark, about 40.

Q Have any of those 40 cases that you testified in involved either, in any way, appendicitis or gastroenteritis?

A Yes.

Q Approximately how many of those?

A As far as court testimony, my answer would be probably two to four.

Q What about deposition testimony?

A A significantly larger number.

Q By "significantly larger," what -- give me a ballpark range, if you can.

A Ten to twenty-five.

Q Then would it be significantly larger for the number of reports that you've issued in cases?

A I have no estimation in number of reports I've issued either in total or in reference to a specific medical condition.

Q Have you testified for -- in favor of a defendant doctor in cases involving appendicitis or gastroenteritis?

A Yes, I have.

Q Do you remember the name of the case or the name of the attorney?

A I do not.

Q Is that something that you could find out for me based on the records that you keep?

A Probably not.

Q And why is that? What type of records do you keep?

A I do not file my cases as defense or plaintiff or by subject matter. It would require reviewing hundreds of files to find out which files contain cases of gastroenteritis or appendicitis and whether they were on behalf of defense or plaintiffs. That's not something I keep track of.

Q Do you have any recollection of the

testimony that you would have given in favor of a defendant in either a gastroenteritis or an appendicitis case?

A No, I do not.

Q Have you offered opinions in favor of plaintiffs in cases that either involved gastroenteritis or appendicitis?

A I have.

Q Let's break it down a little bit further. Have there been cases both appendicitis and gastroenteritis?

A I'm not sure what you're asking.

Q That's fair.

The first time I asked you the question I said gastroenteritis or appendicitis. Have there been cases that involved gastroenteritis where you've testified on behalf of a plaintiff?

A I don't specifically recall gastroenteritis. If that's truly what the patient has is usually not the issue in a case.

Q How about appendicitis?

A Yes, there have been cases where I've testified on behalf of the plaintiff in appendicitis.

Q Have the cases that you've testified in, have any of them involved both of the issues? Like I

would classify this case as involving gastroenteritis and appendicitis in terms of what the physician was thinking of.

MR. CONWAY: Objection.

A At least one that comes to mind involved multiple visits with a diagnosis of gastroenteritis in a, I believe, 12-year-old girl.

Q Was that a plaintiff's or defense case?

A Plaintiff's.

Q Again, what would be involved in you trying to determine what the name of that case was and who the attorneys were?

A The attorney's name I can recall in that case, is William Harvit in North Carolina. I don't immediately recall the name of the young lady involved.

Q But you do have -- you do keep files on each of the cases you testified on; it would just involve looking through those files to find out the information regarding --

A On that specific case? Yes, I can retrieve that specific case.

Q Okay. Have you done any expert review for Mr. Conway or his firm in the past?

A Other than this current case?

Q Yes.

A To my knowledge, the answer is no.

Q How were you contacted to begin your review in this case?

A I received a call from Karen Beth Cohen, who works for a company called MedQuest in New York, sometime in December of 1999, asking me if I would be available to review a case. And she would have given me some very limited information, such as the attorney and the health care providers involved, to make sure I did not have any conflict with any of the parties involved.

Q What is your affiliation or association with MedQuest?

A They are an expert referral service with whom I've worked since the late '80s.

Q What were you asked to do by MedQuest?

A Review the medical records supplied by the attorney.

Q What were you asked to do in reference to your review?

A Offer an opinion about the standard of care and whether it was met or not.

Q Were you asked to review the standard of care regarding all physicians and entities who treated Mr. Toon?

A I was asked to review all the medical records. It is clear from the cover letter that was sent to MedQuest approximately four months before the case was referred to me that the focus of the case involved Madison Urgent Care and Dr. Padival.

Q That was made clear to you at the time that the records were sent to you?

A That was made clear to me by the cover letter sent to me in December of 1999, yes.

Q Can we pull that cover letter out and make that Exhibit 2?

MR. CONWAY: Sure.

(Whereupon, the Letter from Schiff & Dickson to MedQuest dated August 16, 1999, was marked as Defendant's Exhibit 2 for identification.)

Q For purposes of our deposition today, if I say Dr. Padival, will you understand that to also mean Madison Urgent Care Center and Bhat & Padival M.D.s, Inc.?

A I understand Dr. Padival owned Madison Urgent Care as well as being the physician who saw Mr. Toon. So Dr. Padival is involved in this in two fashions, one in the corporate sense, one in the direct medical sense.

Q I think we can communicate effectively. If

I say Dr. Padival, I'm basically looking for any criticisms or comments you would have regarding his care or the care provided by the corporate entities. Is that fair?

A Understood.

Q And if for any reason you have to differentiate between the two, please do so. Otherwise I'm just going to assume that the criticisms or comments are flowing towards Dr. Padival and will move through to the corporation. Okay?

A Okay.

Q What records were you sent to review?

A I was sent a packet of medical records from Madison Urgent Care; some medical records from Dr. Vaidya; medical records from Dr. Golbus; medical records from Mansfield General Hospital. The Mansfield General Hospital records begin, I believe, on 2/26/99 through 3/11/99. The Madison Urgent Care records concern the date of 2/21/99.

Q Is there anything else that you reference as part of your review?

A There was a cover letter that's been marked Exhibit 2. And I believe that's the sum total of the information that was sent to me in December of 1999.

Q Is there anything else that you believe that

you need to review in this case?

A You mean at that time or since that time?

Q How about at that time.

A No, there was not.

Q How about since that time?

A Since that time, I received depositions of Billy Jean Toon, T-o-o-n, Christopher Toon, and Dr. Padival, P-a-d-i-v-a-l. I also received a report from, I believe, Woskobrick. And there are a variety of other cover letters in my file, but none of them, I think, have any, shall we say, medical substance to them.

Q The medical records were all sent to you at the same time, correct?

A Correct.

Q How much time did you spend reviewing those records?

A Approximately half an hour.

Q At the time of your review of the medical records, you didn't review anything other than the medical records and the cover letter from MedQuest, correct?

A At the time I received medical records, I received nothing else other than medical records and the cover letter, so there was nothing else to review.

Q Did you talk to anyone about the medicine that was involved in the case in formulating your opinions?

A No.

Q Did you review any medical literature or publications or outside sources in forming your opinions --

A No.

Q -- in this case?

Did you make any notes, handwritten or otherwise, regarding your review of this case?

A Only those noted on Exhibit 2, which represent the amount of time spent, telephone calls to MedQuest and to Mr. Dickson, who was the original attorney involved in this case.

Q So you had a telephone conversation with someone at MedQuest on January 5th of 2000, correct?

A Correct.

Q Is that when you first shared with them what your opinions were in this case?

A Correct.

Q And what were your opinions -- let's go shorthand of this.

You've issued a report in this case?

A I have.

Q Were the opinions that you shared with MedQuest any different than what are contained in your report in this matter, dated -- I need to look at the date.

A I believe at the time I issued my report, which I think is dated June 3rd of 2000, I had received no other material other than the original records. So my opinions in June of 2000 would have been essentially the same as my opinions in January and February of 2000.

Q Okay. And the other note of a conversation, I see, is a telephone conference with Attorney Dickson on February 3rd of 2000?

A Correct.

Q Attorney Dickson was the original plaintiff's counsel that you communicated with?

A Yes. Attorney Dickson was the attorney and firm from which this case came in August of 1999.

Q Was it during that conversation that you shared your opinions with Attorney Dickson?

A Yes.

Q Okay. And I understand correctly that the opinions you shared with Attorney Dickson were the same as what are contained in your written expert report?

A I believe that's correct.

Q At the time of your conversation with Mr. Dickson, did he ask you to do anything else as part of your review?

A No.

Q Is there anything that he asked you not to do as part of your review?

A No.

Q Did he ask you to prepare a report?

A No.

Q When were you asked to prepare a report?

A I was asked to prepare a report -- I'm not sure if I have the notation -- at some point I received a communication from Martin Delahunty of the Friedman, Domiano and Smith firm. That would have been sometime after March of 2000, at which time I received a letter from MedQuest indicating that the attorney of record is now Martin Delahunty and Mr. Conway. And at some point, and I do not see a specific notation of a conversation, Mr. Delahunty requested me to prepare a written report.

Q Can we mark your report as Exhibit Number 3, please.

(Whereupon, the Report dated June 3, 2000, was marked as Defendant's Exhibit 3 for identification.)

Q The report that is marked as Exhibit Number 3, were there any earlier drafts of that report?

A Only in the sense of spelling and punctuation, which my wife, who is a history teacher, reviews. She has no input into the content, having no knowledge of medical issues. So there probably was a draft that had some spelling, punctuation, grammar problems that she altered for me, but did not alter the opinions in the report.

Q Were you ever asked to review the care -- the appropriateness of the care given to Mr. Toon by anyone other than Dr. Padival and the corporate entities associated with him?

A Not specifically. But, as I do in every case, I review all the medical records sent to me and have opinions about the care rendered by other medical providers.

