IN THE COURT OF COMMON PLEAS

OF RICHLAND COUNTY, OHIO

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Christopher Toon , et al.,

Plaintiffs,

vs.

Case No. 482-H

Bhat and Padival, M.D.'s, Inc., et al.,

Defendants.

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Deposition of ROBERT C. WOSKOBNICK, D.O., an Expert Witness herein, called by the Plaintiffs for cross-examination under the statute, taken before me, Adele L. Helmick, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Robert C. Woskobnick, D.O., 1327 Cameron Avenue, Columbus, Ohio, on Monday, February 24, 2003, at 10:32 o'clock a.m.

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APPEARANCES:

Friedman, Domiano and Smith
Sixth Floor
Standard Building
1370 Ontario Street
Cleveland, Ohio 44113-1704
By Thomas E. Conway, Esq.,

On behalf of the Plaintiffs.

Hammond and Sewards
556 East Town Street
Columbus, Ohio 43215
By James M. McGovern, Esq.,

On behalf of the Defendants.

Monday Morning Session

February 24, 2003

10:32 o'clock a.m.

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It is stipulated by and between counsel for the respective parties that the deposition of ROBERT C. WOSKOBNICK, D.O., an Expert Witness herein, called by the Plaintiffs for cross-examination under the statute, may be taken at this time by the Notary, pursuant to notice and stipulations of counsel; that said deposition may be reduced to writing in stenotype by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualification of the Notary is waived; that the signature of the said ROBERT C. WOSKOBNICK, D.O. to the transcript of his deposition is expressly waived by counsel and the witness; said deposition to have the same force and effect as though signed by the said ROBERT C. WOSKOBNICK, D.O.

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Thereupon, Deposition Exhibit A was marked for purposes of identification.

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ROBERT C. WOSKOBNICK, D.O.

by me first duly sworn, as hereinafter certified, deposes and says as follows:

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CROSS-EXAMINATION

BY MR. CONWAY:

Q. Doctor, my name is Tom Conway. I represent Chris Toon in this case. I'm going to be taking your deposition.

I'd like to go over just a few ground rules with you, so that --

A. Sure.

Q. -- we can move this thing along.

I'm going to be asking you your knowledge of the case, as well as your opinion.

Everything you say is being taken down by the court reporter. It has the same legal significance as if you were in front

of a judge and jury.

Do you understand that?

A. Yes.

Q. Please, if you can, answer any questions with a verbal answer as opposed to a nod of the head so that the court reporter can take it down.

And, obviously, only one of us can speak at the same time.

Okay?

A. Yes.

Q. I don't want you to answer any question that you don't understand. If you don't understand a question that I ask you, somehow indicate that to me. I'll be glad to rephrase it or repeat it for you.

If you do answer a question, I'm going to assume and rely upon the fact that you understood it.

Is that fair?

A. Yes.

Q. At any time you want to take a break, feel free to do so.

At any time that you want to go

back and add, subtract, delete, amend, any part of your previously given testimony, feel free to do so.

Okay?

A. Yes.

Q. I want to leave here today knowing what your thoughts on this case are so that I'm not surprised at trial.

All right?

A. Okay. Yes.

Q. Doctor, would you agree that appendicitis can be a life-threatening medical emergency?

A. Yes.

Q. Do you agree that appendicitis can cause a ruptured appendix, which can cause serious illness or even death?

A. Can you -- well, can you rephrase that?

Q. Sure.

MR. CONWAY: Can you --

THE WITNESS: It doesn't always rupture.

MR. CONWAY: Right.

Could you repeat the question?

(The record is read back as requested.)

THE WITNESS: Appendicitis can be ruptured, but not always.

But, sure, that can cause serious illness or death.

BY MR. CONWAY:

Q. A treating physician has to be, obviously, aware of the potential danger of appendicitis leading to a ruptured appendix, correct?

A. Yes.

Q. Doctor, have you ever written a note for one of your patients excusing them from work?

A. Yes, all the time.

Q. What are your reasons for writing the note excusing a patient from work?

A. A lot of times, they need a few days off to recover, to get better, then go back.

Some jobs, if you're in a labor position, you just simply can't work, where

if you're more of a white-collar, perhaps you could work.

But some patients request it off. They'll say, well, can I have off so-and-so days, and if it's reasonable, I say yes.

We usually never deny them a request, because, then obviously, they're unhappy.

And sometimes, I tell patients, you need to take several days off, whatever amount of time, depending on the condition, because I think you won't get better unless you rest, take care of yourself.

Q. I assume that you've had cases where a patient has come in, you've diagnosed them with a certain sickness, and you've made a determination that they're going to need a certain number of days off work; would that be correct?

A. Yes.

Q. Do you write that note for the time period which you feel the patient will need to take work off?

A. It depends. Sometimes, you have

to fill out an FMLA form with the government.

Q. Let's assume there's no FMLA form.

A. Okay. Sometimes, we do write out specific requests, but we usually ask them. Sometimes, they'll just say, well, I'll take it off. I don't have any -- depends on their boss and their work situation. Some situations, you don't need a note, and some you do.

Q. It depends upon the patient and the type of job he has, correct?

A. And the employer.

If you're self-employed, you don't, obviously. Or if you're a higher level, you usually don't need a note.

Usually, lower level, in my experience, lower-level workers who have less -- what's the word I want?

Say somebody at McDonald's would need a note and somebody --

Q. Somebody with no economic bargaining position needs a note?

A. I agree. I mean, I think that's

fair.
Q. I assume you read Billie Jean Toon's deposition transcript?
A. Yes.
Q. Did you read in there where Chris Toon was given a note to take off work for five days?
A. Yes.
Q. Did you read in Billie Jean Toon's deposition transcript that Chris called his employer and told the employer that he would not be able to work for five days?
A. I remember the first statement you made rather than the second, but I'm assuming he would have called so that they would know.
Q. Would it be -- was it your -- strike that.
Was it your observation or your impression from reading Billie Jean Toon's deposition transcript that both Chris Toon and Billie Jean Toon were under the impression that he was going to be off work for five days due to his illness?

A. Yes.

MR. McGOVERN: Objection.

Tom, can we go off the record for a second?

(A discussion is held off the record.)

BY MR. CONWAY:

Q. Did you read in Billie Jean Toon's deposition transcript that she testified that she observed Dr. Padival only palpating Chris's lower right side?

A. Yes. I recall that.

Q. All right. If her observations are correct, would Dr. Padival have been below the standard of care for a physician evaluating a patient with complaints of abdominal pain?

A. Yes. If that's the truth, sure.

Q. From your reading of this, the depositions, both Chris's and Billie Jean Toon's, were you under the impression that Chris was experiencing severe pain?

MR. McGOVERN: Objection.

THE WITNESS: Answer or --

MR. CONWAY: Yes. You can answer.
MR. McGOVERN: Yeah. Go ahead.
THE WITNESS: Yes.
BY MR. CONWAY:
Q. In fact, I think at one point, do you recall it being rated as a 10 out of 10?
A. I don't recall that specifically.
Q. Did you have an opportunity to read Dr. Padival's deposition?
A. Yes.
Q. Did you read at page 59 where Dr. Padival agreed with the statement that, quote, any patient presenting with the signs and symptoms such as manifested by Mr. Toon on February 21st, 1999 must have appendicitis considered in the differential diagnosis?
MR. McGOVERN: Objection. That is not an accurate recollection of -- or accurate description of the deposition testimony based on the errata sheet.
If you're saying absent the errata sheet --
MR. CONWAY: I'm saying his

deposition transcript.

MR. McGOVERN: You can answer the question. I'm just putting objections on the record.

THE WITNESS: Okay.

MR. McGOVERN: I'm sorry to confuse you.

THE WITNESS: I would say yes.

MR. McGOVERN: And just so that I understand, can you read back his question?

(The record is read back as requested.)

THE WITNESS: Yes.

BY MR. CONWAY:

Q. And that would be the standard of care to include appendicitis in the differential diagnosis, correct?

A. That's correct. Sure.

Q. Doctor, did you read Dr. Padival's deposition where he agreed that, quote, a patient such as Mr. Toon must be told that he has to return to a doctor for reevaluation in eight to 12 hours, in the particular situation that we had in this

case?

MR. McGOVERN: Are you just asking him whether he read that part of the deposition?

BY MR. CONWAY:

Q. I'm asking, do you recall reading that part of the deposition, number one?

A. Yes.

Q. All right. Do you agree with that principle?

MR. McGOVERN: And, again, now, you're asking him whether he agrees with what Dr. Weihl said?

BY MR. CONWAY:

Q. I'm asking, Dr. Padival, in his deposition, I'm not talking about the errata sheet, I'm talking about the deposition, agreed with the proposition that a patient such as Mr. Toon must be told that he has to return to a doctor for reevaluation in eight to 12 hours.

Do you agree with that?

MR. McGOVERN: I'm going to object that Dr. Padival didn't say that in his

deposition.

If you want to read verbatim from his deposition, go ahead.

But you're basically asking him to agree with Dr. Weihl's testimony, and we're not going to go that way again.

If you want to read Dr. Weihl's report and ask him if he agrees with that, that's fine. But don't --

BY MR. CONWAY:

Q. Doctor, you have Dr. Padival's deposition in front of you, don't you?

A. Yes.

Q. Okay. Let's go to that.

A. What page again?

Q. Page 61, okay, the bottom of page 61 to the top of page 62, question, all right, Dr. Weihl is specifically giving a specific period of time that, in his opinion, a patient such as Mr. Toon must be told that he has to return for reevaluation, and the time period that Dr. Weihl believes emergency medicine standard of care requires be given to the patient is eight to 12

hours; do you agree with that?

You see my question there?

A. Mm-hmm.

Q. And then you have to answer out loud, yes or no.

A. Do I agree with Dr. Weihl's?

Q. Do you agree that that's the question, that I read it correctly from the deposition transcript?

A. Bear with me. I'm just looking.

Q. Take your time.

A. We're talking about right here, correct (indicating)?

Q. Correct.

I just read what the question was.

Okay. You understand what the question was that was addressed to Dr. Padival, right?

A. Mm-hmm.

Q. I'm just saying you have to answer out loud instead of saying mm-hmm, because she can't take that down.

A. Yes. I see that.

Q. All right. Do you see

Dr. Padival's answer?

It's, yes, probably?

A. Yes.

Q. Do you agree with his answer to that question?

MR. McGOVERN: And I'm going to object in the sense that Dr. Padival revised his answer in his errata sheet.

MR. CONWAY: I'm aware of that. I'm asking him the question about the deposition. I'm going to ask him questions about the errata sheet in a moment.

