

1 IN THE COURT OF COMMON PLEAS
2 OF CUYAHOGA COUNTY, OHIO

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4 GERALDINE MEDLEN,
5 Plaintiff,

6 vs Case No. 425998

7 KAISER PERMANENTE MEDICAL
CENTER, et al.,

8
Defendants.

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11 DEPOSITION OF DAVID YANG, M.D.

12 WEDNESDAY, JANUARY 2, 2002

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14 Deposition of DAVID YANG, M.D., a Witness
15 herein, called by counsel on behalf of the
16 Plaintiff for examination under the statute,
17 taken before me, Vivian L. Gordon, a Registered
18 Diplomate Reporter and Notary Public in and for
19 the State of Ohio, pursuant to agreement of
20 counsel, at the offices of Kaiser Permanente,
21 12301 Snow Road, Parma, Ohio, commencing at 9:30
22 o'clock a.m. on the day and date above set
23 forth.

24
25

SCANNED
3/27/03

1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

4 HOWARD D. MISHKIND, ESQ.

5 660 Skylight Office Tower

6 Cleveland, Ohio 44113

7 216-241-2600

8

9 On behalf of the Defendants

10 Reminger & Reminger

11 THOMAS KILBANE, ESQ.

12 The 113 St. Clair Building

13 Cleveland, Ohio 44114

14 216-687-1311

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1 DAVID YANG, M.D., a witness herein, called
2 for examination, as provided by the Ohio Rules
3 of Civil Procedure, being by me first duly
4 sworn, as hereinafter certified, was deposed and
5 said as follows:

6 EXAMINATION OF DAVID YANG, M.D.

7 BY MR. MISHKIND:

8 Q. Would you please state your name.

9 A. My name is David Yang, Y-A-N-G.

10 Q. And you are a doctor?

11 A. Yes.

12 Q. We were introduced by Mr. Kilbane
13 before the deposition started. My name is
14 Howard Mishkind. Nice to meet you.

15 A. You too.

16 Q. I'm going to be asking you some
17 questions this morning concerning your
18 involvement with the care of Mrs. Medlen. Do
19 you understand that?

20 A. Yes.

21 Q. Dr. Yang, have you ever had your
22 deposition taken before, sir?

23 A. Yes.

24 Q. How many times?

25 A. Three times.

1 Q. To give me an idea of your experience
2 with this, how long ago was the last time your
3 deposition was taken?

4 A. The last deposition was about six
5 months ago.

6 Q. In that case, or in the other two
7 cases that your deposition was taken in, were
8 you a defendant, were you named as a party in
9 any of those cases?

10 A. The three cases I was deposed, only
11 one I was a defendant. The other two I was not.

12 Q. The one that was taken most recently,
13 were you a defendant in that case?

14 A. Initially, yes, but it was later
15 dropped.

16 Q. Was that the one and only time that
17 you have been named as a defendant in a medical
18 malpractice case?

19 A. No, this was the second one.

20 Q. So you have had your deposition taken
21 three times before today; true?

22 A. Yes.

23 Q. And you have also been named as a
24 defendant in a medical negligence case two
25 times?

1 A. Yes.

2 Q. True?

3 A. Yes.

4 Q. Are any of the cases still pending,
5 still open, to your knowledge?

6 A. No.

7 Q. What happened with the other case? I
8 know you told me the one was dropped. What
9 happened with the other case, to your knowledge?

10 A. The other case was settled.

11 Q. Have all of your depositions and all
12 of the cases that you have been named as a
13 defendant in arisen out of treatment of Kaiser
14 patients?

15 A. The two cases were Kaiser patients.

16 Q. Two lawsuits against you were Kaiser
17 patients?

18 A. One I was a defendant and one I was a
19 witness.

20 Q. The other depositions that you gave
21 were not Kaiser cases?

22 A. I want to make it clear.

23 Q. Please.

24 A. The first one that I was a defendant
25 and I was deposed was not in Kaiser.

1 Q. Where was that located?

2 A. That was in Syracuse.

3 Q. Is that where you practiced before
4 you came to Cleveland?

5 A. Yes.

6 Q. Besides the Syracuse case, have all
7 of your other cases, whether you have been a
8 witness or a defendant, been Kaiser cases?

9 A. The other two, yes.

10 Q. Did any of those cases have to do
11 with the management of a diabetic patient?

12 A. No.

13 Q. Just to save some time, if you could
14 tell me what the cases pertain to.

15 A. The first case in Syracuse was a
16 delayed diagnosis of gastric cancer on a
17 38-year-old male. And the second case, I was a
18 witness. It was a patient who had a heart
19 attack.

20 Q. Was there an argument about a delay
21 in diagnosing coronary artery disease?

22 A. Yes. It was an argument of coronary
23 artery disease.

24 Q. And the failure to diagnose it and
25 treat it to prevent the MI?

1 A. Yes.

2 Q. I'm not trying to put words in your
3 mouth, but that's essentially it?

4 A. Yes.

5 Q. Thank you.

6 (Recess had.)

7 Q. Do you recall the names of any of the
8 patients in any of the lawsuits?

9 A. I recall some.

10 Q. Tell me, please.

11 A. The one was Victoria Parker,
12 P-A-R-K-E-R. That was the last one.

13 Q. Was that the MI case?

14 A. No. This was the one where the
15 patient went to the gynecologist for vagina
16 discharge and had a PAP smear by the gynecology
17 provider and it turned out this patient had a
18 very serious infection and the gynecologist
19 didn't address the issue on the visit, and I was
20 the primary care. I never seen the patient.

21 Q. Your deposition was taken in that
22 case six months or so ago?

23 A. Yes.

24 Q. Do you happen to remember the name of
25 the lawyer who took your deposition?

1 A. I don't remember.

2 Q. Fair enough. The MI case, was that a
3 Kaiser case?

4 A. Yes.

5 Q. What was the name of the patient, if
6 you recall?

7 A. I cannot recall.

8 Q. The delay diagnosis of gastric
9 cancer, the name of that patient?

10 A. The name is Joseph Alesandrelo,
11 A-L-E-S-A-N-D-R-E-L-O.

12 Q. What is the county that the City of
13 Syracuse is located in?

14 A. Onondaga, O-N-O-N-D-A-G-A.

15 Q. Have you told me now the experience
16 that you have had, either as a defendant or
17 having been deposed in any capacity?

18 A. Can you repeat the question?

19 Q. I asked you how many times you had
20 been named as a defendant and you told me about
21 those experiences.

22 A. Yes.

23 Q. You also have now told me the number
24 of depositions that you have given.

25 A. Yes.

1 Q. Have you ever served as an expert
2 witness in a medical negligence case?

3 A. No.

4 Q. Who is your employer currently?

5 A. Kaiser Permanente.

6 Q. Your salary is issued to you by what
7 group or what entity?

8 A. Salary is issued by -- I don't know
9 exactly.

10 Q. Is it Ohio Permanente Medical Group
11 that you are in actuality an employee of?

12 A. Yes, I think so.

13 Q. You said Kaiser Permanente when I
14 asked you who your employer is, but when you
15 look at your W-2 and file your taxes, does it
16 reflect that your actual employer is Ohio
17 Permanente Medical Group or does it reflect that
18 your employer is Kaiser Permanente?

19 A. I cannot tell you right now.

20 Q. You understand that there is an
21 entity called Ohio Permanente Medical Group?

22 A. Yes.

23 Q. And it's my understanding that all of
24 the physicians that work and provide care to
25 Kaiser Permanente patients at Snow Road are

1 employees of Ohio Permanente Medical Group. Is
2 that your understanding?

3 A. Yes.

4 Q. Mr. Kilbane handed me an exhibit, a
5 piece of paper, which I have marked as
6 Plaintiff's Exhibit 1.

7 - - - - -

8 (Thereupon, YANG Deposition
9 Exhibit 1 was marked for
10 purposes of identification.)

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12 Q. Take a look at that, and if you will
13 tell Vivian what that document is.

14 A. This is my curriculum vitae.

15 Q. Is it current?

16 A. Yes.

17 Q. You have two certifications. The
18 first one was in 1982. What certification is
19 that?

20 A. It is an ECFMG certificate.

21 Q. Which stands for what?

22 A. ECFMG stands for Educational
23 Commission for Foreign Medical Graduates.

24 Q. Can you explain that to me?

25 A. This is a certificate for the people

1 who come from other countries that want to come
2 to the United States, they have to pass an
3 examination before they can be allowed to come
4 here to learn or to get more education.