Q Without looking at the cover letters, you mentioned other parts of your file were deposition transcripts, Mr. Toon, Billy Jean Toon, and Dr. Padival.

A Correct.

Q Did those come to you at varying times --

A They did.

Q -- after that?

A They came at quite varying times.

Q Was there anything in your review of any of those depositions that altered the opinions that you'd offered in your report?

A Yes, significantly altered my opinions.

Q Okay. The report was issued before you reviewed those depositions, correct?

A That's correct.

Q And there was a significant altering of your opinions following your review of the depositions?

A That is correct.

Q Okay. We'll get to that.

What did you do to prepare for your deposition today?

A I reviewed my file.

Q How much time did you spend doing that?

A Between two and three hours.

Q Let's talk about a few definitions.

How do you define "appendicitis"?

A It's an inflammation of the vermiform of the appendix of the colon.

Q Simple; nothing further that you'd like to add to your definition of "appendicitis"?

A It depends on how you're asking the question. You asked the question about appendicitis.

By definition, appendicitis, like gastritis, gastroenteritis, pharyngitis, otitis, means an inflammatory process involving the appendix, which in this case is the vermiform appendix of the colon. That is the pathologic process.

Q What are the diagnostic criteria for identifying appendicitis?

A In 1997, the diagnostic criteria would be the pathologic examination of the appendix, identifying them as being inflamed. At the present time a CAT scan also would serve as a reasonable surrogate test to make the diagnosis. But that was not the standard of care in 1999 as part of the routine, but has been used to some extent. It was not used to the routine that it was today.

Q You used the date 1997. You meant 1999?

A I'm sorry. I misspoke.

Q That's fine. I just wanted to make clear --

A My error.

Q How do you define the phrase "below applicable standard of care" as you use it in your report, Exhibit 3, and for purposes of your testimony here today?

A The standard of care is the care that a reasonable and prudent physician with the same or

similar training and experience would render to a patient with the same or similar medical conditions. That is the standard of care. In this case, the care rendered fell below that standard of a reasonable and prudent physician treating a patient with the same or similar condition.

Q How do you define "diffusely tender" with reference to an abdominal examination?

A Well, if I were writing "diffusely tender" in a note, I would mean the patient did not have localized tenderness to one area, meaning not the upper or lower or right or left abdomen. "Diffusely tender" would mean the patient was tender in the upper and lower portions of the abdomen and on both sides.

Q When you said you -- if you were writing the note, that's what you would mean. Have you come in contact with other physicians in your 30 years of experience who might view "diffusely tender" as something other than what you would mean when you write it in a note?

A I have not. I think that is a generally accepted definition of "diffuse tenderness" or "diffusely tender abdomen."

Q Does "diffusely tender" in any way connote the level of pain that the patient is experiencing?

A No, it does not.

Q So you would agree with me that the level of pain is not directly described by the use of the term "diffusely tender"?

A Correct.

Q Okay. What do you understand the term "differential diagnosis" to mean?

A My understanding of "differential diagnosis" would be a series of potential conditions that a patient with a given set of complaints would have as an explanation for their presenting problem.

Q And what is the significance of having a differential or reaching a differential diagnosis?

A It depends entirely upon the situation in which you're encountering the patient.

Q How about in the context of someone presenting with diffuse abdominal pain?

A In an urgent care or emergency setting?

Q Are you drawing a distinction between urgent care and emergency room setting versus to a primary care physician?

A Yes.

Q Okay. Why don't you give me what you believe the significance would be in both contexts, please.

A In the urgent care [slash] emergency setting, patients presenting with abdominal pain that is diffuse and diffuse tenderness, one needs to exclude what we commonly refer to as worst first, that the differential must include the serious conditions that if not recognized and treated promptly could lead to life or limb threats in a near time frame.

In the outpatient ambulatory care office setting, patients are often self-selected with a different set of complaints, and often have more chronic symptoms and usually do not represent an acuity level that you typically would see in urgent care or emergency settings. Now, that is not always the case, but that is typically the case in a scheduled office setting versus an emergency setting.

Q But you and I have agreed that it was difficult for you, as someone with experience in an urgent care and emergency room setting, to estimate the number of cases who are using urgent care and emergency room as a primary care physician. Correct?

A Yes, but that's not really the issue. The issue is the acuity of the patient's presenting symptom complex. If someone came into the office or urgent care and said, "I've had abdominal pain for two months," your differential diagnosis is very different

than somebody saying, "I've had abdominal pain for two days." So that would be the main difference. Patients coming to urgent care often tend to have more acute and short-term illnesses, although they may present with chronic complaints as well.

Q In the context of -- you had mentioned that your answer, in describing what a differential -- the significance of a differential diagnosis would depend on what the patient was presenting with. So let's talk about in the context of some level of abdominal pain in the context of an urgent care setting. Okay?

What if anything does the standard of care require as far as documenting a differential diagnosis?

A I don't believe the standard requires a written documentation of differential in, really, any case. It is certainly an acceptable thing to do, but I don't think it is required that it be done in a written documentation system.

Q So it's appropriate if it's something that is in the back of your mind that you are considering as a possibility to explain the patient's symptoms, correct?

A One would want it to be a lot further forward than the back of one's mind.

Q I think when we -- that was probably not the

best way of putting it, because we're going to have a hard time talking about what the back of someone's mind is versus the front of someone's mind.

When you say "further forward" in your mind, what do you mean by that?

A What I mean is when someone presents with acute abdominal pain and tenderness, one needs to consider very much at the top of one's differential diagnosis certain conditions which vary significantly between men and women of the same age, that might lead to testing diagnoses and treatment in a time frame that would be a very near term time frame as opposed to measured in days or weeks.

Q What do you understand the obturator sign to be?

A The obturator sign is a sign elicited by lying the patient usually on one side or the other and moving the knee forward and backwards so as to flex the hip, which puts tension on the obturator muscle, which is the muscle in the back of the pelvis. If one moves the left side and it elicits no discomfort and then moves the right side and elicits discomfort, that might make you more suspicious of a right-sided process, which, in a man, would be appendicitis until proven otherwise. In a woman the differential is somewhat

broader.

Q We'll narrow this down, but do you mean moving the leg this way or this way (indicating)?

A Side to side.

Q Left to right?

A It is done with the knee flexed and the hip flexed. For example, someone has a broken hip. We have them lying on the back, move the knee in and out; with the knee flexed and moving it back and forth from side to side. I should have been more specific.

Q Would you consider a use of the -- am I saying it right -- obturator sign as something that is used in trying to rule out appendicitis?

A No.

Q Why not?

A Because it does not rule out.

Q What would be the purpose of using or eliciting -- attempting to elicit the obturator sign?

A The presence of a positive obturator sign would increase one's concern about the presence of appendicitis. The absence of a positive obturator sign should not lead one away from the diagnosis. So you're asking about ruling out versus ruling in. It does not rule anything out. If it were positive, it also wouldn't rule anything in, but it would increase one's

index of suspicion for the presence of appendicitis.

Q But you're testifying that the converse isn't true? If it's negative it doesn't take you one step farther away or putting appendicitis one step farther back and, using my terms before, towards the back of your mind as opposed to keeping it right to the front of your mind?

A Well, there's a difference between lowering your index of suspicion and ruling something out. It might lower your index of suspicion, but it doesn't rule things out. That's an important distinction in evaluating cases like this.

Q What is your understanding of the definition of "gastroenteritis"?

A Gastroenteritis is, by definition, an inflammation of the stomach and the intestines that is associated with nausea, vomiting, and diarrhea, is due to a whole host of infectious and noninfectious conditions.

Q You told me before some of what you believe to be the diagnostic criteria for gastroenteritis. I think you said nausea, vomiting, and crampy-type abdominal pain. Is that correct?

A No.

Q Then I'm glad I asked.

A Nausea, vomiting, and diarrhea are basically the requirements to make or suspect that diagnosis, recognizing that those conditions can exist -- those symptoms can exist in other conditions that are not gastroenteritis.

Q What was the significance then of the crampy abdominal pain?

A Often with enteritis, the intestines are hyperactive and manifest it by increased bowel sounds on examination and periods of hypermotility leading to crampy pain, or colicky pain, it's much described in children or infants, that often may accompany gastroenteritis or enteritis.

Q How do you treat gastroenteritis?

A It would depend upon your suspicion of the cause. It may be treated with nothing but clear liquids. It may be treated with clear liquids and antibiotics. It may be treated with clear liquids and other medications to reduce the symptoms the patient might be expressing.

Q So let's talk about the situation in which -- what would you have to be suspecting to be the cause of gastroenteritis if you were going to prescribe antibiotics?

A A bacterial infectious cause.

Q What would you be looking to as the cause of the gastroenteritis if you were simply going to tell the patient to intake large quantities of clear liquids?

A A viral infectious cause or a nonspecific or food-borne toxin cause.