BY MR. CONWAY:

Q. Do you agree with Dr. Padival's answer that he gave at the time of his deposition on July 10th, 2002?

MR. McGOVERN: And I don't want there to be any confusion.

Essentially, you're asking him if he agrees with Dr. Weihl's opinion.

MR. CONWAY: Jim, I haven't had to do this in a number of months.

If you want to object, fine.

If the doctor needs me to explain

a question, I'll be glad to rephrase it.

I'm asking him if he agrees with the answer that Dr. Padival gave to my question back at the time of Dr. Padival's deposition on July 10th. That's all.

BY MR. CONWAY:

Q. Do you agree with the answer that Dr. Padival gave?

A. Do I agree that the answer is there, or do I agree with --

Q. Do you agree with the answer that Dr. Padival gave?

A. No.

Q. You don't?

What do you disagree with?

A. I typically would tell patients one to two days, not eight to 12 hours.

I've seen thousands of abdominal pains over the years.

It sounds like he's equivocal here. He says yes, then probably.

Q. Okay.

A. Probably is a --

Q. What do you believe the standard

of care for an emergency medicine physician is to require a patient such as Christopher Toon to return for reevaluation?

A. If you're in an emergency room, it's different between an emergency room and urgent care, perhaps, because I've worked both venues, in that --

Q. Okay. Go ahead. Finish your answer.

A. In the ER, you have the ability to call a surgeon in relatively easy, especially if you're in a teaching hospital.

Right?

If you're in urgent care, you don't have a surgeon you can call to the center.

Q. Okay. My question, though, deals with the time that a physician, an emergency medicine physician --

A. Sure.

Q. -- should give a patient such as Chris Toon to return for reevaluation.

And you're saying one to two days?

A. I'd say that's reasonable.

Q. Have you ever practiced as an emergency room physician?
A. Yes, for five years.
Q. Have you ever practiced as an urgent care physician?
A. Yeah, for 10 years off and on.
Q. Do you believe that there is a difference between the standard of care required of an emergency room physician and a physician working at an urgent care center?
A. They're different in that the urgent care is open only a certain amount of time during the day, and a lot of times -- anytime you get anything that's really bad, you would have to refer it out.

Like, say, a heart attack comes in. You have limited ability to diagnose at urgent care, so you almost have to be smarter than an ER doctor. An ER doctor can order tests, every test known to medical science, in most emergency rooms, which makes your job easier to diagnose. In urgent care, you have to rely more on your

clinical acumen, if you will.

Q. Doesn't the urgent care physician have the ability to immediately refer a patient to an emergency room --

A. Sure.

Q. -- should he suspect a diagnosis of appendicitis?

A. Sure.

Q. Would you agree that -- that a physician who works at an urgent care center should have the same clinical expertise in evaluating a patient for possible appendicitis as should a physician working in a regular emergency room?

A. That's a tricky question.

Most -- when you have an urgent care setting, most patients that come in there should be ambulatory and be able to leave, in general. So they come in; they go home.

It's rare that they leave by squad or have to go to the ER, in my experience, and I've worked in both venues. There's a fine line. You could go months and not send

anyone to the ER, or you could send two or three people in the same shift from the urgent care to the ER.

Does that help you?

Q. No.

MR. CONWAY: And if you just want to read back that last question I asked?

MR. McGOVERN: Doctor, just try to listen to the question that's asked, and answer that question, and things will go quicker.

(The record is read back as requested.)

THE WITNESS: The answer is yes. That's --

BY MR. CONWAY:

Q. Doctor, you've had an opportunity to read through Dr. Padival's chart from Madison Urgent Care in this case, correct?

A. Yes.

Q. Would you agree that the charting in this matter is deficient?

MR. McGOVERN: Objection --

THE WITNESS: Can I look at it?

BY MR. CONWAY:
Q. Look at whatever you want to. Sure.
MR. McGOVERN: -- as to the meaning of deficient.
MR. CONWAY: Based upon that very good suggestion, I'll rephrase my question.
BY MR. CONWAY:
Q. Do you believe that the charting in this case, on the part of Dr. Padival, is below the standard of care?
A. I would say no or not necessarily.
Q. You want to explain your answer?
A. I've seen physicians write less --
Q. Okay.
A. -- over the years.
Q. I would agree.
But I'm asking you, in this particular case, reviewing Dr. Padival's chart, do you believe his charting in this particular case is below the standard of care?
A. I think it meets the minimal standard of care.

Q. You do?
A. A dictated note would be the gold standard. Like, a dictated report would be the gold standard of care.
He certainly has abdominal exam on here. He has the diagnosis. He has the medications.
Q. Is there any medical history?
A. Two days of diarrhea, abdominal cramps and nausea, not able to eat or drink.
Q. Was it your understanding when you reviewed his chart, Doctor, and prepared your report that Mr. Toon had experienced two days of diarrhea and cramps and nausea and not being able to eat or drink?
A. I think my recollection is two to three days.
Q. In your report, Doctor, showing what's been marked for Exhibit A, did you proofread this report prior to sending it to Mr. Hammond and Mr. McGovern?
A. Mm-hmm. Mm-hmm.
Here, it has a two-day history.
Q. All right. There would be a

difference in this case between a patient presenting with these clinical signs for two days versus three days, correct?

A. Sorry. Rephrase.

Q. Would it be significant to you with a patient such as Mr. Toon that he was experiencing a three-day history of these different symptoms as opposed to the two-day history that you have in your report?

A. Not necessarily.

Q. Why not?

A. Because with gastroenteritis, it could be several days. I mean, there's no specific -- it's not, like, 24 hours, then it becomes something else, or 48 hours becomes another diagnosis. There's no way to quantify it.

Q. Is gastroenteritis the type of condition that can last an indeterminate time period?

A. It can if you have -- due to infectious etiology that's not treated, like traveller's diarrhea.

Q. What's traveller's diarrhea?

A. If you go to Mexico, and you drink the water, and you come back, and you have to have antibiotics for it to clear. I've had patients come back who'd had it for a month off and on.

Q. Off and on?

A. Correct, intermittently.

Q. I wasn't talking so much as the form of the note or the charting that Dr. Padival had done, but rather the content. All right. Let's go through the content of Dr. Padival's note.

Is there anywhere in the charting that you saw any reference to whether or not Dr. Padival asked Chris Toon as to whether or not he'd previously had his appendix removed?

A. I don't see it.

Q. Is that important?

Is that an important question to ask a patient who is suffering from abdominal pain such as Chris Toon was?

A. Well, I'm assuming if he was a new patient there was a long history of things

he had to fill out about past surgical history that should be -- you don't always ask -- with any new patient, you usually have a medical record that shows past surgical history, past medical history, so you have that on file.

You don't necessarily ask the questions, but you review the history with them, which I think there was supposed to be that with this, but I don't see it.

Q. Would it be below the standard of care if Dr. Padival was unaware of whether or not Chris Toon had had a prior appendix removed at the time that he discharged Chris Toon?

MR. McGOVERN: Objection.

MR. CONWAY: You can answer.

THE WITNESS: I think it would -- I think it could be. Sure. I think you could say that.

BY MR. CONWAY:

Q. All right. Let's go to complaints. All right.

You'd agree with me that

Dr. Padival's chart says three days of diarrhea and cramps and nausea?
A. Well, it looks like it could be a two or a three, to be honest with you.
Q. Do you recall what Dr. Padival testified to at his deposition?
A. I believe he said two.
Q. Not able to eat or drink --
MR. McGOVERN: Was that a question?
MR. CONWAY: Not really.
MR. McGOVERN: Okay.
BY MR. CONWAY:
Q. Was there -- looking at this charting, was there any guarding during the examination of Mr. Toon by Dr. Padival?
A. I don't see where it says that.
It looks like it says diffusely tender.
Q. What is the significance of a patient experiencing guarding?
A. That means you have peritoneal irritation, which would be from a ruptured appendix or other entities, but peritoneal

irritation, meaning infection that's spreading throughout the abdominal cavity.

Q. What is guarding, the significance of guarding?

A. A patient -- I've seen patients before that I've -- literally, if you lie your hand gently, they can't -- they're rigid, rock solid. They can't even tolerate the lightest touch.

Q. And there can be degrees of guarding, correct?

A. Certainly. Certainly.

Q. And guarding, whether or not there is guarding, is a valuable piece of information in deciding whether or not you have possibly a ruptured appendix; is that correct?

A. Sure. Yes.

Q. Was there any rebounding noted by Dr. Padival during his examination of Chris Toon?

A. I don't see it.

Q. What's rebounding, Doctor?

A. Rebound is when you push in, and

you let up, and then they get pain.
Q. What's the significance of that as to diagnosing possible appendicitis?
A. Again, it shows peritoneal irritation, or a possible ruptured appendix, or it could be a ruptured something else. But --
Q. So that is a significant symptom that needs to be evaluated by a doctor to determine whether or not there could be possible appendicitis, correct?
A. Sure. I agree.
Q. Was Mr. Toon febrile?
Did he have a temperature at the time he came in?
A. I believe it was 100.2.
Can I look at the record?
Q. Help yourself.
A. Looks like it's 100 something. It's kind of cut off on my -- he has a low-grade fever.
Q. Can a low-grade fever be indicative of an infectious process that's going on with a patient?

A. Certainly.
Q. All right. Is it more probable -- strike that.
What type of infectious process can an elevated temperature be indicative of?
A. Depends on how high the temperature is.
Q. Let's deal with his temperature of 100.2.
A. Sure. This is a moderate elevation.
I see these all the time. I don't even pay attention to them as a rule until it gets above 101.5, 102, 103. It is common to see someone with 100 -- is it point two or --
Q. Common in a patient that you suspect has gastroenteritis?
A. Correct. Exactly.
Q. All right. What type of disease process is gastroenteritis?
A. It could be an infectious process, secondary to a viral etiology, more likely

this time of year.
Q. If it was secondary to a viral etiology, would the patient experience a temperature?
A. Not always, depends on their age. If they're very elderly, they might not. Very elderly don't have a temperature usually. Very young have a high temperature. Young adults can have a temperature and not even have a temperature.
Everyone's different. There's no way to -- it's not cut and dry, like everybody thinks.
Q. Is -- would a person who's experiencing appendicitis have an elevated temperature?
A. Usually be much higher.
Q. Would a patient experiencing a ruptured appendix have a higher temperature?
A. Usually, they'd have a real high temperature, although -- can I continue?
Q. Yes. You may.
A. In medicine, my observation

practicing the last 13 years is you can see anything. I've seen patients very sick who don't have a temperature and end up having pneumonia, for instance. It's not always hard and fast, like everybody thinks outside of medicine.