5 Q. You became board certified in
6 internal medicine in '85; true?

7 A. Yes.

8 Q. Were you successful in your boards
9 the first time through?

10 A. Yes.

11 Q. Have you ever had your license
12 suspended, revoked or called into question?

13 A. No.

14 Q. Have you ever had an application for
15 hospital privileges denied?

16 A. No.

17 Q. Have you ever had privileges at a
18 hospital revoked?

19 A. No.

20 Q. Or suspended?

21 A. No.

22 Q. I suspected the answer was no, but
23 sometimes I have sort of a mental laundry list
24 of things that I ask, so I apologize if I
25 offended you in any way by asking those

1 questions.

2 A. That's okay.

3 Q. Do you have a specialty within the
4 area of internal medicine?

5 A. No.

6 Q. If you are sitting around talking
7 with other doctors, other internal medicine
8 doctors and they asked you about your practice,
9 what type of patients you see, what would you
10 say to a colleague?

11 A. I see patients of all ages, starting
12 from age 20 through and older. It is patients
13 who are not --

14 Q. Take your time.

15 A. I'm the primary care for adult
16 patients.

17 Q. Doctor, you had a chance to meet with
18 Marilena and Mr. Kilbane. Mr. Kilbane is here
19 with you for the deposition. I'm not going to
20 ask you what you talked about with either of
21 those attorneys, or Erin, the other young
22 attorney that was present, but I do want to ask
23 you what you reviewed for purposes of preparing
24 for today's deposition. Don't tell me what you
25 discussed with them, just tell me what you

1 reviewed.

2 A. I have reviewed all the copies of the
3 records that Marilena sent to me and also a copy
4 of the depositions of the providers that Ms.
5 DiSilvio sent to me also.

6 Q. Which depositions do you recall
7 having reviewed?

8 A. Nancy Holmes, Dr. Mistry, and
9 Dr. Matalavage.

10 Q. And the records that were provided,
11 were they an entire copy of Mrs. Medlen's Kaiser
12 Permanente records?

13 A. I don't know entire, but whatever she
14 sent to me, I reviewed.

15 MR. KILBANE: He wants to know which
16 records you have seen. This is the chart. It's
17 in front of you. Have you reviewed this big set
18 of records or did you have portions of the
19 records?

20 THE WITNESS: I reviewed the portion
21 of the record which pertains to the visit of
22 August 4th.

23 Q. August 4, 1999, true?

24 A. Yes.

25 Q. You also had available to you various

1 labs with lab results that originated from that
2 August 4, 1999 office visit; true?

3 A. Yes.

4 Q. And also had available copies of
5 various records for visits that predated the
6 August 4, 1999 office visit; true?

7 A. Yes.

8 Q. And you reviewed those before today,
9 those records?

10 A. Yes.

11 Q. Have you reviewed anything other than
12 the three depositions that you referenced and
13 the medical records for Mrs. Medlen that you
14 just referenced, anything else other than that
15 information?

16 A. No.

17 Q. For example, there is a document
18 called a physician assistant utilization plan,
19 which was marked in Ms. Holmes' deposition as
20 Exhibit 3. Did you have a copy of that attached
21 to the deposition transcript from Ms. Holmes
22 that you saw also?

23 A. Yes, I saw the copy.

24 Q. And you are familiar with the
25 physician assistant utilization plan; correct?

1 A. Yes.

2 Q. You recognize that as a physician
3 that supervises physician assistants that you
4 have certain duties and obligations; true?

5 A. Yes.

6 Q. Let me just ask you this generally.
7 As a primary care physician here at Kaiser, do
8 you work with physician assistants on a
9 day-to-day basis?

10 A. No. We work on a rotational basis.
11 Not every day.

12 Q. Can you explain to me what you mean
13 by that in terms of a rotational basis?

14 A. She would work in our module. We
15 have four doctors in our module. So we
16 proctored her, the physician assistant, one
17 session at a time. But different doctors
18 proctor her different sessions.

19 Q. Are there occasions where you have a
20 physician assistant working under your direction
21 and occasions where you do not have a physician
22 assistant working under your direction?

23 A. Can you repeat that question?

24 Q. Sure. You mentioned proctoring.
25 Let's start with that. Just so that I'm not

1 defining it in my mind differently than how you
2 define it, when you refer to proctoring a
3 physician assistant, what does that mean?

4 A. Proctoring means we supervise. We
5 help out, and we direct the care of the patient
6 through the physician assistant.

7 Q. In the month of January of 2002, are
8 you working full time at Snow Road?

9 A. Yes.

10 Q. Full time, is that a 40 hour week?

11 A. Actually, I am working 80 percent
12 instead of 100 percent at this facility.

13 Q. Do you have any other employment?

14 A. No.

15 Q. Why are you only working 80 percent
16 at this facility?

17 A. I need more time with my family.

18 Q. So you have reduced your workload?

19 A. Yes.

20 Q. When did that become effective?

21 A. I think May of '99.

22 Q. So since May of '99, you have been
23 working --

24 A. May of 2000.

25 Q. Since May of 2000, you have been

1 working roughly 80 percent of a full-time
2 schedule?

3 A. Yes.

4 Q. And it's at your own request?

5 A. Yes.

6 Q. Fair enough.

7 A. Yes.

8 Q. In other words, there wasn't anything
9 that Ohio Permanente or Kaiser said to you that
10 caused them to take away time from you?

11 A. No. I volunteered to reduce my
12 working.

13 Q. Now, your schedule in 2002 at Kaiser,
14 is it exclusively the Snow Road facility that
15 you work at?

16 A. Yes, that is true, except if we work
17 at Cleveland Clinic during the one-week period,
18 then we don't see patients in our Kaiser - Snow
19 Road office.

20 Q. How is that one-week period
21 determined? Explain that to me.

22 A. The one week is determined, actually
23 determined on a rotation basis also. So
24 everybody has to go take care of the patients at
25 Cleveland Clinic because we have Kaiser patients

1 there.

2 Q. Is that one week a month?

3 A. No. Probably one week every two to
4 three months.

5 Q. Are you scheduled to work at the
6 Cleveland Clinic this month?

7 A. No.

8 Q. When are you scheduled to work at The
9 Cleveland Clinic?

10 A. In the future?

11 Q. Yes.

12 A. I haven't got any schedule working at
13 Cleveland Clinic yet.

14 Q. Back in August of 1999, were you
15 working 100 percent of your time at Snow Road?

16 A. Yes.

17 Q. You hadn't reduced your hours at that
18 time?

19 A. No, I didn't.

20 Q. Do you, this month, have a physician
21 assistant that you are supervising?

22 A. This month of January?

23 Q. Yes, sir.

24 A. Yes.

25 Q. You said there are other doctors in

1 your pod.

2 A. Yes.

3 Q. Who are the other internists in your
4 pod?

5 A. Dr. Rachel Abernathy, Dr. Keith Fu.

6 Q. How does Dr. Fu spell his last name?

7 A. F-U. And Dr. Ashwin Turakhia
8 T-U-R-A-K-H-I-A.

9 Q. Do any of the other three doctors
10 that you mentioned have any proctoring of
11 physician assistants this month?

12 A. Yes.

13 Q. How many physician assistants are
14 assigned to your department?

15 A. How many?

16 Q. Yes.

17 A. Four physician assistants in
18 different locations.

19 Q. Different locations within Snow Road
20 or different locations at other Kaiser
21 facilities?

22 A. Different locations in Snow Road and
23 also in other facilities.

24 Q. I guess what I'm trying to understand
25 is, on any given day, how do you know whether

1 you will be seeing a patient on your own or
2 whether you will be supervising a physician
3 assistant who may actually be doing the hands-on
4 examination of the patient?

5 A. We have a schedule.

6 Q. In any event, as I understand it, if
7 a physician assistant is working under your
8 supervision, you are legally responsible for the
9 conduct of the physician assistant; true?

10 A. Yes.

11 Q. How many physician assistants --
12 strike that.

13 If I use the word supervising, is
14 that the same thing in your mind as proctoring?

15 A. Yes.

16 Q. I may use the term supervising and I
17 just want to find out whether we can use those
18 terms synonymously.

19 A. Yes.

20 Q. How many physician assistants do you
21 supervise at any one time?

22 A. One.

23 Q. On August 4, 1999, were you the
24 supervising physician for Nancy Holmes?

25 A. Yes.

1 Q. By the way, doctor, prior to today's
2 deposition, aside from records and deposition
3 transcripts, did you review any medical
4 literature at all?