Q In what situations would you recommend to the patient that -- or would you prescribe medications to -- I think you said control the symptoms or alleviate the symptoms?

A Correct.

It would depend upon the severity and the discomfort the patient was experiencing from their symptoms.

Q How do you determine what level of discomfort the patient is experiencing from their symptoms?

A By asking questions and examining the patient.

Q And you would be more likely to -- what type of medication would you prescribe or medications would you prescribe to alleviate the symptoms a patient would be experiencing as a result of suspected gastroenteritis?

A If the patient were having cramping episodic

pain, you might prescribe an antispasmodic or smooth-muscle relaxant. You might prescribe something like Pepto-Bismol, which is a nonspecific oral agent that can alleviate many of the symptoms of gastroenteritis.

Q What about Lomotil?

A If the patient were having ongoing significant diarrhea, you might prescribe that.

Q What differences if any or what considerations if any would you make in determining whether to suggest Pepto-Bismol versus Lomotil as a medication?

A If the patient had persisting troubling diarrhea, then one might choose Lomotil or might choose Lomotil in addition to something like Pepto-Bismol.

Q If a patient is experiencing consistent diarrhea, consistent with you finding -- and finding it appropriate to prescribe Lomotil, would you agree with me that the level of pain that the patient is experiencing would be more episodic or more continuous in nature?

A It would still be episodic, not continuous or constant.

Q How do you differentiate, in taking a history with the patient, as to whether the pain is

episodic versus continuous?

A By asking the patient questions and examining them, doing a physical exam.

Q What type of questions do you ask of a patient to determine whether the abdominal pain they're experiencing is episodic versus constant, in the context of a patient who you are eventually going to prescribe Lomotil to?

A You ask the patient if the pain is continuous at a given level; is it continuous at a given level with periodic worsening; is it intermittent, in that they have pain-free times followed by cramps, often then followed by diarrhea, followed by relief of the pain. Those would be questions you ask of the patient. In terms of determining whether the pain was purely spasm or colicky pain, or if the patient had constant pain, one would be concerned about other conditions either over and above gastroenteritis or in place of gastroenteritis.

Q It's your testimony that a patient who is suffering from diarrhea -- pretty much continuous diarrhea as a result of gastroenteritis would not be experiencing some level of underlying constant pain in their abdomen?

A They may have a very low level, but you would not expect them to have a constant level of significant pain. If they had a constant level of significant pain in a setting of ongoing diarrhea, you would be worried about other more serious conditions than, shall we say, simple viral gastroenteritis. You would need to think of things such as bacterial gastroenteritis from bacterial pathogens that you would be concerned about.

Q Would it be your understanding that a physician who prescribes Lomotil and Tylenol to help the patient manage the symptoms of gastroenteritis would be considering a viral cause of the gastroenteritis?

A That would be one of the causes they would consider, yes.

Q And the medications wouldn't be doing anything to cure the patient or resolve the problem; is that correct?

A That is correct. And in fact, there are situations where those medications may actually worsen on prolong the illness. If it is a toxin-mediated gastroenteritis, eliminating the diarrhea can actually worsen or prolong the condition.

Q What I need you to first -- at the time that

you issued your report, which is Exhibit 3 -- I need you to share with me each and every opinion you held in this case regarding the evaluation and care and treatment of Mr. Toon.

A Okay. At the time that I issued my report, the only materials that I had were the actual medical records, specifically the Madison Urgent Care records and subsequent medical records. I had no testimony from any of the three people, Mr. and Mrs. Toon or Dr. Padival. Therefore I could rely only upon the written medical records as far as history and physical.

At that time the complaints were those of three days of diarrhea, abdominal cramps, and nausea, not able to eat or drink. That was the history.

The physical exam says, I believe, patient febrile, and I believe it says PT, although one cannot be sure, maybe PA; may be an abbreviation for patient either way. Diffusely tender with burn mark on abdomen, bowel sounds increased. And I believe, from Dr. Padival's deposition, the next term is "legs check."

The impression appears to be abdominal pain, G enteritis, meaning gastroenteritis.

And prescription was for Lomotil, 2 tablets 4 times a day, and Tylenol, 2 tablets 4 times a day.

Based on that record, my opinion was that Mr. Toon was not given appropriate discharge instructions about the timeliness and need for follow-up, depending upon his clinical condition after this visit, which appears to have been approximately 3:00 p.m. on 2/21/99.

So my opinion at that point was based on these records and the fact that there is no advice about follow-up of any sort in terms of when, where, how, or whom he should see. And my opinion was that that was not consistent with the standard of care for a patient presenting with these complaints.

Q Was it your opinion that the discharge instructions needed to be documented, or was it your opinion that without knowing what happened you were going to assume until that time that the discharge instructions were not given?

A The standard of care in 1999 for outpatient urgent care/emergency departments is that discharge instructions should be documented and should be provided in writing. There is no documentation of any discharge instructions as being given either in the written documentation or any copy of any standard discharge instruction, which are readily available through many, many different sources to provide the

patients so that they have some written reference to refer to in case they don't recall all the things that may have been told or may not have been told to them.

So the standard of care in 1999 for emergency departments and urgent care was that written instructions should be provided to the patient. Discharge -- sorry. Verbal instructions certainly can be provided, but at least there should be some minimal documentation for what they consist of. There is no documentation in this record of any verbal or written instructions provided to the patient.

Q So at the time of your review that is what you found to be below the standard of care, that there was no written discharge -- no written note of discharge instructions being given, correct?

A Certainly no evidence from what happened that there was any appropriate discharge instruction given.

Q Okay. No evidence of what happened, what do you mean by that?

A The patient did not return within a time frame consistent with a reasonable discharge instruction.

Q Have you, in your 30 years of experience, encountered patients who have been told to return but

do not?

A Yes, I have.

Q So what was it that led you to assume in this situation that it was the physician's fault rather than the patient fault?

A The fact that medications were given that clearly were meant to be taken 4 times a day for an unknown period of time, since also another deficiency in this record is there is no indication of the quantity of medications given to give any estimate of how long the patient should expect to take them and rely upon medication. Generally if one gives medication in the setting, one dates -- one is given 10, 20, 30, 40 pills. There is no quantity specified for the Lomotil.

Q So, again, you assume it was a longer quantity? What if you had known at that time that the quantity was a one-day supply?

A That would still indicate the patient was not given appropriate time frame to be reevaluated for his condition.

Q Based on your initial review -- and by initial, I mean prior to reviewing the depositions -- were those the only opinions that you held at that time?

A I believe that is what is referenced in my report.

MR. CONWAY: Do you mean by -- standard of care opinions?

MR. McGOVERN: Yes.

MR. CONWAY: Because he does obviously give proximate cause opinions in his report.

MR. McGOVERN: We'll focus on that later.

A As far as standard of care, the fact that appropriate and timely discharge instructions were not provided in any documented form, whether they be oral, written, or combination, yes.

Q And it's your testimony that written discharge instructions had to be provided to the patient and minimal description of what those discharge instructions given to the patient are need to be written in the chart?

A Well, generally what is done when written instructions is given to a patient, a copy is kept with the patient's record. It makes it very clear what the patient has been given. There are many commercial providers that provide these instructions for such entities as abdominal pain.

Q Are you aware of any medical literature or

authoritative writing that you believe supports your opinions regarding the need for written documentation of discharge instructions in an urgent care or emergency room setting?

A Yes. The Joint Commission on Health Care -- JCHO, which has been -- was previously the Joint Commission for Accreditation of Hospitals, is now the Joint Commission for Accreditation of Health Care Organizations -- makes it very clear a patient's discharge from acute urgent care and hospital settings must be provided with written discharge instructions to conform with their standards. You can argue whether that is a standard of care since it's a separate accrediting body. But that is considered the general de facto standard for discharge of patients from settings such as this. And, yes, you can get those off their Web site.

Q Is there anything else you consider authoritative on that issue?

A No.

Q Okay. At the time that you issued your report, did you have any opinions regarding whether other practitioners besides Dr. Padival met the standard of care in their evaluation and treatment of Mr. Toon in February of 1999?

A Yes. My opinion was that when Mr. Toon went to Mansfield General Hospital on, I believe, February 26th of '99, both the emergency department physician and the surgeon, Dr. Golbus, met the standard of care in a very exemplary fashion with an expeditious evaluation and treatment.

Q Again, at the first stage of your review, prior to your review of the deposition testimony, tell me what your opinions were regarding how Dr. Padival's deviation from the standard of care caused harm to Mr. Toon.

A Dr. Padival did not provide instructions for Mr. Toon to seek reevaluation in a prompt and timely fashion, allowing him to develop a ruptured appendix, intra-abdominal abscess, intra-abdominal sepsis, to become critically ill, to have a very complicated hospital course with days in intensive care unit, prolonged stay in the hospital, and prolonged recuperation.