Q. Doctor, what are the signs and symptoms of appendicitis?

A. How I perceive it?

Q. I want to know, yeah, what your knowledge of the signs and symptoms of appendicitis are.

A. Usually, the patient presents. They look deathly ill. A lot of times, with patients, you look at them, and you -- that's my first thing, is I look at them as a whole, check their vital signs, is their pulse --

Q. What vital signs?

A. I would check their temperature, obviously; pulse; respiratory rate; blood pressure --

Q. All right.

A. -- if they've had any weight loss

over the last several days.
Q. Pulse, respiratory rate, blood pressure, and what else?
Weight loss?
A. Weight loss.
Q. What else?
A. I would get a history.
Are we looking at what I would do?
Q. Yeah. I want to know what you would do.
A. I would get a thorough history, ask them how long they've been sick, what they've eaten, have they traveled out of the country, have they drank well water.
Q. Why would well water --
A. Because you can have things, like Giardia lamblia hang out in wells, and you get sick that way, or salmonella.
I had a nurse friend, her son got salmonella from a well, and he ended up in the intensive care and had kidney damage. So --
Q. All right. What else?
A. As far as history or physical

exam?
Q. Just whatever, I want --
A. If they're taking any medications, if you're on long-term antibiotics you can get gastroenteritis from Clostridium difficile.
Q. That's pretty serious, isn't it?
A. Could be. It could kill you.
It's an iatrogenic etiology, then.
I'm trying to think historywise.
MR. McGOVERN: Are you asking him appendicitis or gastroenteritis?
MR. CONWAY: I'm asking appendicitis.
He's giving me the things he's looking at in determining whether someone has appendicitis, correct?
THE WITNESS: Oh, I was thinking we were looking at abdominal pain, but I can specify.
BY MR. CONWAY:
Q. All right. Fine. Yeah. What I was asking, what were the signs and symptoms that you would look for in --

A. Narrowing it to appendicitis?
Q. Yeah.
A. Okay. If they've had nausea, vomiting, diarrhea, if they had a fever, chills, if they measured their fever at home, how long they've been sick is an important thing, I think.
Q. Would you agree that the pulse, respiratory rate, blood pressure, weight loss, are also factors that you would -- you would weigh in determining whether someone has appendicitis?
A. Especially a temperature.
Q. Anything else that you would look for?
A. If they've had an appendectomy before, if they had abdominal surgery before.

Are we talking, now, physical exam?
Q. Let's go to physicals. Well, yeah, let's go to physical exam.

What are you looking for then?
A. I've diagnosed them -- I'm not

trying to be egoistical. I've diagnosed them before just by looking at them, how they walk in the room, if they are walking or if they're in a wheelchair.

Usually, somebody that's really sick will have to be brought in with a wheelchair. They can't walk.

So if they ambulate, that tells me that they're not that sick. If they can move their legs, there's not enough peritoneal irritation, that they can walk on their own.

Does that make any sense?

Q. What else about your physical exam would you look at?

A. Check to see if they're sweating, they're perspiring, see if they're dehydrated, look in their mouth, if they have saliva. That will give you an indication that they're dehydrated. I usually look at the patient's -- I do eyes, ears, nose, throat, check their neck. There could always be meningitis. Listen to the heart and lungs.

Then in the abdominal exam, check the bowel sounds with the stethoscope. You know, a lot of times, you start your abdominal exam with four quadrants, and if I do think they have appendicitis I usually wait for the right lower quadrant last.

Q. Why is that?

A. Because if they're really irritated, I don't want to make them apprehensive by pushing their -- like, I don't want them to jam -- some doctors are heavy-handed. I have a real light touch. I think it serves you well.

Q. Anything else come to mind?

A. When I'm looking for appendicitis?

Q. Or to rule in or to rule out appendicitis?

A. If I had the ability to do blood work, that would be helpful, although, although, you could have a normal white count and still have appendicitis.

If I had the ability to get a CAT scan or x-rays, abdominal films, that might be useful, although a lot of appendicitis is

on clinical exam, in my experience. I can usually tell.

If I had to say the three main things I would look at to narrow it down would be fever; if they can ambulate or not, if they can't ambulate then they're really definitely sick with their abdominal complaint; and then right lower quadrant tenderness that's localized with rebound or guarding.

Some patients are so sick they don't even want you to touch the lightest touch.

Q. Obviously, when a patient comes in and you're looking to rule in or rule out appendicitis, there can be different stages of the disease process --

A. Sure.

Q. -- a patient is at?

A. Of course.

Q. They may be at a very early stage where some of the symptoms and signs aren't as -- aren't as serious as later on?

A. Sure.

Q. Okay.
A. Of course.
Q. Do you believe that you're a reasonable and prudent physician?
A. Yes.
Q. Let's go through some things.
In reading from the chart here, was there any indication of whether or not Chris Toon was evaluated for whether he was sweating?
A. Let me just check.
I don't see that.
Q. Was there any indication that Chris Toon was evaluated for whether he could be dehydrated?
A. I don't see that.
Q. What's the significance of a patient who's dehydrated as it relates to possible appendicitis?
A. It means that they're so sick that they can't take oral fluids -- in two ways: Their fever is high, so they're perspiring; or they're having diarrhea or vomiting, losing fluids that way; and then they can't

take fluids in, they're so sick.
Q. Is there such a concept as third spacing with regard to an abdominal inspection?
A. Yes.
Q. Do you want to explain your knowledge of how that can possibly cause dehydration?
A. If you have fluid in a localized infection in the abdomen, say, you get a fluid buildup there. It's taking fluid away from the intravascular space.
I'm not sure if that's what you're --
Q. Is that your understanding of what third spacing is as it relates to an abdominal infection and how dehydration can occur?
A. Yes.
Q. Were Chris Toon's eyes, ears, nose, and throat ever evaluated by Dr. Padival?
MR. McGOVERN: Objection.
THE WITNESS: Not that I see.

BY MR. CONWAY:

Q. Were Chris Toon's heart or lungs checked or listened to by Dr. Padival?

A. Not that I see --

MR. McGOVERN: Objection.

THE WITNESS: -- in the record.

BY MR. CONWAY:

Q. Have you when you were a -- strike that.

When you were an urgent care physician, and you suspected that a patient came in and would need a blood test to help rule in or rule out a condition, would you order that for a patient?

A. Not always.

Some patients, if they're self-pays, they don't want you to run up their bill. So they'll tell you, well, I don't want to get a blood test, or, I don't want an x-ray, I can't afford it.

Q. If that was the case, Doctor, would you chart the fact that you recommended that the patient have that certain diagnostic test and that the patient

refused?
A. Yes.
Q. That's elemental to cover yourself, correct?
A. Yes. Yes.
Q. All right. Is there any indication that it was suggested to Chris Toon that he needed blood work in this case and that he refused to have the blood work done?
A. I don't see that.
Q. Once again, and I would assume this answer would be similar to your answer on blood tests, if you had -- excuse me. I'm sorry.
A. That's all right.
Q. If you had a situation when you were an urgent care physician in which you determined that potentially the patient had a condition that x-rays would help in diagnosing, have you ordered x-rays for urgent care patients?
A. Sure. Yes.
Q. And you can refer them to a

hospital emergency room to have it done, correct?

A. Yes. Certainly.

Q. If you were -- well, strike that.

When you were at an urgent care center, obviously you're working less hours than an emergency room, correct?

Or did you work 24 hours at your urgent care?

A. Do you mean my shift or how --

Q. Yeah, when you were working as an urgent care physician.

A. I worked 12-hour shifts at the urgent care. I worked 12-hour shifts at the ER, or sometimes it's 10-hour shifts at the ER. It just depends. They're all different.

Q. I didn't phrase myself correctly.

Are most urgent care centers that you worked at open 24 hours?

A. No, not at all. Usually, it's 12 hours.

Q. That's --

A. Okay.

Q. I was not saying this properly.
So an urgent care center has limited hours that it's open, correct?
A. Correct.
Q. You've worked at those type of urgent care centers?
A. Yes.
Q. If you felt that a patient needed to be seen within a time period in which the urgent care center where you were working was not open, would you refer the patient to the emergency room?
A. I've done that before. Sure.
Q. That's reasonable and prudent, correct?
A. Sure.
Q. What was Chris Toon's blood pressure when he came in to be evaluated by Dr. Padival?
A. Can I look at the --
Q. Sure.
A. I mean, I don't remember that.
Q. Sure. Look at whatever you want.
A. 122 over 88.

Q. What was his respiration?
A. Well, I have -- it's cut off. It looks like it's a two, and then I can't see the other number on my -- so I'm assuming it's 20 something, not two. Two is not compatible with living.
Q. Not for long, at least.
A. Right.
MR. McGOVERN: Maybe if you were Houdini.
BY MR. CONWAY:
Q. What about his heart rate?
A. Eighty-four.
Q. Was there any history taken from Chris Toon regarding whether or not he had experienced a weight loss?
A. I don't see that.
I do see his weight documented, though.
Q. But that doesn't really help.
That wouldn't help you if you're trying to determine whether or not the patient has lost weight, correct?
You need to know what he started

with?
A. Correct.
Q. Was Chris Toon experiencing any chills when he came in to be seen by Dr. Padival?
A. I don't see where it's listed.
Q. What other conditions, other than appendicitis, cause the type of abdominal pain that Mr. Toon, a 21-year-old male, was experiencing?
A. We're just going to limit this to males, correct?
Q. Right. We're not going to include females. Yes. Just to clarify, we're dealing with a 21-year-old male.
A. Abdominal pain?
Q. Abdominal pain to the significance that Chris Toon and his wife have indicated they were experiencing -- or he was experiencing.
MR. McGOVERN: So you're asking --
MR. CONWAY: Strike that. I want to start over.
BY MR. CONWAY:

Q. Doctor, we're going to talk about abdominal pain in a 21-year-old male such as Chris Toon.
A. Okay.
Q. I would like to know what other conditions, other than appendicitis, could cause the type of pain that a 21-year-old male such as Chris Toon was experiencing?
A. The most obvious and prevalent would be gastroenteritis, especially the time of year he was seen. He could conceptually have a urinary tract infection, which would be kind of rare in a male; a kidney stone. He could have irritable bowel syndrome. It could be initial onset of Crohn's disease. He could have perforated gastric or a peptic ulcer. It would be rare to see in a male at that age, but he could have gallstones with an infection of the gallbladder. He could have hepatitis of any variety, A, B, or C.
You want me to continue?
I mean, I could keep --
Q. How about appendicitis?