5 A. No.

6 Q. One of the other witnesses -- and I
7 believe it may have been Nancy Holmes --
8 acknowledged Harrison's on Internal Medicine as
9 being a reliable or authoritative resource. Do
10 you also acknowledge Harrison's as being a
11 reliable or authoritative resource in the area
12 of internal medicine?

13 A. I don't think it is reliable or
14 authoritative. I think it is a source of
15 information.

16 Q. Is it a good source of information,
17 in your opinion?

18 A. Yes.

19 Q. Is it something that you refer to
20 from time to time for reliable information in
21 areas of internal medicine?

22 A. I don't rely on one book for the
23 information.

24 Q. I'm not suggesting that you do rely
25 on one book. I'm talking about Harrison's. In

1 other words, do you consider it to be a good
2 resource? And I'm asking from time to time do
3 you refer to it for reliable information in the
4 areas of internal medicine?

5 Regardless of whether you refer to
6 other resources, do you refer to Harrison's from
7 time to time?

8 A. I refer to Harrison's and some other
9 books.

10 Q. Why don't you tell me what the other
11 ones are that you consider to be, perhaps,
12 equally reliable or perhaps more reliable in
13 your mind than Harrison's.

14 A. I think it depends on the subject and
15 depends on the information I'm looking for. So
16 sometimes I look at New England Journal of
17 Medicine and sometimes I go to Scientific
18 American Medicine.

19 Q. I'm sorry?

20 A. Scientific American Medicine.

21 Q. Any other resources that you look to
22 in the area of internal medicine?

23 A. As I told you, it depends on the
24 subject.

25 Q. I understand. What about on the

1 subject of fever of unknown etiology or fever of
2 unknown origin? Harrison's has a lot of
3 material in there. You are aware of that; true?

4 A. Yes.

5 Q. Are there any resources that you
6 consider to be more reliable on the topic of
7 fever of unknown origin or fever of unknown
8 etiology equal to or greater than what's
9 contained in Harrison's?

10 A. No, I don't think there is any.

11 Q. Suffice it to say, for today's
12 deposition, Dr. Yang did not look at any medical
13 literature; true?

14 A. No.

15 Q. Prior to today's deposition, did you
16 do any type of a literature search on any topics
17 relating to fever of unknown etiology or fever
18 of unknown origin to prepare yourself for today?

19 A. No.

20 Q. Did you do any research at all
21 dealing with the management of diabetic
22 patients, either as it relates to fever of
23 unknown origin or management of diabetic
24 patients in general, in preparation for the
25 deposition?

1 A. No.

2 Q. Can you cite me to any studies or any
3 journal articles that you consider to be
4 authoritative or reasonably reliable as it
5 relates to the management of a diabetic patient
6 that had similar history to that which
7 Mrs. Medlen had?

8 A. No.

9 Q. Fair enough. Have we exhausted the
10 topic of information you have reviewed as well
11 as research that you may have done before
12 today's deposition? Have we pretty well covered
13 everything that you have reviewed and touched on
14 what you may or may not have researched before
15 today's deposition?

16 A. Yes.

17 Q. If we have done that, then we are
18 going to start talking about Mrs. Medlen.

19 A. Okay.

20 Q. Although I will caution you, from
21 time to time I do think of something else along
22 the way, so even though I say we are going to
23 talk exclusively about Mrs. Medlen, I may revert
24 to something about your background, experience,
25 or your working here. So it's not to try to

1 trick you. It's just I may think of things or
2 look at my notes at that particular point.

3 A. I understand.

4 Q. Thus far you are doing very well for
5 having only been deposed a few times. I'm
6 hopeful that we will continue along with your
7 full understanding of my questions.

8 But I should have told you that if
9 you don't understand something -- even though it
10 may be clear in my mind, the question may not be
11 clear to you -- just tell me, I don't understand
12 what you are asking and I will be happy to
13 reword it or go back to the drawing board and
14 think of another question that may be clearer.
15 Fair enough?

16 A. Yes.

17 Q. When you reviewed the depositions of
18 the three caregivers, Dr. Matalavage, Nancy
19 Holmes, and Dr. Mistry, did you make any notes
20 at all?

21 A. No.

22 Q. Did you note anything at all on the
23 deposition transcripts themselves?

24 A. Can you repeat the question?

25 Q. Sure. Did you underline anything or

1 perhaps tab any of the pages, do anything as you
2 were reading the depositions of those three
3 people?

4 A. No.

5 Q. After reviewing the deposition
6 transcripts, did you have any conversation --
7 I'm not going to ask you to tell me what the
8 specifics were -- but did you have any
9 conversation before today about what you saw in
10 those depositions with either Mr. Kilbane or
11 Ms. DiSilvio?

12 MR. KILBANE: Objection. You are
13 asking whether he had a conversation with us
14 about his review of the deposition?

15 MR. MISHKIND: I am not going to ask
16 him about the content. After reviewing the
17 deposition transcript, did he talk before today
18 with counsel about what he saw in the deposition
19 transcripts.

20 MR. KILBANE: I'll object. I don't
21 think he has to answer it, but he can answer it,
22 I don't care.

23 A. Of course. I discussed with the
24 attorneys.

25 Q. Okay. Fair enough.

1 Now, did you bring those depositions
2 with you today?

3 A. Yes.

4 Q. These are your copies of the
5 depositions?

6 A. Yes.

7 Q. A copy of Dr. Matalavage, Dr. Mistry,
8 and Nancy Holmes?

9 A. Yes.

10 Q. True?

11 A. Yes.

12 Q. Just very quickly, leafing through,
13 you didn't tab any pages -- or wait, yes, you
14 did. It looks like in Nancy Holmes', page 47,
15 did you tab this?

16 A. I did make.

17 Q. Page 47 refers to the medical record
18 review summary sheet and Kaiser Permanente
19 physician/PA ambulatory medical review policy.
20 At least that's what this page refers to. Can
21 you tell me why it is you dog-eared page 47?

22 MR. KILBANE: If you remember. If
23 you don't, you don't have to guess for him.

24 A. I don't remember. I don't remember
25 why.

1 Q. Have you ever seen that document
2 that's referenced on page 47?

3 A. Yes.

4 Q. When is the last time you saw that
5 document?

6 A. I saw it last week.

7 Q. As I understand it, that document
8 sets forth certain criteria that you use in
9 terms of making sure that the physician
10 assistant is being appropriately supervised in
11 his or her day-to-day care of patients?

12 A. It's guidelines set forth for the
13 physician assistant and the physician to follow.

14 Q. And this is sort of a generic form?
15 It's not prepared specific to any one patient;
16 true?

17 A. No, it is generic.

18 Q. And it sets forth the guidelines that
19 you as a physician use in terms of making sure
20 that the physician assistant is being
21 appropriately supervised in her clinical
22 practice?

23 A. Yes.

24 Q. Have you ever seen a physician
25 ambulatory medical record review document

1 specific to Geraldine Medlen?

2 A. Can you repeat the question?

3 Q. Sure. You told me a moment ago that
4 the document you saw is a generic form that is
5 used in terms of a guideline for making sure
6 that the physician assistant is doing what he or
7 she is supposed to do in the clinical practice
8 under your supervision.

9 A. Yes.

10 Q. Have you ever seen a document similar
11 to the guideline document that you just referred
12 to that relates to what happened on August 4,
13 1999 with Ms. Holmes and Geraldine Medlen?

14 A. I don't recall.

15 Q. The document that you saw, is it fair
16 to say, was just as a preprinted Kaiser
17 Permanente form that sets forth the guidelines
18 that are to be used on a day-to-day basis?

19 A. Yes.

20 Q. Prior to August 4, 1999, had you ever
21 had occasion to either see or supervise a
22 physician assistant that was seeing Mrs. Medlen?

23 A. No.

24 Q. The same question with regard to
25 Mr. Medlen.

1 A. I don't recall.

2 Q. Do you have a recollection of ever
3 meeting Mr. Medlen?

4 A. I don't think so.

5 Q. Do you have a recollection of meeting
6 any of the Medlen children?

7 A. I don't recall.

8 Q. Now, when you say you don't recall, I
9 don't want to interpret that the wrong way. By
10 that, are you saying to me that you may have met
11 the children and you just don't remember one way
12 or another, or are you telling me when you say I
13 don't recall that you don't believe that you
14 have ever met the children?