Had he been treated and reevaluated in a timely fashion after this visit, he more likely than not would have had an uncomplicated appendectomy, which, in 1999, often involved one day in the hospital and a week or so out of work. By the records, Mr. Toon was in the hospital for, I believe, 13 days or 14 days,

something like that. I think 2/26 to 3/11, so 14 days. That's about 13 days longer than a normal hospitalization for uncomplicated appendicitis. He was in the intensive care unit for approximately a week. He was discharged home with an open abdomen that had not been able to be closed, primarily, and had prolonged recuperation, prolonged loss of time from work, increased risk of complication, including bowel obstruction, adhesions, and abdominal hernias.

Q You mentioned that your opinions changed regarding standard of care after reviewing the depositions. Correct?

A Correct.

Q Did your opinions change regarding -- I'll call it proximate cause, regarding the cause, the violations of the standard of care?

A No.

Q Those did not change?

A They did not.

Q Why don't you -- I think now is the best time, then, for you to tell me how your opinions regarding the standard of care violations occur -- are changed after having reviewed one or more of the depositions. For purposes of clarity, why don't you just tell me which deposition it was or what it was in

the deposition that led your opinions to change.

A The deposition was predominantly that of Mr. Toon, but also his wife, who was -- who accompanied him to Madison Urgent Care, and by both his testimony and her testimony, was present at the time of his evaluation by Dr. Padival.

The first difference is the history, given most specifically by Mr. Toon, but also by Mrs. Toon, differs in significant substance from what is recorded by Dr. Padival in the record. Dr. Padival says he has three days of diarrhea, abdominal cramps, and nausea. Mr. Toon said he had one day of diarrhea which had essentially completely resolved. And what he presented to Madison Urgent Care -- he actually was complaining primarily of abdominal pain and to some extent nausea. So that is a very different picture. And, again, not a picture particularly suggestive or -- suggestive in any significant degree of gastroenteritis. So resolved diarrhea followed by increasing pain, which is what Mr. Toon said led him to seek care on the afternoon of 2/21/99, without continued diarrhea, in the presence of nausea, is a different history than what is recorded by Dr. Padival.

However, the main issue that is significant is Mr. Toon's description of both his abdominal pain

and his abdominal tenderness upon his physical exam. Mr. Toon described significant abdominal pain that appeared to be localized at least to the lower abdomen and quite probably localized to the right lower abdomen. And that history basically indicates to me that Mr. Toon, at the time he saw Dr. Padival, more likely than not had appendicitis and needed to be referred immediately to a hospital for further evaluation as appropriate and examination by a surgeon.

So I believe Mr. Toon's deposition, as well as that of his wife, indicates his physical exam and his physical complaints were most consistent with a diagnosis of probable appendicitis on February 21, '99, which, had it been treated on February 21, '99, would have been a much more uneventful or much less eventful convalescence.

Q Are you aware of when Mr. Toon's deposition was taken?

A Whatever date it says on the front. It says 6/27/01.

Q So how long after his visit to Dr. Padival was that deposition taken?

A Two years, four months, and six days, I believe.

Q Am I correct in understanding that you're

accepting Mr. Toon's recollection of the events two-plus years after he was seen by Dr. Padival versus Dr. Padival's contemporaneous notes regarding his examination of the patient?

A I'm accepting that Mr. Toon's remembrance of his condition as being more complete than what limited documentation Dr. Padival provided in his record.

Q In order for you to chart -- have you ever used the term "diffuse tenderness" in charting?

A Yes.

Q In describing an abdominal examination?

A Yes.

Q In order to come to a -- in order for you to chart that, what type of abdominal examination would you have done to chart diffuse tenderness?

A I would have examined the patient's abdomen in all four quadrants.

Q What would you have found? We've already touched on this, but I do want to hear your answer again, if it is again.

What would you have to find --

MR. CONWAY: Are you stipulating that this question is redundant?

MR. McGOVERN: Yes, if need be. If the transcript proves that it is, yes.

Q What would you encounter in your examination of all four quadrants of a patient's abdomen to chart diffuse tenderness?

A I would find tenderness in all four quadrants that was of similar severity.

Q Okay. So if Dr. Padival testified that by writing "diffuse tenderness" he did so after an examination of all four quadrants of the patient's abdomen, are you not -- you are not accepting his contemporaneous notes regarding that as part of his medical record? Is that what I'm understanding you to have done as part of your review in reaching your opinions?

MR. CONWAY: Objection.

You're asking two different questions.

MR. McGOVERN: I don't think so.

MR. CONWAY: You're asking him to take into consideration now Dr. Padival's deposition testimony, which raised credibility questions by itself. If you're asking him to consider Padival's deposition testimony, he has the right to consider the whole thing versus not considering it and just going on his notes.

That, I guess, is my objection, if it makes sense. So objection as to form.

MR. McGOVERN: Okay.

A My answer would be that given Dr. Padival's exam of diffuse tenderness and Mr. Toon's history, I believe the patient, at the time of the visit on 2/21/99, needed further evaluation at that time. Diffuse tenderness is not a finding reasonably and prudently attributed to something as uncomplicated as gastroenteritis. So a patient with the complaints that Dr. Padival wrote, as amplified by Mr. Toon's record of his deposition, which is the only information I have from Mr. Toon, coupled with diffusely tender abdomen findings, would indicate to me that it was not safe or prudent to arrive at what many people consider a wastebasket diagnosis, gastroenteritis.

Q What, for purposes of your opinions, then, after reviewing Mr. Toon's deposition, what are you assuming or understanding his presenting symptoms to have been? I need you to then articulate what those were.

A His deposition says his predominant presenting problem was pain; not diarrhea, not nausea, but pain. And, in fact, his diarrhea, according to his testimony, had been present, I believe he said for Friday and part of Saturday and then resolved. And I believe the 2/21/99 date is supposed to be a Sunday, at

which point Mr. Toon said he had no more diarrhea. He had pain, and that finding, coupled with diffuse tenderness, would say that a reasonable and prudent practitioner must consider the diagnosis of appendicitis and cannot reasonably exclude that diagnosis without further investigation, which was not done.

Q Can you pull out Dr. Padival's records regarding --

A His records?

Q His patient records regarding Mr. Toon.

A Yes.

Q What is the -- under the Physician's Summary, Complaints, what is written there?

A "Three days of diarrhea, abdominal cramps, and nausea, not able to eat or drink."

Q What do you understand that to mean?

A Exactly what it says.

Q Do you understand the diarrhea to have resolved based on what is written there?

A I understand this to say three days of diarrhea.

Q Okay. In reviewing those records, what did you understand that to mean? That the diarrhea was present at the time of the patient giving the history,

or that it had resolved a day or two or more before?

A I could not make any assumption one way or the other.

Q If you could hand me the record that you have for the emergency room or Mansfield Hospital.

A (Handing.)

Q Thank you.

And do you have a record for Dr. Golbus?

A (Handing.)

Q Thank you.

Do you have any reason to doubt the reliability of the records kept by Dr. Golbus?

A No.

Q In fact, you believe that he met the standard of care in all ways, correct?

A Correct.

Q As part of the records you reviewed -- I'm looking now at the medical records from Ronald Golbus, M.D. I'm pointing you to the typed history and physical from the date of admission to Mansfield General, which I believe was February 26th of 1999. Does that appear to be correct, Doctor?

A Correct.

Q Is there anything noted in the history of presenting illness in reference to the course of the

diarrhea?

A It says he had been having diarrhea until three days ago but since that time has not moved his bowels.

Q What do you understand that to mean?

A What it says.

Q Do you understand it to mean that he was having diarrhea -- I'll represent to you that that was a Friday. Okay?

A Okay.

Q Do you understand that to mean that he was having diarrhea on Friday?

A No.

Q Why not?

A Because it said he hadn't.

Q Do you understand that to mean he was having diarrhea on Thursday?

A No.

Q Why not?

A It said he hadn't.

Q Did you understand it to mean he was having diarrhea on Wednesday?

A Probably not.

Q And why is that?

A It appears to say he didn't.

Q Do you understand that to mean that he had diarrhea on Tuesday?

A Probably.

Q And why do you say that?

A Because it dates it three days prior to the date of this note, the 26th.

Q So would you understand that to mean he had diarrhea on Monday?

A He may have.

Q Why?

A Because according to this note he may have been having it.

Q And would you understand it to mean he had diarrhea on Sunday?

A He may have been.

Q Why is that?

A Because that was prior to the three-day interval noted.

Q I'll represent to you that Mr. Toon presented to Dr. Padival on Sunday. Okay?

A That was my understanding from the record.

Q Does this in any way alter your view of whether you're going to accept Mr. Toon's representations regarding his history versus what Dr. Padival has charted in his chart contemporaneous

with his visit -- with Mr. Toon's visit to him on Sunday, February -- what was the date?

A 21st.

Only that Mr. Toon's testimony differs from this history.

Q It differs from what's recorded in the Mansfield record, too, correct?