A. Well, sure.
I thought you said not to say that one.
Q. No.
A. Sure. Obviously, that's in there.
Q. How about small bowel obstruction?
A. Certainly. That's usually in older folks, though. It would be unusual in a young person.
Q. Urinary tract infection can be diagnosed through blood work, correct?
A. Urine.
Q. Okay. I'm sorry.
Urinalysis?
A. Sure, urinalysis.
Q. Have you ever, when you were an urgent care physician, ordered a urine test or urinalysis?
A. Lots of times.
Q. Kidney stones, how would you diagnose that, doctor?
A. Urine, check for blood, and then you could get a KUB or flat plate of the kidneys.

Q. That's an x-ray?
A. Right.
But an IVP is a definitive test. You have to send somebody to the hospital for that. That's a test with dye that goes through the kidney.
Q. How about how do you diagnose the irritable bowel?
A. That's diagnosed as an exclusion. You have to rule out everything else.
Q. How about Crohn's disease?
A. Again, you would probably need a scope of the colon to check. I mean --
Q. An endoscope?
A. Correct.
Q. Colonoscopy?
A. Correct.
Q. What about a perforated ulcer?
A. Again, that would be an emergent condition, certainly. You know, you get blood work, probably get a flat abdominal series of the abdomen to see if you could see anything perforated.
Although, plates don't show much,

like people think.

A CAT scan would be best for that, if you were in an ER setting.

Q. How about gallstones?

A. Ultrasound.

Q. Hepatitis?

A. Blood test.

Q. Small bowel obstruction?

A. Probably, you could get a flat plate of the abdomen, just to see, because you would see the gas building up on the proximal side of the obstruction, but probably a CAT scan would be the best choice.

Q. Doctor, how is appendicitis definitively diagnosed?

A. Well, with surgery, and the appendix goes to the pathologist, if you want definitively.

Q. If a doctor suspects that a patient is suffering from appendicitis, what does the standard of care require him to do as far as diagnosing the patient?

MR. McGOVERN: You're asking if he

suspects, right?

MR. CONWAY: Yes.

THE WITNESS: So I'm thinking if this patient really has appendicitis versus anything else?

I'm narrowing it down?

BY MR. CONWAY:

Q. Yes.

A. I would get blood work. I might get an abdominal x-ray, but I'm not a big fan of those, per se. I would probably call in a surgeon.

Q. That's called a surgical consult, correct?

A. Correct.

Q. And why would you call in a surgeon?

A. Well, you want the honest to God truth?

Q. That's why I drove in this blizzard down here to Columbus. So you tell me what you think the honest truth is.

A. A lot of times, when I worked in the ER, for medical-legal reasons, just to

bless the patient and send them on their way, so to speak. I knew they didn't have appendicitis, but to make sure.

Q. But sometimes it might be nice to send them to a surgical consult if they do have appendicitis, right?

A. Well, certainly. Of course.

Q. Why is a surgical consult an appropriate referral if you suspect a patient is suffering from appendicitis?

A. Because you want to get them operated on as soon as possible so they don't have a bad outcome.

Q. What is the surgeon going to be able to do that an internist is not going to be able to do as far as evaluating a patient for possible appendicitis?

A. Well, he or she can do the surgery, obviously.

But they select out those cases. They see -- that's a routine case for them to see, because surgeons are -- cases are already selected out, pretty much, by the time they get to the surgeon, so they're

used to seeing that presentation. They'd be able to recognize it usually right away, usually. I mean --

Q. And the surgeon -- I guess what I'm getting at is the physician that you want to have making the -- at the end of the algorithm, so to speak, with regards to appendicitis is a general surgeon, correct?

A. Assuming the patient has to go to surgery, sure.

Q. All right. Are there ever cases of appendicitis where the patient doesn't have to go to surgery?

A. Yes. I've had several over the years where I thought for sure they were going to be operated, and they weren't. They put them on IV antibiotics and sent them home.

In my mind, I was thinking, my gosh, you know, maybe they should have operated on them, because they could flare up at another point.

Q. But in those cases where there was a decision, for whatever reason, not to

operate in a particular case, a general surgeon had, in fact, seen?
A. Sure. Yes.
Q. So going back to my question, if an internist suspects that a patient is suffering from appendicitis, eventually the internist wants to get that patient into the position where the patient is seen and evaluated by a surgeon, correct?
A. Sure. Of course.
Q. Then it's the general surgeon that can decide whether or not surgery has to be performed or whether or not you can treat the patient more conservatively, correct?
A. Correct.
Q. When you were working at an urgent care center, did you ever have the occasion to refer a patient for a surgical consult to a general surgeon?
A. On occasion.
Q. What type of cases would you refer patients to a general surgeon for?
A. If I thought they had an aortic aneurysm, appendicitis, kidney stones to a

urologist.

Are we just pertaining to males?

Q. Yes, 21-year-old young males with abdominal pain.

A. Otherwise, we have a whole other ballpark here.

Hernia, testicular torsion, can cause abdominal pain.

Q. That's another -- I was wondering why you didn't mention that.

Testicular torsion can cause severe abdominal pain, correct?

A. Right. It means his testicles were hurting. A patient would say that.

Q. Do we have any evidence that the patient was asked whether or not his testicles hurt in this case?

A. None that I see.

Q. With abdominal pain should -- strike that.

In an urgent care setting, or an emergency care setting, does the standard of care require a patient who's suffering abdominal pain such as Mr. Toon was

suffering to have an examination of his genital area?
A. I don't think so.
Q. Why not?
A. Because a patient will come in complaining of that area.
Lots of times, guys don't want to be examined down there, as a rule.
Q. A lot of times guys can be embarrassed to mention that their testicles hurt, correct?
A. I'll tell you, my observation is when they really hurt, they tell you. Actually, with that, with the genital area, in general, when guys really have a problem, they do come in, and they do tell you. They want you to take a look, because they don't want any problems down there.
But if they're in for an abdominal complaint, they don't prefer that you check that area out, usually, in my observation over the years.
Q. Can testicular torsion at a certain stage in the process present as

abdominal pain --
A. Sure.
Q. -- without testicular pain?
A. It probably could, but it would probably be unlikely.
Q. Is it significant in evaluating a patient for possible appendicitis that there is severe pain in the right lower quadrant?
A. It definitely rules it in more if they have right lower quadrant pain.
Q. How about if they have more pain in the right lower quadrant than the other quadrants?
A. I definitely would be more prone to looking at appendicitis as a diagnosis.
Q. Have you ever diagnosed appendicitis?
A. Yes.
Q. Approximately how many times?
A. Well, when I worked in the ER, I'd say 20 times.

It's not as common as people think. It's one case all laypeople know about, appendicitis. The right lower, you

know -- people even know the side and all that. But it's not as common as gastroenteritis, which is you see thousands of cases.

Q. Gastroenteritis isn't immediately life-threatening, is it?

A. It could be.

Q. How?

A. If somebody was septic or is dehydrated, they need to have IV fluids. So, I mean, it could be. Anything could be.

Q. Doctor, based upon your experience in emergency rooms and urgent care centers, is appendicitis with the potential for ruptured appendix more of a severe condition than gastroenteritis?

A. I would say yes. Sure.

Q. And you're familiar with what a differential diagnosis is?

A. Sure.

Q. Differential diagnosis is you want to list in your mind or on paper what's the various possibilities that a patient could be suffering from, correct?

A. Yes.
Q. The different conditions he could be suffering from?
A. (Nods head affirmatively.)
Q. Did you see any indication here that Dr. Padival had constructed a differential diagnosis in assessing Mr. Toon?
A. I don't see that. No.
Q. Would you -- when you were an urgent care physician, would you put a differential diagnosis down, Doctor?
A. Almost never.
Q. Well, let's assume that you were putting together a mental differential diagnosis as opposed to writing something down.
A. Okay.
Q. The conditions you put at the top of that differential diagnosis are the conditions that can be acutely life-threatening, correct?
A. Sure.
Q. For instance, with regard to chest

pain --
A. Heart attack, myocardial infarction.
Q. Right.
It's probably a lot more likely if the person is a laborer or athletic that he's suffering from some type of musculoskeletal problem with a presentation of chest pain, but the ramifications of having an MI are so much more significant you would put that at the top of your differential diagnosis?
A. Sure, always.
Q. And even though a condition may be much more common, you want to rule out that more serious --
A. Correct.
Q. Okay. If Mr. Colon had had surgery done and his appendicitis -- strike that.
See, I need some coffee.
Let's start over.
MR. McGOVERN: I thought that was some new character, Mr. Colon.

MR. CONWAY: No.

BY MR. CONWAY:

Q. If Mr. Toon had had his appendix surgically removed prior to its rupturing, do you have an opinion as to how long he would have been in the hospital?

A. It would have been a noncomplicated or uncomplicated course, three, four days, at the most.

Q. Could it have been one to two days?

A. Sure.

Nowadays, they kick you out maybe the same day, depending on his insurance.

Q. If Mr. Toon's surgery had been done before the appendicitis ruptured, he would not have suffered peritonitis or sepsis, correct?

A. Sure, most likely.

Q. Most likely he would not have?

A. Would not have, correct.

Q. Did you come across any indication in the medical records that Mr. Toon had suffered an incisional hernia as a result of

the surgery?
A. Yes.
Q. Is an incisional hernia more probable a complication with the type of surgery he had to have done in this particular case versus a routine appendectomy?
A. Sure, because the incision is larger.
Q. How much larger is the incision?
A. I don't know. It's hard to say, depends on what the surgeon -- how -- I mean, I don't know that it was documented specifically in centimeters or inches.
An appendectomy scar is obviously less.
Q. So you would agree that the increased risk of -- or excuse me, that the risk of sustaining an incisional hernia was increased for Mr. Toon with the operation he was required to undergo in this particular case, correct?
MR. McGOVERN: Objection.
You can answer, if you know.

THE WITNESS: Can you rephrase that again?
BY MR. CONWAY:
Q. Yeah. That was very poorly phrased.
The fact that Mr. Toon had to undergo the type of surgery he did in this particular case because his appendix had perforated increased the risk of sustaining an incisional hernia as opposed to if he had undergone the more simpler procedure to remove the appendix before it ruptured, correct?
MR. McGOVERN: Objection.
THE WITNESS: I would say that's mostly correct.
BY MR. CONWAY:
Q. What's not correct about it?
A. Well, he's a cigarette smoker, so he's going to have impaired wound healing.
There's evidence he's noncompliant with follow-up care. At least he didn't show up for two appointments.
Q. Would the noncompliance have

anything to do with the incisional hernia he developed?