15 A. I don't recall meeting any of them as
16 a patient.

17 Q. What about outside of a
18 physician/patient relationship, do you recall --

19 A. I am pretty sure I have never seen
20 them outside of the practice.

21 Q. After August 4, 1999, did you have
22 any involvement, direct or indirect, with regard
23 to Mrs. Medlen's care at Kaiser?

24 A. No.

25 Q. I want to show you what was marked in

1 Ms. Holmes' deposition as Exhibit 2. Hopefully,
2 when you saw her deposition, you saw this, as
3 well. Do you recall seeing that document?

4 A. Yes.

5 Q. When you reviewed the medical records
6 that were sent to you by counsel, was Exhibit
7 2 -- which, for the record, is a letter written
8 by Ms. Holmes to Dr. Mistry -- did you see that
9 in the actual medical records for Mrs. Medlen?

10 A. I saw it in the copy of the medical
11 record.

12 Q. You saw a copy of what is Exhibit 2;
13 true?

14 A. Yes.

15 Q. The information that Ms. Holmes is
16 relaying to Dr. Mistry in this note, Exhibit 2,
17 with regard to the results of the tests, is she
18 accurately reflecting the results of the tests,
19 as best as you could tell?

20 A. Yes.

21 Q. Do you know why this document,
22 Exhibit 2, was sent to Dr. Mistry as opposed to
23 being sent to you?

24 A. I don't know why.

25 Q. Should this document have been sent

1 to you instead of Dr. Mistry?

2 A. I think so.

3 Q. And why is that?

4 A. Because I was the supervising
5 physician for this visit.

6 Q. And as a supervising physician for
7 this visit, of what importance was it that the
8 physician assistant bring to your attention the
9 results of tests that were done on that visit?

10 A. The blood sugar was abnormal, the
11 urine sugar was elevated, so these are abnormal
12 lab results.

13 Q. And of what significance, if any, is
14 that in a diabetic patient that is a high risk
15 amputation patient?

16 A. The significance depends on the
17 clinical context, the clinical impression after
18 the examination.

19 Q. Are those labs potentially consistent
20 with an infectious state?

21 A. Possibly.

22 Q. Again, it has to be taken in the
23 context of the clinical examination; correct?

24 A. Yes.

25 Q. Is it fair to say that Ms. Holmes

1 never sent you the results of the CBC or the
2 urinalysis that was done?

3 A. Yes.

4 Q. And is it fair to say that as a
5 supervising physician, she should have done that
6 in order to comply with the physician assistant
7 utilization plan?

8 A. Yes.

9 Q. And that she should have provided
10 that to you in order to provide appropriate care
11 to this patient, Mrs. Medlen?

12 A. Yes.

13 Q. And her failure to do that represents
14 substandard care; true?

15 A. It depends on the degree of
16 abnormality on the result.

17 Q. Certainly she had a duty to provide
18 this information to you as a supervising
19 physician so that clinical decisions could be
20 made; true?

21 A. Yes.

22 Q. And failure to do that so that
23 clinical decisions could be made represents care
24 which falls below accepted standards; true?

25 A. As I told you, it depends on the

1 finding of the lab result, and based on the lab,
2 the slip of the lab report, I'm not sure if this
3 is going to make much difference in terms of
4 decision-making.

5 Q. Why do you say that, doctor?

6 A. The random blood sugar 261, the urine
7 glucose more than 1000 is abnormal, but not
8 remarkable -- not severely remarkable to me.

9 Q. What about the results of the CBC?

10 A. There was no CBC on this sheet.

11 Q. I'm going to show you Plaintiff's
12 Exhibit 4, which was marked in Ms. Holmes'
13 deposition. Do you recall seeing that as an
14 attachment to Ms. Holmes' deposition?

15 A. Yes.

16 Q. And those are results of labs that
17 were drawn on August 4, 1999; correct?

18 A. Yes.

19 Q. And there are some abnormalities in
20 those labs, as well; true?

21 A. Yes.

22 Q. Were those abnormalities ever brought
23 to your attention by Ms. Holmes?

24 A. No.

25 Q. Can we agree that Ms. Holmes should

1 have brought those lab results to your attention
2 as the supervising physician?

3 A. Yes.

4 Q. And can we agree that her failure to
5 do so is not in accordance with the physician
6 assistant utilization plan?

7 A. Yes.

8 Q. If you take into account the results
9 of the CBC and the results of the urine glucose
10 and the random blood sugar that was drawn, are
11 both of these results in conjunction with each
12 other in Mrs. Medlen important pieces of
13 information that should have been brought to the
14 attention of the supervising physician that was
15 responsible for the patient on August 4, 1999?

16 A. Yes.

17 Q. Why is that?

18 A. Because they are not normal.

19 Q. And in the context of a patient that
20 has diabetes that has -- you have seen her
21 history from the record; correct?

22 A. Yes.

23 Q. And certainly on August 4, 1999, the
24 information concerning her history of treatment
25 and her diagnoses was available to Ms. Holmes

1 and available to you, as necessary; true?

2 A. Yes.

3 Q. So I'm not going to repeat the
4 history. You are fully familiar with the
5 history and certainly had it reaffirmed to you
6 when you read over the depositions; true?

7 A. Yes.

8 Q. In the context of a patient with a
9 history that Mrs. Medlen had as of August 4,
10 1999, of what significance, if any, are these
11 abnormal random blood sugar and glucose results,
12 urine glucose results and the CBC results?

13 A. What are the significance?

14 Q. Of what significance, yes.

15 A. The sugar was elevated, her sugar
16 control was not good, and there was a mild
17 elevation of white counts.

18 Q. There are also some results toward
19 the bottom. In addition to the white blood
20 count that shows percentage lymphs and
21 percentage -- it says percentage gran. Do you
22 see those two references?

23 A. Yes.

24 Q. First, to find out and in simple
25 parlance, what do those two items that I just

1 referred to indicate?

2 A. The elevation of white counts and
3 increased granulocyte percentage usually means
4 it was some kind of inflammation process going
5 on.

6 Q. What about the other reference,
7 percentage gran?

8 A. Gran means granulocyte.

9 Q. And above that lymphocytes?

10 A. Yes.

11 Q. Are both of those indicative of some
12 type of inflammation?

13 A. Yes.

14 Q. Can they also be indicative of some
15 type of infectious process, as well?

16 A. Possibly.

17 Q. Certainly you can't rule out
18 infection based upon those results, can you?

19 A. You cannot.

20 Q. And in a patient that is a diabetic
21 patient, are they at increased risk of
22 developing infections where their glucose is not
23 adequately controlled?

24 A. Yes.

25 Q. And of what significance is that in a

1 patient that is high risk amputation, where
2 their blood glucose is not under control and
3 they have results from a CBC that at least
4 raises the possibility of an inflammatory and/or
5 an infectious process going on?

6 A. Can you rephrase the question?
7 Because it's too long. I lost track.

8 Q. Not a problem. You are doing exactly
9 what you should do.

10 As a specialist in the area of
11 internal medicine, when you have lab results
12 that show the random blood sugar, the urine
13 glucose and the CBC abnormalities that we have,
14 of what significance is that to you as an
15 internist in a patient with the history that
16 Mrs. Medlen presented with on August 4, 1999?

17 A. Based on all this mildly abnormal lab
18 report, it's very hard to say the significance.

19 Q. Did this patient need to be evaluated
20 further based upon the results that were
21 obtained on August 4, 1999?

22 A. It depends on the clinical context
23 and the examination.

24 Q. Now, perhaps we can frame what you
25 have just said in terms of it depends upon the

1 clinical context and the examination by moving
2 on to another topic, and then perhaps we will
3 come back to this, okay?

4 A. Yes.

5 Q. Do you have any recollection of
6 Mrs. Medlen?

7 A. In person?

8 Q. Yes.

9 A. No, I don't have any recollection.

10 Q. On August 4, 1999, were you present
11 at Kaiser - Snow Road?

12 A. Yes.

13 Q. I'm going to have marked as Exhibit 2
14 a document that I believe may also be an exhibit
15 in Nancy Holmes' deposition. I want to have
16 this specific to the deposition for your
17 transcript.