A Correct.

Q Okay. You were describing to me how the deposition testimony that you'd reviewed had changed your opinions from those contained in your initial report. And you had begun to do that. Are there any other ways that your opinions had changed based on your review of the deposition testimony?

A No.

Q Was there anything else besides what you had mentioned to me regarding what you reviewed in Mr. Toon's deposition and Mrs. Toon's deposition that led you to change your opinions?

A Anything else?

Q Besides the things that you've already mentioned and our court reporter has presumably captured regarding what it was, what testimony it was that led you to change your opinions from what you had initially wrote in your report, which is marked as

Deposition Exhibit Number 3.

MR. CONWAY: Objection to the form of the question.

I've been sitting here -- if you have a specific question you want to ask him about opinions, fine. But I don't know that he can sit back in a vague manner and recall every word he's told you when they haven't been -- in response to a direct question. So -- and on top of that, I'm objecting as to form.

Go ahead, if you can.

MR. McGOVERN: If he feels uncomfortable --

Q Based on the ground rules I set forth earlier, you can ask me to ask the question in a different way. That's fine. If you can answer, I encourage you to.

A My recollection is Mrs. Toon's testimony also corroborated her husband's testimony that abdominal pain was a very significant complaint that led him to seek medical attention on the February 21st date. That appears to be different from what is described in the medical record of Dr. Padival on that date.

Q Do you remember -- did you read Mrs. Toon's testimony that on the Sunday that she saw -- that he

saw Dr. Padival, Mr. Toon looked like he was -- I think she used the term, three, four, or five months pregnant. Do you remember her saying that?

A I recall some comment about abdominal distension. I don't recall anything specifically about the gestational age of her husband.

Q But you would take such comments to refer to abdominal distension, correct?

A I would.

Q Kind of a layperson's description of what you would call abdominal distension, correct?

A Correct.

Q Were you accepting that as part of your opinions?

A I don't think I factored that in one way or the other as being helpful in my analysis.

Q Why wasn't it helpful?

A Because abdominal distension is a very nonspecific feature that can be seen in many different conditions. It would not lead one to or away from any specific condition.

Q Was there any charting or mention of abdominal distension by Dr. Padival?

A No.

Q Was there any charting or mention of

abdominal distension or history of abdominal distension in the record of Dr. Golbus or the hospital that you recall?

A Let me -- there was in Dr. Golbus's chief complaint, yes.

Q What was the history that he took regarding that?

A His chief complaint was abdominal pain, nausea, pain, vomiting, abdominal distension, fever, unable to move bowels.

Q Was there any reference in Dr. Golbus's record as to the onset of abdominal distension?

A He says in the last 24 hours.

Q So you take that to mean that the abdominal distension would have become apparent on either -- sometime on Thursday, prior to the Friday admission?

A Yes.

Q And that's based on the history that was presumably given by Mr. Toon at the time of his admission, correct?

A Correct. This history would appear to come from Mr. Toon, according to the record.

Q Okay. In a situation like that, where the patient may appear at the emergency room in a level of distress, do you or -- is it common for the history to

also be obtained from a family member?

A Yes.

Q Is there any way of telling from Dr. Golbus's record or the Mansfield record which part of the history was obtained from a family member and which of it was obtained directly from Mr. Toon?

A Well, some of it says "he," so the implication would be -- it says "he noted," so the implication would be that was obtained from the patient.

Q That was the exact answer I was looking for. Thank you.

Was there anything else that you reviewed in Mr. or Mrs. Toon's deposition that contributed to you modifying your opinions in this case?

A I don't believe so.

Q Okay. Do you have an opinion as to when Mr. Toon's appendicitis was diagnosable?

A I think it was quite possibly diagnosable on the 21st of February 1999.

Q At what time?

A 3:00 p.m. and thereafter.

Q On Sunday, February -- you're picking the day. I want to make sure. You're selecting the date that Dr. Padival examined the patient, correct?

A Correct.

Q And it's your opinion that the appendicitis was diagnosable that day?

A Had he been evaluated for such, yes, I believe so.

Q And is it your testimony one way or the other that the standard of care required it to be diagnosed that day?

A It required that he be evaluated for that condition on that day.

Q Okay. Help me understand the distinction between requiring him to be evaluated that day versus actually diagnosing it or recognizing it that day.

A At certain stages of the clinical presentation of appendicitis, the diagnosis may not be immediately made, especially if one is not utilizing abdominal imaging with CAT scans, which, as I said, in 1999 was done to some extent but certainly not to the extent it is done now.

In 1999 there were numerous options one had in evaluating such a patient, including observation over a period of time, short period of time, by someone, specifically a surgeon. And that might have been the choice of a surgeon who saw the patient in February of 1999, to evaluate the patient. If he did

not feel he could diagnose the patient's condition based on his initial history, physical, and routine laboratory testing, he might elect to observe the patient and reexamine him serially to see if his condition changed on physical exam.

He might also have elected to do a CAT scan, which can be very helpful. Because if the appendix can be visualized -- it can be visualized as being normal, then one can send the patient home, still with follow-up in a timely fashion, but say, "At this point your appendix is normal." Conversely, the appendix, even at the early stage, can be clearly abnormal, in which case one does not delay for serial observation. One simply takes the patient to the operating room, removes the appendix, and they recover quickly.

So how the evaluation would have transpired would depend somewhat on the personal practice of the specialist involved, namely a general surgeon seeing the patient.

Q Now I'm a bit confused. Are you saying that the standard of care required Dr. Padival to refer Mr. Toon to a general surgeon on Sunday, on the Sunday that he saw him?

A His options would have been to refer the patient to the emergency department where further

evaluation and consultation could be obtained or directly to a general surgeon. It would depend on his own practice patterns. On a Sunday, more often people are sent directly to an emergency department rather than a surgeon's office, which would be closed. At 3:00 p.m. on a Tuesday, he might have sent the patient to a surgeon's office.

Q So it's your opinion that that is what the standard of care required Dr. Padival to do based upon the presentation of Mr. Toon on that Sunday?

A As amplified by the depositions of Mr. Toon and Mrs. Toon.

Q That was going to be my next question.

I want you to -- so that we're clear, you have to factor in the depositions of Mr. and Mrs. Toon to reach this opinion as to what Mr. Toon was presenting with that would have led to your opinion as to the standard of care requiring either referral to a general surgeon or an emergency room that day, correct?

A Correct.

Q Okay. Do you have an opinion regarding when Mr. Toon's appendix ruptured?

A I do not. I cannot -- I would not try to extrapolate backward. Certainly more than 24 hours before his surgery. But beyond that, I cannot further

delineate between the 21st and the 26th, exactly what time it was likely to have ruptured. That would best be asked of the surgeon who operated on him.

Q When an appendix ruptures, how quickly do the signs and symptoms of sepsis start to appear?

A The best answer to that question is to say that is an unanswerable question.

Q Tell me why, though.

A Patients can have an appendix rupture, and this happened to my boss, that was diagnosed months later. So the sequelae of a ruptured appendix range from catastrophic rapid deterioration, sepsis, and death within hours; to gradual deterioration and development of peritonitis and sepsis over days; to a localized, what we call a walling off to the body mechanism, essentially forming an abscess which can become walled off and fully sequestered from the body and can present weeks, months, or years later, or to be found as an incidental finding at autopsy.

So the range of clinical presentation with appendiceal rupture can be immediate and catastrophic to never diagnosed in life and anything in between. The variation is very much dependent upon the individual patient, variations in their anatomy, and their ability to localize and wall off an infectious

process.

Q But you would agree that it's medically probable that the appendix could have ruptured the day before his admittance to the hospital, and that would have been Thursday?

MR. CONWAY: Objection as to the form of that question.

A I would say it is possible. I would not say it is probable. That is a possibility. I would allow the surgeon who operated on him to offer an opinion about the length of time between surgery and the preceding rupture.

Q In your review of Dr. Golbus's records, did that point you in any direction as to . . . .

A I do not recall. Quite frankly, that is not a question I'd been asked before and therefore not one I searched the records for.

Q That's fine. I was asking if you recall.

A I do not recall. It's not a question that previously had arisen. I don't know if his operative note would help me. It may have helped him. He may have an explicit opinion if asked about the length of time the appendix was ruptured prior to surgery. But I did not look at his deposition with that question in mind, so, no, I don't know.

Q Do you have any opinions regarding Mr. Toon's outcome if he had returned for follow-up, evaluation, and care on Wednesday? Just so that we're clear, I think the sequence of dates, Sunday Dr. Padival, Friday operation. If he had returned for further evaluation on Wednesday, do you have any opinions regarding Mr. Toon's outcome, if he had returned for evaluation on Wednesday?