A. Sure. If the surgeon said, I don't want you lifting anything over, say, two pounds until I see you back in whatever amount of weeks, and the guy was out messing around with his truck or something, or lifting whatever, like his child, that could have provoked it.

Q. Do you have any opinion as to what provoked the incisional hernia in this case?

A. I definitely think that it's hard -- it's hard to say what exactly provoked it. We don't know.

If he lifted anything, he's probably not going to tell us that, certainly at this stage in the game.

But I do know that patients who smoke two packs of cigarettes a day have definitely impaired wound healing and, as a rule, tend to be more noncompliant. The very fact that he smokes two packs a day tells us what he thinks about his health.

Q. Or it could tell us that he's

addicted to nicotine?

A. Well, that's obvious if you're smoking that much, but he's not a health seeker.

Q. He's not?

How do you know that?

A. Because anyone who smokes two packs of cigarettes a day is not seeking health or they have little regard for health. It's not on their important things.

Q. Do you have an opinion as to when Mr. Toon's appendix ruptured?

A. Based on reading the record and the deposition, he was well enough to go to the court date he had, which is 100 miles from his home, because he had a traffic ticket, so he had his mother-in-law drive him.

Usually, somebody with appendicitis is really ill. They just -- they can't even sit up. They're toxic.

To go 100 miles, based on that, he either ruptured that morning or shortly thereafter on that trip.

Q. What morning did he rupture?
A. The Friday that he went to the court trial, like, I don't know the date offhand.
Q. Was that -- was that the 26th?
A. I don't know.
I know he was seen by Dr. Padival on the 21st, so it would have been the following Friday, so 26th sounds right for Friday.
Q. What time on Friday do you believe that the appendix probably ruptured?
A. Well, the judge said that he -- said something to the fact that he should go to the hospital or go to the ER. The judge noted something.
So this is only an opinion. Of course, we don't know the truth. It's hard to know exactly when it happened.
But perhaps the car trip, maybe they hit a pothole. Maybe they hit a bump. Maybe the car trip in and of itself, the jostling around, was enough to rupture it at that time. Obviously, we know he had

appendicitis and a perforated appendix, so perhaps the car trip was enough to push him over the edge.

Of course, we can't prove that.

But then subsequently, he did go to the ER that day and was operated.

Q. Do you recall reviewing any medical records or deposition transcripts which indicated as to whether or not Chris Toon had become jaundiced?

A. I read in his record that he said that he did not notice that he was, but that I think his mother-in-law made note of it that Friday morning, and I believe his wife may have noticed it.

I can't be certain, though.

Q. How would appendicitis cause a person to become jaundice?

A. I've frankly never seen a case that caused anyone to become jaundice, unless they were really sick from peritonitis, perhaps. Then you get maybe liver failure and maybe kidney failure.

But as a rule, you don't get

jaundice from appendicitis.

If you had a gallbladder problem that was infected, you could get jaundiced.

Q. Could you get jaundice from a ruptured appendix?

A. I'm sure it's possible.

Q. Do you have any idea how long it would take for a person to develop jaundice after --

A. After they ruptured?

Q. Yes.

A. I would say within 12 to 24 hours.

Q. What causes jaundice?

A. It's when the liver starts failing or is inflamed, could be infectious etiology, like hepatitis, or it could be an obstruction.

Q. Let's deal with the situation where there's a ruptured appendix.

A. Probably, because of, quote, unquote, blood poisoning or septicemia, the liver could become affected.

We don't know if he had any underlying condition, like hepatitis, that

was undiagnosed that could have caused this to be aggravated, for instance. I don't have any knowledge if the guy is a heavy alcohol user or if he drinks at all.

Q. Would that be something that you would have asked Mr. Toon as part of your differential diagnosis if you were treating him in an urgent care center?

A. Not necessarily.

MR. McGOVERN: Objection.

THE WITNESS: If he came in jaundice to the urgent care, I would.

But if he came in nonjaundice, I wouldn't necessarily make an issue out of that.

BY MR. CONWAY:

Q. And if you don't know the answer, that's fine.

How long does it take, usually, after the liver becomes impaired for jaundice to occur in an individual?

A. If you want an exact textbook answer, I can't give you that, because you can always look up here, there, and

everywhere and find whatever suits you.

But I would say certainly 24 to 48 hours.

Q. What's diffusely tender mean?

A. Diffusely tender is the whole abdomen is, in my opinion, minimally irritated. You can't localize one spot that provokes pain or tenderness.

Common with patients with gastroenteritis, that's a real common -- they have nonlocalizing diffuse tenderness, is how I always describe it. You can push anywhere, and it doesn't cause any great amount of pain, but anywhere is a little bit sensitive, perhaps.

Q. So, Doctor, you believe that Chris's appendix ruptured sometime the morning of the 26th, right?

A. Possibly, or it could have been Thursday.

Q. When Chris was evaluated by Dr. Padival on February 21st, 1999, do you believe that he had appendicitis at that time?

A. Not based on the vital signs and the medical records that I see.

Q. Do you have an opinion as to when Mr. Toon first would have developed appendicitis?

A. Reading his deposition, it seemed like he was eating meat and potatoes after he saw Dr. Padival, in the middle of the week, say Tuesday, Wednesday, Thursday. We could find it somewhere, if you wanted to look.

So when I see that, I'm thinking he's not that sick from the gastroenteritis at this point if he's eating that kind of heavy diet, quote, unquote.

Then he changes his diet again later in the week, I think, to a lighter diet, quote, unquote, like vegetable soup, something of this nature.

So I would have to say maybe from Thursday on, based upon his -- it would be unlikely somebody would want to eat a heavy meal if they had appendicitis, in my opinion. Because if you're that sick, you

don't want to even see food.
Q. So it's your belief that from sometime Thursday on he began suffering from appendicitis?
A. Based on what I can tell.
Of course, I don't know.
Q. Can an appendix rupture that quickly?
A. Oh --
Q. Let me put that question in context.
You're stating that you believe that the appendicitis maybe started Thursday, and yet you're also saying that the rupture may have occurred on possibly Thursday.
Can an appendix that's inflamed, appendicitis, rupture that quickly?
A. I believe it could if it was -- if he was sick enough. Sure.
Q. What are the mechanics for an appendix that has appendicitis to rupture?
A. If it gets inflamed and filled with pus, gets red, it swells up, it

ruptures.

I mean, I'm not sure what you're trying to --

Q. I'm just saying so it can happen rather quickly, then?

A. I think it could. Sure. It could.

Anything could or could not happen in medicine. There's no -- medicine, it's like a bell curve. A lot of things fall within, but sometimes there's outliers on either end.

Q. In this particular case, it's obvious that you feel that the appendicitis started on about Thursday.

Then, within a very short period of time, possibly even that same day, the appendix ruptured?

A. Or Friday.

Q. Okay. About Thursday or Friday it ruptured?

A. Approximately. It's hard to say.

Q. Doctor, should Dr. Padival have given written discharge instructions under

the standard of care?

A. If you look at the gold standard of care, most emergency rooms that are joint commissioned with the hospital do do that, or even typewritten.

A free-standing urgent care, the minimal standard would be to give verbal instructions.

Q. You don't believe that an urgent care physician has the duty under the standard of care to give written discharge instructions?

MR. McGOVERN: Objection.

MR. CONWAY: You can answer.

THE WITNESS: Okay.

MR. McGOVERN: Asked and answered.

THE WITNESS: I think if you have a -- gastroenteritis would be a mild or minor illness. If you gave verbal instructions, it would probably be adequate.

I've done that before to patients. I do it here all the time. I give them verbal instructions.

I've worked in a -- the emergency

room, there's more of a gold standard, because hospitals have to be joint commissioned. They have to have certain criteria to be standardized. So it's common to give written instructions.

BY MR. CONWAY:

Q. What do you mean, joint commissioned?

A. To be accredited, the emergency department would have to be accredited, the whole hospital would be accredited to be in business.

Q. There's a governmental body that issues different --

A. Correct.

Q. -- procedures and protocols that the hospital must follow to receive accreditation, correct?

A. Correct, like to receive Medicare payments and things like that.

Q. And those different guidelines which are issued by the joint commission are medically prudent and reasonable guidelines, have you found?

MR. McGOVERN: Objection.

THE WITNESS: Yes. I mean, I have.

BY MR. CONWAY:

Q. Let's go to your report, Doctor. That's Exhibit A.

By the way, if you -- strike that.

You've read Chris Toon and Billie Jean Toon's deposition transcripts, correct?

A. Mm-hmm.

Q. Specifically Billie Jean Toon's deposition transcript indicates that the only place that Dr. Padival found pain on palpation was the right lower quadrant, would you agree, according to Billie Jean Toon?

A. According to her.

Can I --

Q. Sure.

A. I don't know how she could know what he was feeling though, the physician. I mean, her hands weren't on the abdomen. It was his.

Q. But she was watching where he was

palpating, correct, according to her testimony?

A. According to her testimony.

Q. If you believe her testimony, and I want you to assume that what she testified to is accurate, that the only place that Chris was feeling pain was the right lower quadrant --

A. If I --

Q. -- if you believed that --

MR. McGOVERN: You're asking him to assume if the only place Chris was experiencing pain was in his right lower quadrant?

You're asking him to assume that that is the case?

MR. CONWAY: Yes. Yes.

BY MR. CONWAY:

Q. Would that be a strong indication that Chris Toon was suffering from appendicitis?

MR. McGOVERN: Objection.

THE WITNESS: I can answer this on many different -- I don't believe her

testimony after reviewing it.
BY MR. CONWAY:
Q. You don't believe her testimony?
A. No. I don't.
Q. Why not?
A. It's hard for me to believe her testimony when I see that she may have been having an affair behind his back; and they recently separated and are still married; and has a girlfriend, he, and she has a boyfriend. Her testimony to me is not credible.
Q. All right. What about Chris Toon's testimony?
Do you find his testimony to be credible, Doctor?
A. I probably find his testimony more credible than hers.
MR. McGOVERN: I'm going to object, object to that question.
BY MR. CONWAY:
Q. Is there any particular part of Chris Toon's testimony that you specifically find not credible?

MR. McGOVERN: Objection.

THE WITNESS: Not credible?

BY MR. CONWAY:

Q. Yes.

A. Just regarding the physical exam, he said that the doctor listened to his heart and lungs and all that in the body of the deposition. So he's telling us that the doctor did do that much, and then the abdominal exam, obviously, for I believe he said a minute or more, palpated the abdomen. That's a long time to palpate an abdomen. So the patient is telling us the doctor did give him a good exam.

So there's discrepancy between the patient's perception of reality and the wife's perception of reality.