18

- - - - -

19 (Thereupon, YANG Deposition

20 Exhibit 2 was marked for

21 purposes of identification.)

22

- - - - -

23 Q. Exhibit 2 for your deposition is a
24 two-page document. Can you identify what this
25 two-page document is, please?

1 A. This is Nancy Holmes' notes on August
2 4th, '99.

3 Q. And so there is no question, on
4 August 4, 1999, you were the supervising
5 physician to Nancy Holmes; true?

6 A. Yes.

7 Q. Had you worked with Nancy Holmes
8 prior to August 4, 1999 on any other patients?

9 A. Yes.

10 Q. Doctor, the note that Nancy Holmes
11 sent to Dr. Mistry that was marked as Exhibit 2
12 from her deposition, when did you first become
13 aware of this note?

14 A. Only when my attorney sent me the
15 copy of the medical record and the deposition.

16 Q. Have you ever talked to Nancy Holmes
17 about the letter that she sent to Dr. Mistry?

18 A. No.

19 Q. Have you ever asked her why she
20 didn't send it to you?

21 A. No.

22 Q. The results of the labs that we
23 talked about, both the urine glucose, the
24 random -- the blood sugar, the random glucose
25 and the CBC results, when was the first time you

1 saw those results before today's deposition?

2 A. That was when the attorneys sent me
3 the copies.

4 Q. Did you ever talk to Ms. Holmes about
5 those results in terms of why she didn't send
6 them to you?

7 A. No.

8 Q. Why she didn't bring them to your
9 attention?

10 A. No.

11 Q. If those lab results had been brought
12 to your attention as the supervising physician,
13 what would you have done?

14 A. I probably will talk to Nancy
15 Holmes -- it depends on the clinical history --
16 and I probably would ask Nancy Holmes to call
17 the patient.

18 Q. Why? What is it about the results
19 that would have caused you to do that?

20 A. Because of some abnormality in the
21 lab.

22 Q. And you know what the term
23 differential diagnosis is, don't you?

24 A. Yes.

25 Q. Would you have had some things in

1 your mind as potential differentials for causing
2 those abnormalities?

3 A. Yes.

4 Q. What would have been within your
5 differential?

6 A. A lot of differentials. Such as
7 urinary tract infection, such as pneumonia, such
8 as flu, anything.

9 Q. Now, you referred to urinary tract
10 infection. Given the fact that this patient had
11 a diabetic condition and had been treated for
12 ulcers in her feet, that she had an infection
13 emanating from the heel ulcers, would that also
14 be within the differential?

15 A. Possible.

16 Q. And again, it depends upon the
17 clinical picture on the patient; correct?

18 A. Yes.

19 Q. Obviously, the clinical picture
20 depends upon a thorough examination of the
21 patient?

22 A. Yes.

23 Q. Absent a thorough examination, one
24 cannot obtain an accurate clinical picture;
25 true?

1 A. Yes.

2 Q. When should the results of the random
3 glucose, the urine glucose, the blood sugar, the
4 CBC, when should those results have been
5 presented to you as the supervising physician?

6 A. If it was ordered stat, this should
7 be available within two, three hours.

8 Q. Can you tell from looking at the
9 chart or looking at anything in this case how
10 they were ordered?

11 A. Chest x-ray was ordered stat, but for
12 other tests, I'm not sure.

13 Q. Who was it that determined that the
14 chest x-ray should be ordered stat?

15 A. It was me.

16 Q. And who was it that was responsible
17 for determining whether the chest x-ray should
18 be ordered stat or on a nonstat basis?

19 A. It was me.

20 Q. Who was it that was responsible for
21 determining whether the blood work and the urine
22 test was to be done on a stat basis?

23 A. It was me also.

24 Q. And is it fair to say that there is
25 no indication in the record how you wanted those

1 results done; whether you wanted them stat or
2 whether you wanted them done whenever they could
3 be done?

4 A. I recall the lab was also ordered
5 stat.

6 Q. So the labs should have been
7 available within, what did you say, two to three
8 hours?

9 A. Yes.

10 Q. And once the labs are done and they
11 are reported back within two or three hours, is
12 there a system where the results from the labs
13 are to be brought to someone's attention?

14 A. It depends on the degree of the
15 abnormalities in the tests we order. So, for
16 example, the lab has certain numbers, which when
17 it was reached, the lab has to call the
18 provider.

19 Q. Do you know in this case whether the
20 results that were obtained from Mrs. Medlen were
21 within a range that required that the lab
22 actually pick up the phone and call the
23 provider?

24 A. I don't recall.

25 Q. Let's just assume hypothetically that

1 the labs are not within that range that they
2 have to pick up the phone and call the provider,
3 yet the results are ordered on a stat basis.
4 Are they supposed to be entered into a computer
5 and somehow communicated back to the provider,
6 short of actually picking up the phone and
7 calling the provider?

8 A. Yes.

9 Q. And when something is ordered on a
10 stat basis, the general practice and custom here
11 at Kaiser is within two to three hours?

12 A. Yes.

13 Q. And do you know of any reason in this
14 case on August 4, 1999 that the results of the
15 labs could not have been reported back and
16 entered into the computer within two or three
17 hours?

18 A. I don't.

19 Q. Would you agree that in order to have
20 provided safe and acceptable care, the results
21 of the labs should have been available in the
22 computer on August 4, 1999 within two to three
23 hours of Mrs. Medlen's tests?

24 A. Yes.

25 Q. Can we agree that they were not?

1 A. I don't know. I don't know what time
2 the lab report was put on the computer.

3 Q. Well, if you just assume for purposes
4 of this question that the lab results were not
5 put on the computer until, at the earliest, the
6 following day, August 5, 1999, would you agree
7 that that would not be in keeping with what you
8 would expect from Kaiser in terms of responding
9 to stat urine and CBC on this particular
10 patient?

11 MR. KILBANE: Objection. Go ahead.

12 A. I don't know what is the lab's policy
13 in terms of putting the lab report on the
14 computer. I don't know their policy about that.

15 Q. But certainly from a medical
16 standpoint, forgetting about the lab's policy,
17 when you asked for something stat, you expect in
18 order to provide safe and acceptable care that
19 the information be available minimally within
20 two or three hours; true?

21 A. Yes.

22 Q. And if it's outside of those ranges
23 where the lab has guidelines, not only do they
24 make it available on the computer within two or
25 three hours, but they have to pick up the phone

1 and contact the provider; true?

2 A. Yes.

3 Q. In this case, you don't know whether
4 or not the lab was required to pick up the
5 phone, because you don't know what their
6 parameters were; true?

7 A. I don't know.

8 Q. You said that had you been provided
9 with the lab work, the CBC, and the results of
10 the urine, I think you told me the first thing
11 you would have done is contacted Nancy Holmes?

12 A. Yes.

13 Q. And then depending upon the clinical
14 circumstances, might you have had Nancy contact
15 Mrs. Medlen?

16 A. Yes.

17 Q. For what purpose?

18 A. To tell her about the report and
19 evaluate a list on the phone about the patient's
20 condition.

21 Q. Now, there is an indication that
22 Mr. Medlen called the following day on August 5
23 wanting the results and also indicating that his
24 wife was febrile and was having certain
25 symptoms. Do you know in this case why that

1 information was not brought to your attention on
2 August 5?

3 A. I don't know.

4 Q. Should that information have been
5 brought to your attention on August 5?

6 A. Yes.

7 Q. If that information in terms of her
8 being febrile and having symptoms where I think
9 it may have been described as dry heaves or
10 certainly nauseous -- but you saw that telephone
11 contact -- had that information been brought to
12 your attention in conjunction with the labs
13 which should have been brought to your
14 attention, what would you have done on August 5,
15 1999?

16 A. I would call the patient back and
17 discuss about the symptoms, and so it's very
18 hard to say what else I would have done.

19 Q. This would have been something that
20 needed to be acted upon immediately, not within
21 a 24 or 48 hour period; true?

22 MR. KILBANE: Objection. Go ahead.

23 A. Immediately?

24 Q. As soon as the information came to
25 your attention, on August 5, that there were

1 abnormal labs from August 4 that had not been
2 brought to your attention and the patient is now
3 calling with continuing and perhaps worsening
4 symptoms, that's something that in order to meet
5 the standard of care you would have acted upon
6 immediately, not the next day or 48 hours later;
7 true?