A My opinion, without being able to quantitate in percent, would be to say that his -- the magnitude of his illness and duration of his being sick would have been shortened. But I cannot give you a percentage to say whether it would have been 10 percent or 30 percent or 50 percent. Had he had treatment earlier than Friday, such as on Wednesday, likelihood is he would have had a less severe illness. He would not have been as critically ill as it appears he was on Friday, the 26th. Would have had a shortened length of stay in the hospital and potential -- reduction in potential future complications. But, again, I cannot quantitate that to any numeric percentage.

Q For purposes of my question, I'd like you to assume that his appendix ruptured on Thursday. Okay?

A Okay.

Q If he had returned for further evaluation

and treatment on Wednesday, how would that have impacted Mr. Toon's outcome?

A Assuming his appendix was unruptured on Wednesday, he would have had a routine, uncomplicated appendectomy. He would have been home on Thursday or Friday, and back to work substantially sooner, given that he did a fairly heavy lifting job, so he would not have been back to work on Monday. You and I might have been back to work on Monday.

Q Okay. Am I correct in understanding, then, that as long as he had returned for further evaluation and treatment prior to the rupture, your opinion that you just stated would be the same? So whether the rupture happened on Wednesday and he returned for further evaluation and treatment on Tuesday, the outcome that you just testified to would be the same. Is that correct?

A Correct. The major difference would be the removal of an unruptured appendix, which is a simple 20-minute procedure, versus a laparotomy with lysis of adhesions and drainage of intra-abdominal abscess formation, which is a much more extensive, prolonged surgery, with much more prolonged recovery.

Q You did place some reliance on Mr. Toon's deposition in formulating your opinions, correct?

A That is correct.

Q Just give me a second here.

Representing to you that Mr. Toon testified that he received a supply of medications from Dr. Padival that he took as directed and ran out of on Wednesday -- okay?

A I believe he said either Tuesday evening or Wednesday morning, correct. That's my recollection.

Q And that it was his understanding following his examination by Dr. Padival and what Dr. Padival told him when he prescribed the medications that the medications would clear things up for him.

MR. CONWAY: Objection.

A Okay.

Q Is that your understanding of his deposition testimony?

A His understanding was the medications would alleviate his problem.

Q What do you mean by "alleviate"?

A It would improve his symptoms and sense of feeling ill.

Q Okay. Then would you agree with me that Mr. Toon, in his deposition, said that he did not -- the medications did not alleviate his condition on Wednesday?

MR. CONWAY: Objection.

A My recollection is he said while taking the medications he felt intermittent improvement, and when he ran out of the medication he continued to feel intermittently ill.

Q Okay. Do you agree with me that given Mr. Toon's recollection of the -- of what Dr. Padival said the medications would do for him, and Mr. Toon's testimony regarding what he was continuing to experience on Wednesday, having run out of medications, that he as a patient had an obligation to return for further treatment or evaluation or additional medications on Wednesday?

A No. I don't think I would arrive at that conclusion.

Q And why not?

A Mr. Toon is a layperson. His understanding of medical conditions is nonexistent. I don't know what one could presume he would presume or assume. That is one of the difficulties of being someone who is not medically knowledgeable.

Q Do you attribute any fault to Mr. Toon for not returning to receive further care or evaluation prior to Friday?

A No, I do not.

Q And why not?

A Because Mr. Toon is not a medically knowledgeable individual. He's relying upon the assurance of a physician that this is just a gastroenteritis and would get better on its own. He expected to get better.

Q If the doctor had told him he expected him to get better in a couple of days, certainly by the time the medication ran out, does that alter your opinion at all?

A No, it does not.

Q Okay. In diagnosing appendicitis, what is -- or diagnosing or recognizing appendicitis, is there any significance to the presence or absence of diarrhea?

A Diarrhea is seen in less than 50 percent of patients with appendicitis.

Q Do you know how much less than 50 percent of patients with appendicitis don't have diarrhea -- or do have diarrhea, I guess would be the correct way.

A My estimate would be in the range of 20 to 25 percent.

MR. CONWAY: I'm unclear. Have or do not have?

MR. McGOVERN: I'm going to clear it

up.

Q So it would be your testimony that between 20 to 30 percent of patients who end up being determined to suffer from appendicitis do have diarrhea?

A Correct.

Q Is the presence of diarrhea upon physical examination or taking a history of someone, is that something that you find reasonable for a physician to consider as a factor in putting appendicitis more towards the back of their mind versus keeping it towards the front?

A No. I don't think it would change my ranking of the diagnosis based on the physical examination.

Q Again, that's the physical examination as testified to by Mr. and Mrs. Toon; is that correct?

A And Dr. Padival.

Q What was your understanding of how Dr. Padival testified regarding his abdominal examination of the patient?

A I believe he said what was in his record, that the patient had diffuse tenderness or was diffusely tender.

Q Am I correct in -- did Dr. Padival -- to

your recollection, did Dr. Padival testify to examining all four quadrants of Mr. Toon's abdomen?

A I believe his testimony was that he did.

Q And you are accepting Mr. Toon's representations regarding that examination versus Dr. Padival's representation or recollections of that examination as he recorded in his chart as a basis for forming your opinions; is that correct?

MR. CONWAY: Objection. He's testified he's accepting Christopher Toon's and Billy Jean Toon's.

A I'm also accepting Dr. Padival's. If a patient has diffuse tenderness, in this setting one still needs to include appendicitis high on one's list of considerations, because appendicitis begins with poorly localized so-called visceral pain and tenderness. And then it only becomes localized when they develop what's called somatic or localized tenderness in the right lower quadrant. In the early stages of appendicitis, patients often do not have localized pain or tenderness. So I'm taking into account Dr. Padival's record and testimony.

Q How long after the patient begins experiencing abdominal pain of any variety does it typically take for it to localize when appendicitis is

at issue?

A Typically between 8 and 24 hours.

Q If Mr. Toon was complaining of abdominal pain for two to three days before he saw Dr. Padival, you would have expected the abdominal pain to have localized by that time if he was in fact suffering from appendicitis, correct?

A If his original complaint was from appendicitis, that is correct.

Q Okay.

MR. McGOVERN: Would you read back that last question and answer, please.

(The requested testimony was read.)

Q In your report, you mention that the standard of care requires follow-up examination within 8 to 12 hours, I believe. Is that correct?

A Correct.

Q Has that opinion changed? I just want -- I'm a little unclear as to, you know, before -- for purposes of trial, is that going to be your opinion? Or is your opinion now that the referral was necessary, to a surgeon or the emergency room, that day?

A Okay. My opinion is that patients are discharged, the standard requires follow-up within 8 to 12 hours. This patient, my opinion currently, should

not have been discharged from Madison Urgent Care with or without instructions. Should have been referred to a surgeon, if one was available. Probably one was not, and therefore the emergency department would have been the most reasonable next step for evaluation.

Q But if the patient was discharged, then you're saying they needed to be returned for evaluation within 8 to 12 hours?

A Yes, assuming their symptoms had not essentially resolved to a major extent.

Q What type of discharge instruction was required to be given by the standard of care in that context?

A An instruction that the patient may have a serious underlying condition, specifically appendicitis, and if his pain did not greatly resolve or completely resolve within 8 to 12 hours he should be reevaluated in an appropriate facility, which by definition and Dr. Padival's testimony would not have been Madison Urgent Care, because they were not a 24-hour facility. 8 to 12 hours would have been 3:00 to 4:00 a.m., and that's what the emergency department is available to provide.

Q Have you ever treated patients for strep throat?

A Yes.

Q How do you do that? After you make a diagnosis of strep throat, what do you do?

A You give them an appropriate antibiotic to which they are not allergic.

Q Give me an example of an antibiotic that you would typically use.

A Typically penicillin if they're not allergic to it and you're not in an area where penicillin resistant streptococci are common.

Q What would be the duration of the prescription?

A Ten days.

Q Would your instructions be "Take all of this medication"?

A Correct.

Q "And if you're not better after the ten days of taking it, return to see me or obtain further treatment"?

A Generally, no, because the concern with strep throat would not be a complication in ten days for failure to respond, but the development of other problems in the next 12 to 48 hours, such as an abscess.

Q I'm not talking about that. I'm talking

about what your instructions would be to the patient with strep throat who you prescribed a ten-day course of antibiotics.

A I'm sorry.

Yes, it would be to be reevaluated if symptoms had not resolved at the completion of treatment.

Q And can you imagine a -- or can you -- have you encountered a situation where the antibiotics may be -- for resistance purposes, do not resolve the strep throat the patient's experiencing?

A Occasionally that may happen.

Q Based on the instructions you would have given to the patient, would you feel it is incumbent upon the patient to then return to you if the supply of antibiotics has run out and they're still not feeling better?

A I would expect if they're not feeling significant improvement they would be reevaluated either by myself or somewhere else.

Q But do you feel it's incumbent upon the patient to return for evaluation upon that time, or is it incumbent upon you as the physician to call that person after ten days and make sure they're okay?

A For what appeared to be an uncomplicated

strep throat, I would not expect the health care provider to call the patient.