Q. I'm just asking if you can point to a specific part of Chris Toon's deposition that you find uncredible?

MR. McGOVERN: Objection.

THE WITNESS: It would be hard -- I'd have to review it again and go over it. You know, it's a long deposition.

BY MR. CONWAY:
Q. But you think he's more credible than his wife?
MR. McGOVERN: Objection.
THE WITNESS: I think that when -- why would he tell us that the doctor did a complete exam, and then she would tell us the doctor did not do a complete exam?
I find that curious. That's all.
BY MR. CONWAY:
Q. All right.
A. It would not be in his vested interest to make the doctor look like he did a better exam, I guess.
Q. All right. Well, I don't want to beat a dead horse, but I'm trying to find out.
We got three different versions of what occurred here, am I correct?
We got Dr. Padival version, correct?
A. Right.
Q. You've got Billie Jean Toon's version, correct?

A. Right.
Q. And you got Chris Toon's version, correct?
A. Correct.
Q. And I guess my question is, without pinning you down or going back to specifics, did you find Christopher Toon's version of what occurred to be more credible than Billie Jean Toon's version?
MR. McGOVERN: Objection.
THE WITNESS: Do I answer?
MR. CONWAY: You may answer.
MR. McGOVERN: Yes.
THE WITNESS: I guess inasmuch as he's the patient, and he knows how he feels, I believe him more than her, who's not with him 24 hours a day, if we look at it from that point of view.
BY MR. CONWAY:
Q. Let's go through your report.
MR. McGOVERN: You know, I'm going to have to take just a couple minute break to use the rest room.
MR. CONWAY: Sure. That's fine.

(A short break in proceeding occurs.)

BY MR. CONWAY:

Q. We're going through your report real quick, Doctor.

MR. McGOVERN: You're looking at his report; is that right?

MR. CONWAY: Yes.

BY MR. CONWAY:

Q. On the third line, you indicate that, quote, with a two-day history of loose bowel movements, not able to eat or drink --

A. Uh-huh.

Q. -- so forth, so on.

As we sit here today, is it your understanding that that was a two-day or three-day history?

A. Two-day history.

Q. Based on Dr. Padival's chart?

A. Right. I mean, that's what I wrote.

Q. Were you wrong when you wrote that, Doctor?

A. I don't believe so. I mean, I

wrote -- I wouldn't put it down in the report if I didn't think it was correct.

Q. What are you basing the two-day figure on, then?

A. Well, I didn't interview the patient. It would have to be in the medical record, obviously. That's all I have to go on.

Q. You indicate, then, going through, no current meds, no past medical history, no past surgical history.

On what do you base your statement that this patient had no past medical history?

A. A lot of times, we just put down pertinent positives. So if it's -- I know we put down pertinent positives. So if he had a past medical history that is negative, no past surgical history -- and I believe he was supposed to have filled out some sort of patient history form.

Am I right, or is that not --

MR. McGOVERN: Doctor, you have to go on what is before you.

THE WITNESS: Right.

MR. McGOVERN: Okay. Use the records that are before you. That's what I sent you.

BY MR. CONWAY:

Q. I'm just interested in finding out how you came to the conclusion that Chris Toon had no past medical history or no past surgical history, what you based that on.

MR. McGOVERN: I think he answered that.

THE WITNESS: We would put down pertinent positives.

For instance, if he had past surgical history of a heart valve replacement, he would have probably mentioned that to the doctor.

BY MR. CONWAY:

Q. Are you basing this on your review of Dr. Padival's chart?

A. Correct.

Q. Lomotil and Tylenol?

A. Uh-huh.

Q. What was your understanding as to

why those two medications were prescribed for Mr. Toon?
A. Tylenol for the fever, Lomotil to slow down the diarrhea.
Q. Then it goes, based upon your representation to me.
Who's the "your" that you're referring to?
A. I believe I had discussed this with Mr. McGovern, because I had -- I did not have the deposition in front of me at that point in time. That's why that's worded as such.
Q. What specific representation did Mr. McGovern make to you?
A. That Dr. Padival had verbally told the patient to return in one to two days' time to the urgent care, if it was open, or the ER, if the urgent care was not open.
Q. Anything else you remember Mr. McGovern representing to you?
A. I believe it was fairly straightforward.
MR. McGOVERN: I think you need to

ask him specifics, if you want it to be particular, very particular, whatever I represented to him regarding --

BY MR. CONWAY:

Q. Well, you put together this report, Doctor, right?

A. Mm-hmm.

Q. You based your report on various things, including your review of the medical records, correct?

A. That's correct.

Q. And I assume, from reading this particular sentence, there was -- there were things that were told to you by Mr. McGovern which you took into consideration in rendering your expert witness report, correct?

A. Correct.

Q. And I'm just wondering what the specific things he told you were that you incorporated into your analysis. That's all.

A. It's hard to remember some months later.

Q. Was it -- were these oral representations over the phone; or was it written, something written, he sent you?
A. It would be oral, because the written I had.
But I did not have the depositions at this point when this was made from the -- for several people.
Q. You've got, then, in your final paragraph, several facts point to the patient's own negligence for the outcome of his health. You say, patient waited five days before reporting to the emergency room.
How was the -- how was Chris Toon negligent?
A. Can I back up a second --
Q. Sure.
A. -- regarding the past medical and past surgical history?
Q. Sure.
A. I think I got that from the hospital record or reviewed it from the ER physician or the surgeon. Okay. There was

a -- I believe that's where I got it, not necessarily Mr. McGovern telling me.

Q. The emergency room physicians, in fact, when Mr. Toon presented to them on February 26th, asked him what his medical history was, correct?

A. Family history of asthma, as I recall.

Q. But they asked him his medical history, correct?

A. Right.

Q. And they documented that history, correct?

A. I'm assuming. I don't have -- we can look it up. I don't -- it's not right --

Q. And they asked his surgical history, as well, correct?

A. I would believe so.

Q. Would that be the standard of care for an emergency room physician to do?

MR. McGOVERN: Objection.

THE WITNESS: Sure.

BY MR. CONWAY:

Q. Okay. Let's go now to the third paragraph. Patient waited five days before reporting to the emergency room.

How was the patient negligent in doing that?

A. I think any -- I think any reasonable person, when they're that ill, and they're not getting better, and they're told verbally to follow up, and they choose not to, it goes back to showing a disregard for health in general.

This gentleman smokes two packs of cigarettes a day. I'm sure he's been told at some point in this life by some physician, although we can't prove this, to not do that. It's obviously not advantageous. No one would disagree with that.

In his wife's testimony, or her deposition, there's an area where she says that it's hard to get him to go to the doctor, or he doesn't ever go, or something of that nature, which we could find if you wanted to glean through it all, that I

remember reading it. So right there we have her having a statement regarding his compliance.

I mean, I think everyone's responsible for their own health care, really. It's not -- the physician is a consultant. He or she can make recommendations. If you choose not to follow them, and you have a bad outcome, it's not always the physician's fault. That's part of what's going in this country right now.

Q. When should Chris Toon have returned to the emergency room or to Dr. Padival, in your opinion, Doctor?

A. I would say within two days, would be a reasonable thing. He should have at least called, perhaps, or had his wife call, say, hey, I'm not better; do you have any recommendations?

Certainly, to wait until five days out until he had a ruptured appendix puts his life in jeopardy with a ruptured appendix.

He appears to me to be the kind of person that he'll drive to his court date 100 miles. And we're not talking about a five-minute drive, but 100-mile drive on a bumpy road. We're going to assume wherever he's going there's at least one pothole. It could have caused him to rupture or certainly aggravated his situation.

But if he was that sick, why didn't he call the doctor?

The fact that he doesn't have a family doctor, he doesn't have a personal physician, that's why they go to urgent care, he doesn't believe in health care. He doesn't have -- he didn't seek out a family doctor for himself.

Q. Do you know -- do you have any idea what his reasoning could have been in not having a family doctor?

A. I don't know. I mean, I'm not him. I can't say.

I can make the assumption that health care is not a priority for him.

Q. All right. Then you say, any

reasonable person would have followed Dr. Padival's verbal instructions to return for follow-up sooner, either to the urgent care or to the emergency room, at which point the patient would have had a noncomplicated appendectomy?

A. Assuming he had come in before it ruptured.

Q. And I guess that's what I'm asking you: What is your opinion as to what date he should have came in for follow-up medical care in order to avoid having his appendix rupture?

A. He was seen on Sunday, correct?

Probably Tuesday, Wednesday, which would have definitely been well before Friday.

Q. And do you have an opinion as to what would have -- what his condition would have been on Wednesday upon presentation to a physician?

A. It's hard to say.

But I can remember reading in his deposition it sounded like he was eating in

the midweek, meat and potatoes at some point. Then, he shifted later in the week to vegetable soup or less hardy meals.

Appendicitis is an evolving diagnosis. Had he presented one, two, three days later, even to Dr. Padival, maybe he would have had the right lower quadrant tenderness localized, and he would have sent him right over.

Q. If you believe Billie Jean Toon's deposition transcript, should Chris Toon have been referred to a surgeon on February 21st?

A. I don't believe her deposition.

Q. It's a hypothetical. Okay.

If you believe Billie Jean Toon's testimony in her deposition --

A. Right.

Q. -- should Dr. Padival have sent Mr. Toon either to the emergency room or gotten him a surgical consult on February 21st?

MR. McGOVERN: Objection.

But you can answer.

He's just simply asking you, if you assume that her testimony is correct and accurate, and Dr. Padival perceived exactly what Mrs. Toon was perceiving -- is that what you're asking him?

MR. CONWAY: Yes.

BY MR. CONWAY:

Q. I thought my question -- it's not a trick question.

You're looking over at him.

Believe me, it's a hypothetical.

Okay. I'm asking you, if doctor -- excuse me. Strike that.

If you believe the accuracy of Billie Jean Toon's deposition testimony regarding Chris's visit to Dr. Padival on February 21st, would you agree that Dr. Padival should have referred Chris Toon to an emergency room or referred him for a surgical consult?

A. No. She's a layperson. She's a nursing --

Q. We'll try it one more time.

A. She's a nursing aide or something

of this nature. She's not a physician.
Q. All right. We'll try one more time.
A. Okay.
Q. All right.
MR. McGOVERN: Why don't you just ask the question in the sense of, if Dr. Padival noticed extreme pain by Mr. Toon --
MR. CONWAY: Well, I guess we'll have to do it that way.
I thought it was self-evident anyway.
BY MR. CONWAY:
Q. You're aware of what Billie Jean Toon testified to regarding her observations of Chris's physical examination, correct?
A. Correct.
Q. I want you to assume that what she observed was accurate, and, furthermore, that Dr. Padival observed the same thing during his examination that she testified to observing herself, okay?
A. Okay, if that's possible.