8 A. Personally, I act within 24 hours.

9 Q. In this particular case, with these
10 results, are you suggesting that it would have
11 been okay for you to say, okay, well, I will
12 call her back the following day, or more likely
13 would you have picked up the phone within
14 minutes after getting that information and
15 checked on the patient?

16 MR. KILBANE: Objection. Go ahead.

17 A. Yeah, based on the message that the
18 husband called, I would have acted within that
19 day.

20 Q. But suffice it to say, that was never
21 brought to your attention, so you couldn't act;
22 true?

23 A. True.

24 Q. Do you know why all of that
25 information was never brought to your attention?

1 A. I don't know.

2 Q. It should have been; true?

3 A. Yes.

4 Q. And depending upon the information
5 that you gathered from looking at the labs and
6 talking to the patient, one of the ways that you
7 might have treated this patient was to have her
8 come to the emergency room or come to internal
9 medicine to be reevaluated; true?

10 A. It depends on the evaluation on the
11 form first.

12 Q. Sure. But we know that no evaluation
13 took place, according to what you can see in the
14 records; true?

15 A. True.

16 Q. There doesn't appear to be any
17 indication -- and correct me if I am wrong --
18 there doesn't appear to be any indication that
19 anyone got back to Mr. Medlen on August 5 to
20 give him information or to respond to his wife's
21 symptoms; is that correct?

22 A. That's true.

23 Q. And that's not good care, is it,
24 doctor?

25 A. That is not adequate care.

1 Q. On August 4, 1999, did you physically
2 examine Mrs. Medlen?

3 A. No.

4 Q. On August 4, 1999, did you even meet
5 Mrs. Medlen?

6 A. No.

7 Q. The diagnosis of fever of unknown
8 etiology that's noted on Exhibit 2, was that
9 your diagnosis or was that Nancy Holmes'
10 diagnosis?

11 A. It was Nancy Holmes' diagnosis.

12 Q. Would you agree that before one can
13 arrive at a fever of unknown etiology or fever
14 of unknown cause that you have to search for an
15 explanation for a febrile illness?

16 A. Yes.

17 Q. Frequently a fever of unknown
18 etiology or fever of unknown cause is a
19 diagnosis of exclusion, is it not?

20 A. Yes.

21 Q. Would you agree that there were test
22 results pending at the time that diagnosis of
23 fever of unknown etiology was noted by
24 Ms. Holmes?

25 A. Yes.

1 Q. Can we agree that a fever of unknown
2 etiology was not an appropriate diagnosis to
3 have noted based upon the fact that the test
4 results, looking for a cause for the fever, were
5 still pending?

6 MR. KILBANE: Objection. Go ahead.

7 A. Yes.

8 Q. Would you agree that as part of an
9 investigation into fever of unknown origin or
10 fever of unknown etiology that the clinician
11 must consider the fever pattern in order to
12 determine what type of illness a patient is
13 suffering from?

14 A. Yes.

15 Q. Would you agree that when Mrs. Medlen
16 presented on August 4, 1999, that she was
17 presenting to internal medicine as an
18 established patient?

19 A. Yes.

20 Q. Would you agree that on August 4,
21 1999, she was presenting as an established
22 patient with a new condition?

23 A. Yes.

24 Q. You did not personally evaluate
25 Mrs. Medlen; true?

1 A. True.

2 Q. Can we agree that you should have
3 personally evaluated Mrs. Medlen?

4 A. No.

5 Q. Can we agree that the physician
6 assistant utilization plan requires that all
7 established patients with new conditions must be
8 seen and personally evaluated by a supervising
9 physician prior to the initiation of any
10 treatment?

11 A. This is a guideline of Kaiser.

12 MR. KILBANE: You just asked him if
13 that's what it said; right?

14 MR. MISHKIND: I am reading from it,
15 but I asked whether all established patients
16 with new conditions -- strike that.

17 Q. We have already established that
18 Mrs. Medlen was an established patient; true?

19 A. Yes.

20 Q. And she presented with a new
21 condition on August 4, 1999?

22 A. Yes.

23 Q. And the physician utilization plan
24 indicates that all established patients with new
25 conditions be seen and personally evaluated by a

1 supervising physician prior to the initiation of
2 any treatment. Did I accurately read that?

3 A. Yes.

4 Q. There is no question that Nancy
5 Holmes had the same information available to her
6 that you would have had available to you; true?

7 A. True.

8 Q. And certainly, if she was acting
9 within the standard of care, she should have
10 been able to recognize that this was a new
11 condition that the patient was presented with;
12 true?

13 A. Yes.

14 Q. The utilization plan that Kaiser
15 filed with the State Medical Board indicated
16 that a physician assistant is required to refer
17 the patient to the supervising physician when a
18 new condition is identified by the physician
19 assistant; true?

20 A. Yes.

21 Q. And Nancy Holmes did not refer this
22 patient to you when she identified a new
23 condition, did she?

24 A. She referred patients to me.

25 Q. Did you personally examine

1 Mrs. Medlen?

2 A. No.

3 Q. Were you available to have personally
4 examined Mrs. Medlen?

5 A. Yeah, I was available.

6 Q. Why didn't you personally examine
7 Mrs. Medlen on August 4, 1999?

8 A. Based on Nancy's evaluation and the
9 patient's presentation, I evaluate the patient
10 and draw the conclusion that this is the flu,
11 consistent with flu syndrome.

12 Q. Doctor, you mentioned a moment ago
13 guidelines. What I would like to know is where
14 in this document filed with the State Medical
15 Board it indicates that there is any discretion
16 in terms of the supervising physician personally
17 evaluating the patient as opposed to relying on
18 information provided by the physician assistant
19 when a new condition is discovered. There is no
20 discretion, is there?

21 MR. KILBANE: I think you are
22 leaving out prior treatment being initiated in
23 your question.

24 Q. In order to make a diagnosis on the
25 patient, we have already established that a

1 thorough physical examination needs to be made
2 where fever of unknown etiology or fever of
3 unknown cause is under consideration; correct?

4 A. Yes.

5 Q. Should Nancy Holmes have told you
6 that she was considering fever of unknown
7 etiology as a diagnosis?

8 A. I don't recall.

9 Q. Do you agree that in performing a
10 physical examination on a diabetic patient who
11 is being evaluated for fever of unknown etiology
12 or has been diagnosed with fever of unknown
13 etiology, that special attention in the physical
14 examination must be paid to skin, the nail beds
15 and the musculoskeletal system of the patient?

16 A. You have to pay to every part of the
17 body -- pay attention to every part of the body.

18 Q. Got it.

19 The parameters that one normally
20 encounters in a fever of unknown etiology are
21 where the fever continues for two to three weeks
22 as opposed to an acute onset of fever; true?

23 A. That is a definition of fever of
24 unknown origin.

25 Q. Do you have any explanation in this

1 case for why Nancy Holmes arrived at a fever of
2 unknown etiology on August 4, 1999?

3 A. No.

4 Q. Would that have been your diagnosis
5 had you seen this patient on August 4, 1999 with
6 the history that she presented with?

7 A. No.

8 Q. What would have been your diagnosis
9 on August 4, 1999 if you had seen this patient
10 with a history that she presented with?

11 A. My tentative diagnosis would be flu
12 syndrome.

13 Q. Would you have been able to rule out
14 infection?

15 A. No.

16 Q. Would you have done a thorough
17 examination of the patient if this new condition
18 had been presented to you and you personally
19 evaluated the patient?

20 A. Yes.

21 Q. Now, on the physician assistant
22 utilization plan -- strike that.

23 When did you plan to see this patient
24 again?

25 A. When did I plan to see the patient

1 again?

2 Q. After the August 4 visit.

3 A. It depends on the clinical course.

4 Q. What instructions were given to this
5 patient when she left Kaiser on August 4, 1999?

6 A. To treat as a flu syndrome.

7 Q. And what does that mean?

8 A. That is taking care of the fever,
9 taking care of the ache and pain with
10 over-the-counter medicine.

11 Q. So that was the treatment plan?

12 A. Yes.

13 Q. Was she advised to come back to the
14 office at any given time in the future?

15 A. There is no particular day to be seen
16 again.

17 Q. What other instructions, if any,
18 would be given to this patient on August 4,
19 1999, other than what you told me in terms of
20 treating with flu-like syndrome, other than that
21 treatment plan that you have described?