Q So in that situation it's reasonable for the physician to rely on the patient to look out for their own health in that situation and return for further evaluation and treatment if the medications the physician said would likely resolve it did not work. Correct?

A For that condition, that's correct.

Q I'm sure that you would like to differentiate that situation from abdominal pain that someone might feel is gastroenteritis but others might feel are appendicitis. So go ahead and differentiate those two situations.

MR. CONWAY: Objection as to the form of the question.

A The expected or frequency of expected complications of strep throat would be fairly minuscule. There is actually controversy, in adults, whether one needs to treat strep throat. Many people feel there is no clear advantage in doing so because it resolves on its own 99 percent of the time and does not progress to significant -- certainly not life- or limb-threatening complications, virtually ever. As opposed to undifferentiated or undiagnosed abdominal

pain, where the risk of appendicitis and ultimately perforated ruptured appendicitis with abscess formation, peritonitis is a very significant complication, which is also very treatable or preventable with early treatment. So it's a very different type of situation.

There are many other -- many conditions where you have in your differential a significant and serious complication or illness that you need to exclude. Strep throat is not one of them.

Q What do you believe the standard of care required of Dr. Padival on the Sunday that he evaluated Mr. Toon to do to rule out appendicitis?

A Send him to a facility that had the resources, which I would not expect him to have in his urgent care, to further evaluate the patient. Again, either a surgeon, if one were available, or more likely the emergency department.

Q Do you anticipate doing any further record review as part of preparing to offer opinions at trial in this case?

A Only if additional records are sent to me that I don't currently possess.

Q Are there any other opinions that you will offer at trial besides those that you've offered here

today?

A Not unless asked by Mr. Conway.

Q Do you have any other criticisms of Dr. Padival or the corporate entities besides those that you've set forth here today?

A No.

MR. McGOVERN: You can advise him of his right to read the deposition.

MR. CONWAY: That's up to you, Doctor. Do you want to read it?

THE WITNESS: As long as I have a copy, that's fine with me.

MR. McGOVERN: Does that mean you're waiving your right to read it?

THE WITNESS: Yes.

MR. McGOVERN: We're finished.

(Whereupon, the deposition was adjourned at 10:32 a.m.)

(The original Defendant's Exhibit 1 and copies of Defendant's Exhibits 2 and 3 were retained by the court reporter to be attached to the original transcript.)

C E R T I F I C A T E

STATE OF CONNECTICUT

JUDICIAL DISTRICT OF ANSONIA/MILFORD

I, LYNNE STEIN, Notary Public within and for the State of Connecticut, duly commissioned and qualified, do hereby certify that pursuant to Notice, ALBERT CARL WEIHL, M.D., the deponent herein, was by me first duly sworn to testify the truth, the whole truth and nothing but the truth of his knowledge touching and concerning the matters in controversy in this case; that he was thereupon carefully examined upon his oath and his testimony reduced to writing by me; and that the deposition is a true record, to the best of my ability, of the testimony given by the witness.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand this 13th day of February, 2003, at Milford, Connecticut.

My Commission Expires:
January 31, 2004

LYNNE STEIN, Lic. No. 00110
Notary Public
State of Connecticut

INDEX TO TESTIMONY

INDEX TO DEFENDANT'S EXHIBITS

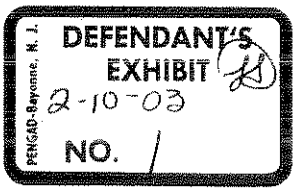
CURRICULUM VITAE

ALBERT C. WEIHL, M.D., FACEP
Suite 260, 464 Congress Ave.
New Haven, Connecticut 06519
(203) 785-5174 (office)
(203) 785-4580 (office fax)
e-mail: albert.weihl@yale.edu

Date of Birth: August 22, 1946, Cincinnati, Ohio

Positions:

9/2002 – Present	Co-Director, Chest Pain Center Yale-New Haven Hospital New Haven, Connecticut
12/2000 – 7/2001	Acting Section Chief/Department Chair Section of Emergency Medicine/Department of Emergency Services Yale University School of Medicine/Yale-New Haven Hospital New Haven, Connecticut
2/2000-9/2000:	Acting Residency Program Director Emergency Medicine Residency Program Yale-New Haven Medical Center New Haven, Connecticut
1997- Present:	Oral Board Examiner American Board of Emergency Medicine
1993 - 1998:	Residency Program Director Emergency Medicine Residency Program Yale-New Haven Medical Center New Haven, Connecticut
1991 - Present:	Assistant Professor Section of Emergency Medicine Departments of Surgery and Internal Medicine Yale University School of Medicine New Haven, Connecticut
1991 - Present:	Education Director Department of Emergency Services Yale-New Haven Hospital



1990 - 1998:	Assistant Medical Director Department of Emergency Services Yale New Haven Hospital
1989 - 1990:	Medical Director New Haven Sponsor Hospital Program Yale-New Haven Hospital/Hospital of Saint Raphael
1988 - 1990:	Acting Medical Director Department of Emergency Services Yale-New Haven Hospital
1987 - 1991:	Attending in Internal Medicine Department of Emergency Services Yale-New Haven Hospital New Haven, Connecticut
1982 - 2000	Emergency Department Physician Middlesex Hospital/Shoreline Clinic Middletown/Essex, Connecticut
1980 - 1991:	Assistant Clinical Professor Department of Internal Medicine Yale University School of Medicine New Haven, Connecticut
1982 - 1987:	Attending in Internal Medicine Hospital of Saint Raphael New Haven, Connecticut
1978 - present:	Attending Physician in Internal Medicine Yale-New Haven Hospital New Haven, Connecticut
1978 - 1987:	Physician, Department of Internal Medicine Community Health Care Plan 150 Sargent Drive New Haven, Connecticut
1977 - 1978:	Associate Staff Department of Emergency Services Fairfax Hospital Falls Church, Virginia

1976 - 1978:	Lieutenant Commander, Medical Corps United States Naval Reserve Hyperbaric Medicine and Physiology Department Naval Medical Research Institute Bethesda, Maryland
1975 - 1976:	Emergency Department Physician Winchester Hospital Winchester, Massachusetts
1974 - 1976:	Clinical and Research Fellow Endocrine and Thyroid Units Massachusetts General Hospital
1973 - 1974:	Senior Assistant Resident in Medicine Yale-New Haven Hospital
1972 - 1973:	Junior Assistant Resident in Medicine Yale-New Haven Hospital
1971 - 1972:	Intern in Medicine Yale-New Haven Hospital

Degrees:

1971	M.D. Yale University School of Medicine
1967	B.S. Molecular Biophysics - Yale College Degree earned in three years

Professional Organizations:

1994 - present	American Medical Informatics Association
1988 - present	Society for Academic Emergency Medicine
1987 - present	American College of Emergency Physicians
1975 - present	American College of Physicians

Board Certification:

1998	Re-certification, Diplomate, American Board of Emergency Medicine
1989	Diplomate, American Board of Emergency Medicine
1977	Diplomate, Subspecialty Board in Endocrinology and Metabolism
1974	Diplomate, American Board of Internal Medicine
1972	Diplomate, National Board of Medical Examiners

Licenses:

1992	Hawaii
1973	Connecticut

Committees and Boards:

September 2002	Co-Chairman, 5th Fifth National Congress of Chest Pain Centers Society of Chest Pain Centers and Providers New Haven, Connecticut
2001-present	Claims Committee (Risk Management) Yale-New Haven Medical Center
2000-present	Ethics Committee Yale-New Haven Medical Center
2/2000-9/2000	Graduate Medical Education Committee Yale-New Haven Medical Center
1998-present	Editorial Board Emergency Medicine Reports
1996- 1998	Chairman, Subcommittee on Medical-Legal Education Graduate Medical Education Committee Yale-New Haven Medical Center
1995 - present	Chairman, Clinical Computer Workstation Committee Yale-New Haven Medical Center
1995 - 1998	Graduate Medical Education Committee Yale-New Haven Medical Center

1995 - 1998	Computer Committee Department of Surgery Yale University School of Medicine
1994 - 1998	Education Committee Department of Surgery Yale University School of Medicine
1993 - present	Clinical Computer Workstation Committee Yale-New Haven Medical Center
1994 - present	Pharmacy and Therapeutics Committee Yale-New Haven Hospital
1993 - 1995	Committee of Residency Program Directors Yale-New Haven Hospital
1992 - 1995	Clinical Firm Chiefs Committee Department of Internal Medicine Yale University School of Medicine
1992 - 1998	Clinical Education Committee Department of Medicine Yale University School of Medicine
1988 - 1990	Utilization Review Committee Yale-New Haven Hospital
1988 - 1990	Quality Assurance Committee Yale-New Haven Hospital
1988 - 1990	Claims Committee (Risk Management) Yale-New Haven Hospital
1987 - 1989	Pharmacy and Therapeutics Committee Yale-New Haven Hospital
1987 - 1990	Emergency Service Advisory Committee (Chairman 1988 - 1990) Yale-New Haven Hospital
1987 - 1990	Disaster Committee (Chairman 1988 - 1990 Yale-New Haven Hospital

Honors and Awards:

1999	Emergency Medicine Residents Award for Excellence in Emergency Medicine
1991	Teaching Award, Department of Internal Medicine
1990	Fellow, American College of Emergency Physicians
1971	M.D., Cum Laude, Yale University School of Medicine
1971	Campbell Prize, Yale University School of Medicine; Highest rank in class
1971	Thesis selected as one of ten best in medical school class
1971	Alpha Omega Alpha Medical Honor Society
1967	B.S., Magna Cum Laude, Yale College
1967	Honors with Exceptional Distinction in Field of Major, Yale College
1966	Phi Beta Kappa, Yale College

9/16/02

Publications:

1. Weihl, A.C., G.H. Daniels, E.C. Ridgway and F. Maloof. Thyroid function during the early phase of subacute thyroiditis. J. Clin. Endo. and Metab. 44:1107-1114, 1977.