Q. All right.
A. Then, yes.
Q. All right. So let's go, now, since that is so convoluted, the question and answer, if Dr. Padival had while -- strike that.

If Chris Toon, during his examination by Dr. Padival, had exhibited severe lower right quadrant pain, such as Billie Jean Toon has described in her testimony --
A. Okay.
Q. -- would you agree that the standard of care would have required Dr. Padival to refer Chris Toon to either an emergency room or to a general surgeon for a surgical consult?
A. Sure. Yes.
Q. Patient's laboratory on 2-27-99 showed a glucose of 237.

Can that be consistent with sepsis?
A. If you're diabetic.
Q. Do you have any reason to believe

that Chris Toon is diabetic?
A. I don't know. I mean, a blood sugar that high could indicate diabetes.
Perhaps he's not a forthcoming historian. Maybe he had undiagnosed diabetes, which would have masked the abdominal pain.
Q. Do you have any evidence that Chris Toon was ever diagnosed with diabetes?
A. No, not except for a blood sugar of 237.
Q. At Mansfield Central Hospital -- or Mansfield Med Central Hospital where Chris Toon was admitted for surgical treatment of his ruptured appendix, was there any diagnosis given by any physician that he was suffering from diabetes?
A. None.
Q. Is there any evidence you have, and if there is let me know, that he's somehow misrepresenting his medical history to any doctor?
A. None at all.
Q. You say, the most glaring example

of this patient's noncompliance is after going through this ordeal he did not show up for two follow-up appointments on March 17th, 1999 and April 15th, 1999?

A. Correct.

Q. And I believe you're referring to Dr. Golbus's chart showing that he did not show up on March 17th; is that correct?

A. As I recall, he was a no-show for the appointment.

Q. Do you have those medical records?

A. Somewhere here. I just saw it again yesterday.

3-17-99, patient was a no-show, called, left message to reschedule. I mean, he didn't even call to reschedule. He just didn't show up. I mean, that shows --

Q. What does the entry under that line, written presumably by the same nurse, say?

A. Patient scheduled to see Doctor, looks like, Fahmy today, 3-17-99.

Q. Who's Dr. Faime, do you know, Doctor?

A. I believe the infectious disease -- I don't know.

I know Dr. Golbus was the surgeon.

Q. So it appears from at least this note that you're citing to that Mr. Toon had another appointment on the same day to see another doctor; is that correct?

A. Well, I'm assuming his appointment is not for the whole eight-hour day.

Q. I'm just asking, it appears that there's another doctor that he was supposed to see on that date; is that correct?

A. It does say that, doesn't say if this Dr. Golbus's office scheduled it or what.

Q. Also, on that 3-17-99 entry, there's handwriting by another individual underneath that, as well, correct?

Can you read what that note says?

A. Looks like, complained of discomfort from retention sutures, eating well, denies fever-chills, abdomen soft, wound granulation with no evidence of infection.

Q. What does it say below that?
A. Retention sutures, clips, drain removed. Return to center in one week for wound check.
But there's no date on that note.
Q. It says return -- what does it say, return to what?
A. Center.
That's a common medical lingo.
Q. In one week for wound check?
A. Correct.
Q. So they would want him to return -- whenever this note was written, they'd want him to return in one week to have that wound checked, correct?
A. Correct.
Q. All right. And going to March 24th, 1999, what does the note for March 24th, 1999 show, Doctor?
A. Well, it's kind of hard to read it, to be honest with you.
Q. Does the first two words say, doing well?
A. Could be.

Q. Without problem?
A. I guess you could interpret it -- I mean, I'm not being facetious. I'm just saying it's hard to read.
Q. I'm not the doctor.
A. Right.
Q. And underneath there it says -- I don't know.
Healing very well, period; does that look like what that is?
A. I guess it could be. I mean --
Q. Then it says, return to center in two weeks, recommendation, correct?
A. Yes.
Q. And it appears that two weeks later, he comes back in there on 4-7-99, correct?
A. Yes.
Q. Doctor, you then cite to April 15th of 1999 for him missing an office visit.
Are you referring to Dr. Vaidya's chart?
A. I don't know, to be honest. I

mean, I have to look at the --
Q. Well, it says 4-15-99, in Dr. Vaidya's chart, patient didn't come to the 11:00 o'clock appointment?
A. That must be it, then.
Q. Do you know what Chris Toon was doing on April 15th, 1999?
A. I don't know.
Q. Do you know what his occupation was, Doctor?
A. He's a truck driver.
Q. Do you know if he was treating with any other physician other than the physicians which you have medical records for?
A. I'm not -- I don't know. I couldn't honestly --
Q. All right. Doctor, are all your opinions -- do you have anything -- strike that.

Do you have any opinions you want to add to your expert witness report of December 2nd, 2002?
A. Not at this time.

Q. Now, off the record your attorney had indicated that you at one point had written a report, sent a handwritten draft to him?
A. Correct.
Q. He then had his secretary put it into writing --
A. Correct.
Q. -- and sent it back to you?
A. Correct.
Q. Did he send back your handwritten draft?
A. No.
Q. Did you ask for your handwritten draft back?
A. No.
I read this report, and I had the medical record, and I reconciled it, and I thought it was reasonable.
Q. Okay. Did you keep a copy of that handwritten report that you sent to him?
A. No. I didn't.
I'm assuming he must have it.
Q. Why didn't you just give a

dictated one to --

A. Because I don't dictate my notes. I handwrite them.

MR. CONWAY: We can just mark this?

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Thereupon, Deposition Exhibit B was marked for purposes of identification.

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BY MR. CONWAY:

Q. Doctor, is this your current CV?

A. Yes.

Q. Are you board-certified in any area of medicine?

A. Family medicine.

Q. Any board certification in emergency medicine?

A. No, sir.

Q. Have you attempted to get a board certification in emergency medicine?

A. Never wanted one.

Q. Okay. All right. So I take it you have not attempted to get a board

certification in emergency medicine?
A. No.
Q. Have you published any type of articles on any area of medicine?
A. I may have published one when I was a resident, but it was so long ago I don't even have a copy of it, but no. I'm not a published -- it's not my interest.
Q. Do you teach at all?
A. No.
Q. Doctor, do you have a board certification in family medicine?
A. Yes, sir.
Q. Are you a member of an organization that -- strike that.
Are you a member of any type of medical organization?
A. I'm a diplomat of the American Board of Family Practice.
Q. Do they publish any type of journal?
A. Oh, yes, every month.
Q. What's the name of that journal?
A. I believe it's the American Family

Physician.

Q. That sounds right.

A. I get so many magazines. It's hard to keep the names straight sometimes.

Q. Have you ever published in that?

A. No, sir.

Q. Have you ever edited that?

A. No.

Q. Do you read it?

A. Oh, yes. Sure.

Q. Do you find it to be reliable?

A. It take everything I read with a grain of salt. Nobody's 100 percent correct and perfect.

Q. Are there any emergency medicine textbooks that you own?

A. I have some at my house.

I don't work in the ER currently.

Q. When you did work in the ER, were there any?

A. I would use Harrison's Internal Medicine. I would use Washington Manual a lot, Harriet Lane Pediatrics.

Q. How about Barkin and Rosen?

A. I may have had that to refer to in the ER, but I haven't worked in the ER for --

Q. Do you find Harrison's to be a reliable textbook?

MR. McGOVERN: Objection.

THE WITNESS: Again, I take it with a grain of salt.

Yeah. It's one of the gold standards, certainly.

BY MR. CONWAY:

Q. All right. How many expert medical reviews have you performed?

A. This is the first one.

Q. Do you know how you were contacted to perform this one?

A. I believe I was working at the urgent care, and I was the medical director there, and the guy that was over me, Dr. Zeeb, asked me if I'd be interested in doing this, and they referred me to Mr. McGovern, or we somehow got in contact with each other.

Q. What urgent care facility were you

working at?
A. It was on the West Side. It was Health South at the time, and it's gotten bought by somebody else. I think it's US Health Works. I'm not sure.
Q. Health South?
A. Correct, the big conglomerate in the South, mostly.
Q. Where was your actual urgent care facility?
A. On Phillipi Road on the West Side. I'm not sure the exact number.
Q. What were your hours there?
A. Oh, I'd work --
Q. No. I'm sorry.
What was the urgent care hours?
A. 8:00 a.m. to 8:00 p.m.
Q. Were you open on Sundays?
A. Yes, initially, and then, I think, subsequent, I think, they deleted that. But when I was there, we were.
Q. What was the doctor that referred you to Mr. McGovern?
A. I think his name was Dr. Zeeb,

Z-E-E-B.

Q. Z-E-E --

A. B.

Q. -- B?

What type of doctor was he?

A. Family practice, but he's worked in the ER a lot and urgent care.

Q. Do you have admitting privileges at any hospitals?

A. I'm on staff at St. Ann's, Riverside, and Doctors.

I don't admit, though. I choose not to do that.

Q. Why not?

A. Just don't have any interest in it.

Q. Have you ever had your license suspended or disciplined?

A. Never.

Q. Ever received any kind of disciplinary action from a hospital?

A. Never.

Q. You ever been sued for medical malpractice?

A. Well, I've had 180-day letters twice, but I've never been to trial or even a deposition for them.
Q. Was there ever a lawsuit filed against you, other than the 180-day letters?
A. No.
You mean, like, a medical malpractice lawsuit?
Q. Yeah.
A. No.
Q. Well, you turned the 180-day letters over to your insurance carrier, right?
A. Right.
Q. Were you ever contacted by a defense attorney to help you out?
A. No, never talked about it further than the letter.
Q. Who's your insurance carrier?
A. You asked me -- it's G.E., General Electric.
Q. Medical Mutual?
A. It was something like that. They took the policy.

Q. I'm sorry.

Med Pro?

A. Something like that. Yes. I'm sorry. I don't know exactly.

It changed, because they bought out the other one I had, and like that.

Q. Have you ever testified before?

A. No, sir.

Well, let me correct that.

Q. Please do.

A. When I worked in the ER one time, there was a patient that came in for spouse abuse. I testified on her behalf as the ER physician of record, but it wasn't a malpractice. It was, you know, a criminal trial.

Q. Did you have an opportunity to review the deposition --

MR. CONWAY: Have we gotten the deposition transcript of Dr. Weihl?

MR. McGOVERN: Yeah.

MR. CONWAY: We have?

MR. McGOVERN: Yes.