22 A. Usually we tell the patient to call
23 or come back if there is a change of condition,
24 such as mental status, such as new symptoms,
25 such as fever is not getting better within two,

1 three days.

2 Q. Now, doctor, I'm going to ask you
3 whether you can explain to me in the utilization
4 plan of physician assistants, which is Exhibit 3
5 from Nancy Holmes, what you understand the words
6 -- and I'm going to read it into the record, .

7 I'll hand you my copy. It's
8 highlighted in the language, but if you want to
9 take a look at the highlighting.

10 It says, pursuant to, and there is a
11 section of the law, ORC 4730.21, a patient new
12 to the supervising physician's practice or an
13 established patient with a new condition -- the
14 word must in all capital letters and
15 underlined -- must be seen -- so again I'll read
16 it.

17 A patient new to the supervising
18 physician's practice or an established patient
19 with a new condition must be seen and personally
20 evaluated by the supervising physician prior to
21 initiation of any treatment plan.

22 Have I read that accurately?

23 A. Yes.

24 Q. Can you explain to me what that
25 means, as you understand it, especially with

1 regard to the word must be seen, which is in all
2 capitals and underlined?

3 A. Explain to you? These are very
4 clear. If the patient is new to the supervising
5 physician practice or an established patient
6 with a new condition must be seen and personally
7 evaluated by the supervising physician prior to
8 initiation of any treatment plan.

9 Q. Pretty clear language, isn't it?

10 A. Yes.

11 Q. You were the supervising physician;
12 true?

13 A. Yes.

14 Q. This was a new condition; true?

15 A. Yes.

16 Q. She must be seen and personally
17 evaluated by you prior to initiation of any
18 treatment plan; true?

19 A. True.

20 Q. You did not see and personally
21 evaluate this patient, did you?

22 A. I didn't.

23 Q. A treatment plan was initiated when
24 she was discharged on August 4, 1999; true?

25 MR. KILBANE: Objection.

1 A. No, we didn't initiate any specific
2 treatment plan.

3 Q. You were treating her for a flu-like
4 syndrome; correct?

5 A. Yes.

6 Q. You had a treatment plan initiated
7 for a flu-like syndrome; correct?

8 A. Treatment, yeah.

9 Q. You would agree with me that this
10 language isn't just a guideline. This is
11 something that if you are going to have a
12 physician assistant seeing the patient, you as
13 the supervising physician, in order to provide
14 safe and reasonable care for a patient, must
15 comply with; true?

16 A. Yes.

17 Q. And you didn't comply with it; true?

18 MR. KILBANE: Objection.

19 A. I act not inconsistent with this
20 sentence.

21 Q. I'm sorry, tell me how you did not
22 act inconsistent with that sentence.

23 A. Because we didn't initiate any
24 treatment plan, other than regular
25 over-the-counter medicine.

1 Q. Why didn't you see this patient when
2 she presented with a new condition?

3 A. We didn't initiate any planning.

4 Q. Why didn't you see her? What was
5 preventing you from examining this patient on
6 August 4, 1999?

7 A. I evaluate the patient after Nancy
8 Holmes' presentation and evaluation.

9 Q. Where were you?

10 A. In the facility.

11 Q. On the floor?

12 A. Yes.

13 Q. There is nothing physically that was
14 preventing you from coming and seeing this
15 patient with a new condition; true.

16 MR. KILBANE: Objection. Asked and
17 answered.

18 A. There was nothing preventing me.

19 Q. Tell me what the physical examination
20 included with regard to the lower extremity of
21 this patient.

22 A. In the chart?

23 Q. Yes.

24 A. It was not mentioned.

25 Q. The upper extremity -- there was an

1 examination -- some things noted to be normal;
2 correct?

3 A. Yes.

4 Q. And I think there may have been a
5 couple abnormalities in the upper extremity
6 exam, the head --

7 A. The upper extremities were not
8 mentioned.

9 Q. What is at the very bottom of that
10 where it says objective, what does that mean?

11 A. Alert and oriented times three.

12 Q. And then right below that, what does
13 that mean?

14 A. HEENT. Head, ears, eyes, nose,
15 throat examination.

16 Q. So that indicates that the head,
17 ears, eyes, nose and throat were examined;
18 correct?

19 A. Yes.

20 Q. A moment ago you said it doesn't
21 mention anything about an upper extremity
22 examination. You misspoke, did you not?

23 A. Upper extremities means arms and
24 hands and fingers.

25 Q. Maybe I misstated it and I apologize.

1 When I meant upper extremity, I suppose you are
2 correct, I'm talking about, is there any
3 examination recorded above the belt, so to
4 speak?

5 A. Yes.

6 Q. And that would be of the head, ears,
7 eyes, nose and throat?

8 A. Yes.

9 Q. Some of the exam was normal; correct?

10 A. Yes.

11 Q. And there was some mild
12 abnormalities?

13 A. Yes.

14 Q. The examination continued. There was
15 an examination done of the lungs, of the heart,
16 and of the abdomen; true?

17 A. Yes.

18 Q. There is no reference to any
19 examination of the legs, the feet, the toes;
20 correct?

21 A. Correct.

22 Q. Do you recall having the conversation
23 with Nancy Holmes about this patient on August
24 4, 1999?

25 A. Yes, I vaguely recall.

1 Q. Tell me what you vaguely recall her
2 telling you.

3 A. She told me the patient's symptoms
4 and her examination, and her impression was flu
5 syndrome.

6 Q. Did she also tell you that this was a
7 diabetic patient with a history of diabetic foot
8 ulcers?

9 A. Yes.

10 Q. Did she also tell you that that was a
11 patient that was a high risk amputation?

12 A. I don't recall.

13 Q. Should she have told you that in
14 order to give you sufficient history so that you
15 could make clinical decisions?

16 A. Yes.

17 Q. Do you have diabetic patients that
18 you treat?

19 A. Yes.

20 Q. And do you have diabetic patients
21 that have peripheral neuropathy that you treat?

22 A. Yes.

23 Q. Do you have diabetic patients with
24 peripheral neuropathy that present with
25 recurrent diabetic foot ulcers?

1 A. Yes.

2 Q. And when you have that type of
3 patient that presents with fever, chills, body
4 aches, would you agree that the physical
5 examination of that patient should include the
6 lower extremities to ascertain whether or not
7 the ulcers in a diabetic patient with peripheral
8 neuropathy and recurrent diabetic foot ulcers
9 are infected?

10 A. Can you repeat your question?

11 Q. Sure. Would you agree that a
12 physical examination of the lower extremities
13 when you are seeing a patient that's diabetic,
14 has peripheral neuropathy, that has recurrent
15 diabetic foot ulcers and presents with fever,
16 chills and body aches, that a physical
17 examination should be done which would include
18 the lower extremity to determine whether or not
19 the ulcers are, in fact, infected?

20 A. Yes.

21 Q. And no such examination was done on
22 this patient; correct?

23 A. It was not documented.

24 Q. Well, you know of no evidence that
25 her lower extremities, including the ulcers on

1 her feet, were examined by Nancy Holmes, do you?

2 A. It was not documented, but I cannot
3 tell you examined or not.

4 Q. Is it fair to say that she does not
5 have any documentation of examining her feet on
6 this report?

7 A. There is no documentation.

8 Q. A good physical examination would
9 include in a patient with this history an
10 examination of the feet, as well; true?

11 MR. KILBANE: Objection. Asked and
12 answered.

13 A. No, that is not always true.

14 Q. In a patient that presents, a high
15 risk patient, high risk amputation that is being
16 treated for diabetic foot ulcers, that presents
17 with a new onset of symptoms, including fever,
18 chills, body aches, would you agree that a
19 reasonable and prudent examination would include
20 a lower extremity examination?

21 A. That would include.

22 Q. And the lower extremity examination,
23 just so we are not playing semantics, lower
24 extremity examination would include looking at
25 the feet; true?

1 A. Yes.

2 Q. That would be a reasonable and
3 prudent thing to do; correct?

4 A. Yes.

5 Q. There is no documentation in the
6 record that Nancy Holmes did that on August 4;
7 true?

8 A. No documentation.

9 Q. And you can't say to me that Nancy
10 Holmes told you that she examined her feet;
11 true?

12 A. I don't recall.

13 Q. Doctor, do you have an opinion in
14 this case as to whether or not Mrs. Medlen's
15 infection clinically would have been noted on
16 August 4, 1999 had a lower extremity examination
17 been done, including an examination of her
18 diabetic feet?