2. Hier, D.B., and A.C. Weihl. Chronic hydrocephalus associated with growth hormone deficiency and short stature. Ann. Neurol. 2:246-248, 1977.

3. Weihl, A.C. Endocrine responses to elevated ambient pressure. In: Proc. of Satellite Sympo. on Environmental Endocrinology. XXVII Internl. Physiol. Congr. Pub. Springer-Verlag, 1977.

4. Re, R.N., I.A. Kourides, A.C. Weihl and F. Maloof. Relationship between endogenous hyper-prolactinenia and plasma aldosterone. Clin. Endocr. 10 (2):187-193, 1979.

5. Weihl, A.C., H.C. Langworthy, R.P. Layton, P.F. Hoar and L.W. Raymond. Metabolic responses of resting divers immersed in 25.5 C. and 33 C. water. Unders. Biom. 5 (1):31-31, 1978.

6. Robertson, C.H., A.C. Weihl and M.E. Bradley. Plasma catechol changes on intermittent positive pressure breathing with positive end -expiratory pressure. Ann. R. Resp. D. 117 (4):385, 1978.

7. Weihl, A.C., H.C. Langworthy, A.R. Manalays and R.P. Layton. Metabolic responses of resting man immersed in 25.5 C. 33 C. water. Aviat. Sp. En. 52 (2): 88-91, 1981.

8. Ragosta, M., A.C. Weihl and L.E. Rosenfeld. A potentially fatal interaction between erythromycin and disopyramide. Am. J. Med 86 (4): 465-466, 1989.

9. Newton, E. and A.C. Weihl. Emergency Department Treatment of Alcohol Abuse: Impact On Availability of Emergency Services. Ann. Emerg. Med. 19(4):495 abst., 1990

5/8/98

Schiff & Dickson, L.L.C.
Attorneys at Law

The Standard Building - Sixth Floor
1370 Ontario Street
Cleveland, Ohio 44113-1701
telephone (216) 621-7743
facsimile (216) 621-6528

3:10
3:35
T.C. MP
1/5/00
T.C. 2/3/00
atty. Dickson

August 16, 1999

MEDQUEST
116 East 30th Street
New York, NY 10016

Attention: Donna

RE: Christopher B. Toon

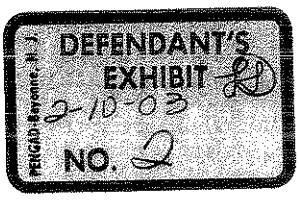
Dear Donna:

Please be advised that we represent Christopher B. Toon. On February 21, 1999, Christopher B. Toon was having gastrointestinal problems and presented himself to Madison Urgent Care with a swollen stomach. Mr. Toon was also experiencing diaharea, nausea, vomiting, fever and his complexion was darker than normal. Dr. Padival took Mr. Toon's vitals. He diagnosed Mr. Toon as having gastritis. No x-rays were taken and no blood work was done at this time. Dr. Padival told Mr. Toon that he would be better in two days. Mr. Toon's condition worsened. He hardly ate. He was sleeping more than usual and his complexion continued to darken. Christopher B. Toon noticed that he was jaundiced and his stomach was even more bloated than before. Mr. Toon went to MedCentral/Mansfield General where he was admitted for surgery for a ruptured appendix.

The potential Defendants in this case are Madison Urgent Care and Dr. Padival.

I am enclosing copies of records from Madison Urgent Care, Mansfield General Hospital, Ronald J. Golbus, M.D., and Prity S. Vaiddya, M.D. If you need any additional records or materials, please call me.

Please have an appropriate expert review all of these records to determine whether or not any of the care that was rendered to Mr. Toon was inadequate or unreasonable in any way. Specifically, I would like an expert to investigate whether

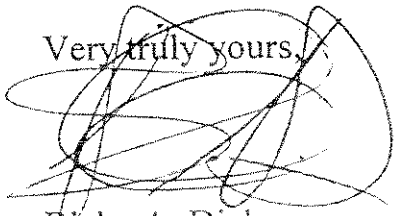


or not there was a delay in the diagnosis of Mr. Toon's condition and whether or not that delay caused Mr. Toon any injury.

Please call me if you have any questions or concerns. As always, I would like the doctor to call me with his or her opinion.

Thank you very much for your time and consideration.

Very truly yours,



Blake A. Dickson

BAD:ama
Enclosures

12/20

Dear al

Enclosed is the Christopher, Tom case for your review.

Please call **Karen Beth Cohen, EXT # 107** or E-mail: **kbcohen@medquestltd.com** with your findings **on or before**

1/7

Should you require more than 2 hours for review, **please call medQuest** first so we can secure prior approval from the attorney.

If **prior approval is not obtained** through our office, we are **unable to guarantee payment**.

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Yale University

School of Medicine
Department of Surgery
Section of Emergency Medicine
464 Congress Avenue
New Haven, Connecticut 06519-1315

Friedman, Domiano & Smith Co., L.P.A.
1370 Ontario Street, # 600
Cleveland, Ohio 44113-1701

June 3, 2000

RE: Christopher B. Toon

Dear Attorney Delahunty:

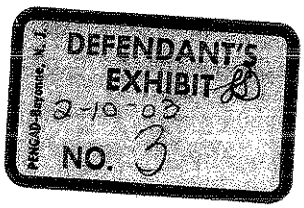
I have reviewed the medical records on the above named individual with particular attention to the visit to Madison Urgent Care on February 21, 1999, and provide the following summary and analysis:

Mr. Christopher Toon, an obese 22 year old man, presented to Madison Urgent Care on February 21, 1999 with a chief complaint of "loose BM's-not able to eat, stomach pain-nausea red rash on back and abd". Vital signs revealed a temperature of 100.9 degrees. Past medical history and medications were listed as none.

Evaluation by Dr. Padival recorded "3 days of diarrhea, abd cramps and nausea, not able to eat or drink". Physical examination noted "febrile, pt diffusely tender with burn mark on abd, BS increased" Impression listed diagnoses of "abd pain, G. enteritis", and the patient was prescribed Lomotil and Tylenol. No discharge instructions are contained within the medical records from Madison Urgent Care.

Mr. Toon next presented to Mansfield General Hospital on February 26, 1999 where he was found at surgery on that date to have "1. Ruptured appendix with peritonitis, acute small bowel obstruction and overwhelming sepsis, and 2. Cecal perforation". He remained in the hospital until March 11, 1999, requiring intravenous antibiotics.

It is my considered opinion that the evaluation and treatment provided to Mr. Toon at Madison Urgent Care on February 21, 1999 fell below applicable standards of care. Mr. Toon was discharged without appropriate discharge instructions, allowing him to wait an additional five days before seeking reevaluation of his abdominal condition. Any patient presenting with signs and symptoms such as manifested by Mr. Toon on February 21, 1999, must have appendicitis considered in the differential diagnosis, and



must be told to return for reevaluation within eight to twelve hours after discharge if his symptoms do not improve. Reevaluation within this time frame allows the diagnosis, which may not be immediately apparent on first presentation, to be made much earlier in the clinical course, and allows early surgical treatment. Allowing this patient to wait five days before diagnosis and treatment permitted Mr. Toon to develop perforation and diffuse peritonitis, leading to prolonged hospital stay, and exposing him to greater risk of complications in the future, such as increased risk of adhesions and bowel obstruction.

Had Mr. Toon been told to return for reevaluation in the time frame indicated above, more probably than not the diagnosis of appendicitis would have been made, leading to immediate surgery, avoidance of prolonged hospitalization and reduction in future complications.

Sincerely yours,

Albert C. Weihl, M.D., FACEP
Assistant Professor of Medicine and Surgery
Section of Emergency Medicine
Department of Surgery
Yale University School of Medicine
Director of Education
Department of Emergency Services
Yale-New Haven Hospital