BY MR. CONWAY:

Q. Have you had an opportunity to review the deposition transcript of Dr. Weihl?
A. I looked at that.
Q. That was provided to you?
A. Mm-hmm.
Q. I don't see that that's in your stack of --
MR. McGOVERN: And, Tom, I apologize.
When I said he reviewed all three of the depositions, I'm pretty sure I said that, there would be four, not three.
THE WITNESS: I'm positive I remember reading his. I think it was attached to the back of it.
There it is.
BY MR. CONWAY:
Q. Can I see that just for a second?
You have a few things underlined by Dr. Weihl?
A. Mm-hmm.
Q. Basically, on page 61 and page 64, why do you have those items underlined,

Doctor?

A. Well --

Q. What page are you referring to, first?

A. Looks like 64, line nine, I'm assuming this is Dr. Weihl giving the answer that patients can have an appendix rupture, and this happened to my boss. This was diagnosed months later. The quality of ruptured appendix range from catastrophic rapid deterioration with sepsis onset within hours to gradual deterioration with peritonitis and sepsis over days.

Q. Do you agree with that statement?

A. Mm-hmm.

Q. You do?

A. Mm-hmm.

Q. You got to answer yes or no.

A. I'm sorry.

Yes.

Q. Yes.

All right. Anything else you underlined?

A. Under page 61, line 14, again, I'm

assuming this is Dr. Weihl answering it, at a certain stage of the clinical presentation of appendicitis the diagnosis may not be immediately made, especially if one is not utilizing abdominal imaging and CAT scans, which, as I said, in 1999 was done to some extent, but certainly not to the extent it is done now.

Q. Okay. And do you agree with that?

I'm just wondering why you underlined those two different parts.

A. I believe he was saying that it's not always easy to diagnose this, is what the two things were showing me that his opinion was.

Q. Do you agree that the standard of care requires a physician to instruct a patient to return within 12 hours to a doctor for a serial evaluation of his abdominal complaints?

A. That -- it depends on what you're thinking they have.

If it's gastroenteritis, it could

be two, three days.
Q. How about if -- let's go to his report, because you have Dr. Weihl's report, Weihl's report, somewhere here.
Here it is. This will be easier.
All right. And you have something underlined in his report, too, on the second page, right?
A. I just underlined, allows the diagnosis which may not be immediately apparent on first presentation. That's all I underlined.
Q. All right. And the language preceding that was, any patient presenting with signs and symptoms such as manifested by Mr. Toon on February 21st, 1999 must have appendicitis considered in the differential diagnosis and must be told to return for reevaluation within eight to 12 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

allow us earlier surgical treatment.

Do you agree with what I just indicated?

A. No.

MR. McGOVERN: Objection.

BY MR. CONWAY:

Q. What do you disagree with?

A. If he thought he had appendicitis, he should have sent him right to the ER then and not be lollygagging around.

Q. Okay.

A. If he thought he had gastroenteritis, there's no need to come back in eight to 12 hours if his vital signs were stable, which they were.

Q. Mr. Toon is going to be susceptible to possible long-range problems, medical problems, as a result of this ruptured appendix, would you agree?

MR. McGOVERN: Objection.

THE WITNESS: That's certainly possible.

Again, if you're health-seeking and want to get better, you can do things to

strengthen your abdominal walls, sit-ups, not smoke, pursue health excellence.

If you disregard your health, sure, he'll probably have health problems.

BY MR. CONWAY:

Q. Even if he was taking care of his health to the extent that you want him to take care of his health, doesn't the fact that he had sepsis and a rupture, ruptured appendix, doesn't that make it more likely that he's going to have future medical problems associated with his abdomen?

MR. McGOVERN: Objection.

BY MR. CONWAY:

Q. Am I asking the question properly or not?

A. Yeah.

I don't believe that that's necessarily true. I really don't.

He's young.

Q. Is he more susceptible -- because of having this ruptured appendix, is he more susceptible to adhesions?

A. That's a possibility.

Q. So he's more susceptible than if he had not had the appendix rupture, correct?
A. All things considered equal, sure, based on that.
Q. Is he more susceptible to having a small bowel obstruction in the future --
MR. McGOVERN: Objection.
BY MR. CONWAY:
Q. -- because he had the ruptured appendix?
A. If he had adhesions.
Q. Because the adhesions will affect the --
A. Peritoneum.
Q. -- peritoneum, correct, which may make him more susceptible to small bowel obstruction, correct?
A. Could.
Q. What are some other common sequelae of a ruptured appendix to the extent that Mr. Toon had?
A. Well, death would be a possibility.

Q. Okay. Thankfully, he did not die in this case.
A. Right. Of course.
Q. All right. Let's deal with some medical issues that he's looking at as a result of having a perforated --
A. He could have incisional hernia, and they can repair it, and it can reherniate. That's a possibility.
He could have chronic abdominal pain or intermittent abdominal pain.
Q. What would be causing that?
A. Could be scar tissue, or adhesions, or if they used mesh to repair it sometimes that could cause inflammation or irritation.
Q. Doctor, have we covered all your opinions in this case?
A. I think fairly certainly, for the most part.
Q. Now, that's, like, the most ambiguous answer I've ever heard in my life.
A. I'm sure that I'll think of things later when I go home.

MR. McGOVERN: That's the purpose of this here. You have to tell him.

BY MR. CONWAY:

Q. Right.

You've given your report, correct?

A. Right.

Q. I've come in here, and I've asked you about your report, and I've asked you about other opinions.

And I want to make sure when I leave here today, I know what your opinions are, so that I'm not surprised at trial.

A. I see.

Q. Have we covered everything?

A. As far as I know, yes. I'm not holding anything back, no big secret.

MR. CONWAY: All right. I don't have anything further.

Thanks, Doctor.

Do you want to explain to him his right --

THE WITNESS: Thank you.

MR. CONWAY: -- to review?

MR. McGOVERN: Yeah. You have a

right to review the deposition testimony that you've given today after it's been transcribed.

I suggest that you waive that right.

THE WITNESS: Okay.

MR. McGOVERN: So say, I waive.

THE WITNESS: I waive.

- - - - -

Thereupon, the deposition was concluded at 12:40 o'clock p.m.

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CERTIFICATE

STATE OF OHIO :

COUNTY OF FRANKLIN : SS.

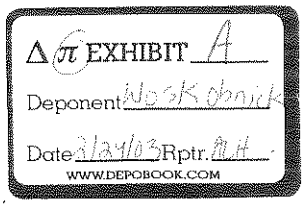
I, Adele L. Helmick, a Registered Professional Reporter and Notary Public in and for the State of Ohio duly commissioned and qualified, do hereby certify that ROBERT C. WOSKOBNICK, D.O. was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotype in the presence of said witness, afterwards transcribed by means of computer; that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid; and that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party herein, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this 24th day of February, 2003.

ADELE L. HELMICK, Notary Public - State of Ohio.

My commission expires November 15, 2004.



December 2, 2002

Gary Hammond
James McGovern
1328 Dublin Road, 4th Flr.
Columbus, OH 43215

Re: Christopher B. Toon

Dear Mr. Hammond and Mr. McGovern:

I have reviewed all medical records including urgent care and hospital records regarding the above named Patient and submit my summary of this case. Christopher Toon ("Patient") presented to Madison Urgent Care on 2/21/99 at 3:05 p.m. with a 2 day history of loose BM's, not able to eat or drink, stomach pain, nausea, red rash on chest and abdomen. No current meds, no past medical history, no past surgical history. Social history, married, smokes 2 packs of cigarettes daily. Patient had oral temperature of 100° F. Blood pressure was 122/88. Pulse was 84. Height 5'4". Weight 190 lbs. Physical exam showed diffusely tender abdomen with burn mark from heating pad. Bowel sounds were increased. Patient was diagnosed by Dr. Padival with gastroenteritis, which is very common in the winter months. Patient was prescribed Lomotil and Tylenol. Based upon your representation to me, Dr. Padival verbally told the Patient to return to urgent care or the emergency room if his symptoms did not resolve or became worse. Patient reported to the emergency room five days later and was operated on for ruptured appendix with peritonitis.

It is my opinion that Dr. Padival met the standard of care in evaluating the Patient diagnosing gastroenteritis, prescribing Lomotil and Tylenol and informing him to return for further treatment if his symptoms did not resolve or become worse.

Several facts point to the Patient's own negligence for the outcome of his health. Patient waited five days before reporting to the emergency room. Any reasonable person would have followed Dr. Padival's verbal instructions to return for follow up sooner either to the urgent care or the emergency room at which point the Patient would have had a non-complicated appendectomy. The Patient's laboratory on 2/27/99 showed a glucose of 237. If the Patient is diabetic (and withheld this part of his health history from Dr. Padival) he may have presented with atypical abdominal pain. Patient smokes 2 packs of cigarettes daily. This shows he has little regard for his own health, especially with a family history of asthma. The most glaring example of this Patient's noncompliance is after going through this ordeal he did not show up for 2 follow-up appointments on 3/17/99 and 4/15/99. This is consistent with his pattern of not following physician's recommendations and noncompliance.

Professionally yours,

Robert C. Woskobnick D.O.

Robert C. Woskobnick, D.O.
Diplomatic American Board Family Practice
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Curriculum Vitae

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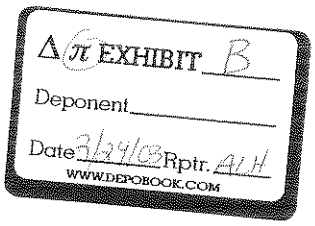

Primary Specialty Family Medicine

Other areas of interest Emergency medicine and Urgent Care, Occupational medicine, Rheumatology, Pediatrics, Dermatology

Work Experience

2000-2001 U.S. Healthworks Columbus, OH
Urgent Care and Occupational Medicine Medical Director

1995-2000 Ohio Health Columbus, OH
Family Practice Staff Physician

1992-present (part-time) Riverside Hospital Columbus, OH
Patient Early Registration System - Assistant Medical Director

1992-1995 Olentangy Emergency Physicians Columbus, OH
Emergency Room Physician

1990-1991 Dublin Medical Clinic Dublin, OH
Staff Physician

1989-1990 MedOhio Columbus, OH
Urgent Care Physician

Education and Training

1987-1990 Ohio State University Family Medicine Residency Columbus, OH

1983-1987 Ohio University College of Osteopathic Medicine Athens, OH
Doctor of Osteopathy degree

1977-1983 Ohio University Athens, OH
Bachelor of Science

Interests Guitars and music, bicycling, weight lifting, travel.

Personal Married, three children ages 12, 7 and 5.