19 A. I cannot say one way or the other.

20 Q. Is it fair to say you just don't have
21 an opinion to a reasonable degree of
22 probability?

23 A. I don't have an opinion.

24 Q. So I take it you will not testify at
25 trial that had the test results been acted on

1 stat, had you examined the patient, had all the
2 things that occurred on August 4, 1999 been
3 done, whether or not an infection would have
4 been diagnosed on August 4, 1999? You don't
5 have an opinion one way or another?

6 A. I don't have an opinion.

7 Q. Assuming hypothetically that an exam
8 had been done, the labs had been appreciated and
9 reported back within the period of time that you
10 wanted them reported back, and an infection had
11 been suspected, do you have an opinion as to
12 whether or not treatment on August 4, or perhaps
13 even the morning of August 5, 1999 would have
14 prevented Mrs. Medlen's subsequent amputation of
15 her foot and then the below the knee amputation?

16 A. I don't have any opinion.

17 Q. Fair enough. If you had sufficient
18 information from the labs and from an
19 examination on August 4, 1999, and her history,
20 that would have caused you to believe that she
21 had an infection in her foot that was causing
22 her fever, her chills, her body ache, what would
23 have been the treatment of choice as of August
24 4, 1999?

25 MR. KILBANE: Objection.

1 A. Can you repeat the question?

2 Q. Sure. Absolutely. Labs are done,
3 urine is processed, and the information is
4 reported back to you on August 4, or early
5 August 5 -- let's say August 4, and you had
6 examined the patient on August 4, and felt that
7 her fever, her chills, her body ache, and the
8 test results were consistent with a diabetic
9 foot ulcer on a diabetic patient that was
10 developing or had an infection in that diabetic
11 ulcer, what would the treatment have been at
12 that point in time on August 4, if all that
13 information was available?

14 A. If my impression was a foot infection
15 after the examination, the treatment would be to
16 start IV antibiotics, and depending on the
17 situation, I may send her directly to the
18 hospital.

19 Q. Now, the IV antibiotics, is that
20 something that you can administer here at
21 Kaiser - Snow on an outpatient basis?

22 A. One dose maybe we can administer, but
23 more than that, we cannot do it.

24 Q. And you would have to assess the
25 patient based upon the response to that one dose

1 as to whether or not she would have to be
2 admitted to the hospital or could be safely
3 treated on an outpatient basis; correct?

4 A. Yes.

5 Q. If you had within your differential a
6 foot infection based upon the labs, and actually
7 examining the patient, would it be reasonable to
8 let the patient go home without the initiation
9 of any antibiotic treatment?

10 MR. KILBANE: Objection. Go ahead.

11 A. If there is evidence of foot
12 infection, I would not send the patient home
13 without antibiotics.

14 Q. When you say evidence, obviously you
15 may not have definitive evidence, but at least a
16 high index of suspicion that she has an
17 infection, you would treat the patient?

18 A. Yes.

19 Q. And would the same thing apply if the
20 information on August 5 came to your attention;
21 in other words, you examined the patient on
22 August 4, clinically you appreciated that she,
23 within her differential, may have an ulcer, a
24 foot infection, you got the results back of the
25 labs on August 5, and they were consistent with

1 the possibility of an infection, would you have
2 then taken steps to have the patient come back
3 for IV antibiotic treatment?

4 MR. KILBANE: Objection.

5 A. I think the foot infection or any
6 kind of infection is based on the clinical
7 examination; mainly the examination, not based
8 on the other lab result.

9 Q. And you don't know what you would
10 have seen of her foot on August 4, because you
11 did not come and examine her; true?

12 A. I didn't see the patient, but based
13 on Nancy Holmes' evaluation, I didn't think
14 there was a foot infection going on.

15 Q. How could you make that decision? I
16 want to understand, doctor, under oath, how you
17 can say that you didn't feel there was a foot
18 infection when there is no evidence that I'm
19 aware of that Nancy Holmes did a lower extremity
20 examination, including an examination of her
21 feet?

22 A. That was based on a routine practice
23 of the physician assistant. We check everything
24 when the patient comes in.

25 Q. Well, the standard and routine would

1 be, in order to meet the standard of care, to do
2 a full body exam; true?

3 A. Yes.

4 Q. And if Nancy Holmes didn't do a full
5 body exam on this patient on August 4, 1999,
6 there is no question in your mind that she did
7 not comply with the standard of care?

8 A. She didn't comply with the standard
9 of care.

10 Q. And just so that we can conclude,
11 because I don't want to be surprised by anything
12 when you take the stand at the time of trial,
13 you are not able to tell me to a probability
14 that Nancy Holmes told you that she inspected
15 her feet and that she found no evidence of
16 infection in her feet; true?

17 A. I do not recall.

18 Q. Do you recall anything else about
19 your conversation with Nancy Holmes? And the
20 reason I say that, you said a moment ago I
21 vaguely remember the conversation. I want to
22 find out if there are any other vaguetries or
23 any specifics that you recall about the
24 conversation with Nancy that you haven't already
25 told me about?

1 A. No.

2 Q. You didn't have any contact with the
3 Medlens at the hospital, The Cleveland Clinic?

4 A. No.

5 Q. Did you ever talk with Nancy at any
6 time about what happened on August 4, 1999 after
7 August 4, 1999?

8 A. No.

9 Q. In a diabetic patient that has a
10 history of foot ulcers, that's a high risk
11 amputation patient, what would you need to see
12 in a physical examination of the feet to at
13 least suspect the possibility of an infection
14 when the patient presents with fever, chills,
15 body ache?

16 MR. KILBANE: Objection. Go ahead.

17 A. I would expect to see swelling of the
18 part of the foot, redness, and even drainage
19 from the ulcer, if there is an ulcer there.

20 Q. Do you necessarily have to have
21 drainage if there are early signs of an
22 infection?

23 A. It may not be there.

24 Q. And do diabetic patients that have
25 diabetic neuropathy always appreciate the

1 swelling and redness of their feet?

2 A. It usually would be noticed.

3 Q. And it should be noticed in an
4 examination, as well?

5 A. Yes.

6 Q. Diabetic patients that have diabetic
7 neuropathy don't always have the same kind of
8 sensory appreciation for pain and swelling in
9 their feet; true?

10 A. They may not feel the pain.

11 Q. And they may not appreciate the
12 swelling, as well; true?

13 A. Swelling, they can see the swelling.
14 They may not feel the swelling.

15 Q. Do you always have swelling if the
16 infection is earlier in the acute stages?

17 A. Early stage you may not see the
18 swelling.

19 MR. MISHKIND: Doctor, I have no
20 further questions for you.

21 MR. KILBANE: We will read it.

22 - - - - -

23 (Deposition concluded at 11:35 a.m.)

24 (Signature not waived; 28 day stipulation.)

25 - - - - -

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AFFIDAVIT

I have read the foregoing transcript from
page 1 through 75 and note the following
corrections:

PAGE LINE	REQUESTED CHANGE
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DAVID YANG, M.D.

Subscribed and sworn to before me this
day of , 2001.

Notary Public

My commission expires .

1 CERTIFICATE

2
3 State of Ohio,

4 SS:

5 County of Cuyahoga.
6
7

8 I, Vivian L. Gordon, a Notary Public within
9 and for the State of Ohio, duly commissioned and
10 qualified, do hereby certify that the within
11 named DAVID YANG, M.D. was by me first duly
12 sworn to testify to the truth, the whole truth
13 and nothing but the truth in the cause
14 aforesaid; that the testimony as above set forth
15 was by me reduced to stenotypy, afterwards
16 transcribed, and that the foregoing is a true
17 and correct transcription of the testimony.

18 I do further certify that this deposition
19 was taken at the time and place specified and
20 was completed without adjournment; that I am not
21 a relative or attorney for either party or
22 otherwise interested in the event of this
23 action. I am not, nor is the court reporting
24 firm with which I am affiliated, under a
25 contract as defined in Civil Rule 28 (D).

18 IN WITNESS WHEREOF, I have hereunto set my
19 hand and affixed my seal of office at Cleveland,
20 Ohio, on this 7th day of January, 2002.

21
22 

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

23 My commission expires June 8, 2004.
24
25

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