IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO
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GERALDINE MEDLEN,
Plaintiff,
vs Case No. 425998
KAISER PERMANENTE MEDICAL CENTER, et al.,

Defendants.

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DEPOSITION OF DAVID YANG, M.D.
WEDNESDAY, JANUARY 2, 2002
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Deposition of DAVID YANG, M.D., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Kaiser Permanente, 12301 Snow Road, Parma, Ohio, commencing at 9:30 o'clock a.m. on the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind
HOWARD D. MISHKIND, ESQ.
660 Skylight Office Tower
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendants

Reminger & Reminger
THOMAS KILBANE, ESQ.
The 113 St. Clair Building
Cleveland, Ohio 44114
216-687-1311

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

EXAMINATION OF DAVID YANG, M.D.

BY MR. MISHKIND:

Q. Would you please state your name.

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

Q. And you are a doctor?

A. Yes.

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

A. You too.

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

A. Yes.

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

A. Yes.

Q. How many times?

A. Three times.

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

A. The last deposition was about six months ago.

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

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

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

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

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

A. No, this was the second one.

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

A. Yes.

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

A. Yes.
Q. True?
A. Yes.
Q. Are any of the cases still pending, still open, to your knowledge?
A. No.
Q. What happened with the other case? I know you told me the one was dropped. What happened with the other case, to your knowledge?
A. The other case was settled.
Q. Have all of your depositions and all of the cases that you have been named as a defendant in arisen out of treatment of Kaiser patients?
A. The two cases were Kaiser patients.
Q. Two lawsuits against you were Kaiser patients?
A. One I was a defendant and one I was a witness.
Q. The other depositions that you gave were not Kaiser cases?
A. I want to make it clear.
Q. Please.
A. The first one that I was a defendant and I was deposed was not in Kaiser.

Q. Where was that located?
A. That was in Syracuse.
Q. Is that where you practiced before you came to Cleveland?
A. Yes.
Q. Besides the Syracuse case, have all of your other cases, whether you have been a witness or a defendant, been Kaiser cases?
A. The other two, yes.
Q. Did any of those cases have to do with the management of a diabetic patient?
A. No.
Q. Just to save some time, if you could tell me what the cases pertain to.
A. The first case in Syracuse was a delayed diagnosis of gastric cancer on a 38-year-old male. And the second case, I was a witness. It was a patient who had a heart attack.
Q. Was there an argument about a delay in diagnosing coronary artery disease?
A. Yes. It was an argument of coronary artery disease.
Q. And the failure to diagnose it and treat it to prevent the MI?

A. Yes.
Q. I'm not trying to put words in your mouth, but that's essentially it?
A. Yes.
Q. Thank you.
(Recess had.)
Q. Do you recall the names of any of the patients in any of the lawsuits?
A. I recall some.
Q. Tell me, please.
A. The one was Victoria Parker, P-A-R-K-E-R. That was the last one.
Q. Was that the MI case?
A. No. This was the one where the patient went to the gynecologist for vagina discharge and had a PAP smear by the gynecology provider and it turned out this patient had a very serious infection and the gynecologist didn't address the issue on the visit, and I was the primary care. I never seen the patient.
Q. Your deposition was taken in that case six months or so ago?
A. Yes.
Q. Do you happen to remember the name of the lawyer who took your deposition?

A. I don't remember.
Q. Fair enough. The MI case, was that a Kaiser case?
A. Yes.
Q. What was the name of the patient, if you recall?
A. I cannot recall.
Q. The delay diagnosis of gastric cancer, the name of that patient?
A. The name is Joseph Alesandrelo, A-L-E-S-A-N-D-R-E-L-O.
Q. What is the county that the City of Syracuse is located in?
A. Onondaga, O-N-O-N-D-A-G-A.
Q. Have you told me now the experience that you have had, either as a defendant or having been deposed in any capacity?
A. Can you repeat the question?
Q. I asked you how many times you had been named as a defendant and you told me about those experiences.
A. Yes.
Q. You also have now told me the number of depositions that you have given.
A. Yes.

Q. Have you ever served as an expert witness in a medical negligence case?
A. No.
Q. Who is your employer currently?
A. Kaiser Permanente.
Q. Your salary is issued to you by what group or what entity?
A. Salary is issued by -- I don't know exactly.
Q. Is it Ohio Permanente Medical Group that you are in actuality an employee of?
A. Yes, I think so.
Q. You said Kaiser Permanente when I asked you who your employer is, but when you look at your W-2 and file your taxes, does it reflect that your actual employer is Ohio Permanente Medical Group or does it reflect that your employer is Kaiser Permanente?
A. I cannot tell you right now.
Q. You understand that there is an entity called Ohio Permanente Medical Group?
A. Yes.
Q. And it's my understanding that all of the physicians that work and provide care to Kaiser Permanente patients at Snow Road are

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

A. Yes.

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

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

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

A. This is my curriculum vitae.

Q. Is it current?

A. Yes.

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

A. It is an ECFMG certificate.

Q. Which stands for what?

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

Q. Can you explain that to me?

A. This is a certificate for the people

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

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

A. Yes.

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

A. Yes.

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

A. No.

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

A. No.

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

A. No.

Q. Or suspended?

A. No.

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

questions.

A. That's okay.

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

A. No.

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

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

Q. Take your time.

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

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

reviewed.

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

Q. Which depositions do you recall having reviewed?

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

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

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

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

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

Q. August 4, 1999, true?

A. Yes.

Q. You also had available to you various

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. No.

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

A. Yes, I saw the copy.

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

A. Yes.
Q. You recognize that as a physician that supervises physician assistants that you have certain duties and obligations; true?
A. Yes.
Q. Let me just ask you this generally. As a primary care physician here at Kaiser, do you work with physician assistants on a day-to-day basis?
A. No. We work on a rotational basis. Not every day.
Q. Can you explain to me what you mean by that in terms of a rotational basis?
A. She would work in our module. We have four doctors in our module. So we proctored her, the physician assistant, one session at a time. But different doctors proctor her different sessions.
Q. Are there occasions where you have a physician assistant working under your direction and occasions where you do not have a physician assistant working under your direction?
A. Can you repeat that question?
Q. Sure. You mentioned proctoring. Let's start with that. Just so that I'm not

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

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

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

A. Yes.

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

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

Q. Do you have any other employment?

A. No.

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

A. I need more time with my family.

Q. So you have reduced your workload?

A. Yes.

Q. When did that become effective?

A. I think May of '99.

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

A. May of 2000.

Q. Since May of 2000, you have been

working roughly 80 percent of a full-time schedule?

A. Yes.

Q. And it's at your own request?

A. Yes.

Q. Fair enough.

A. Yes.

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

A. No. I volunteered to reduce my working.

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

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

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

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

there.

Q. Is that one week a month?

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

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

A. No.

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

A. In the future?

Q. Yes.

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

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

A. Yes.

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

A. No, I didn't.

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

A. This month of January?

Q. Yes, sir.

A. Yes.

Q. You said there are other doctors in

your pod.

A. Yes.

Q. Who are the other internists in your pod?

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

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

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

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

A. Yes.

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

A. How many?

Q. Yes.

A. Four physician assistants in different locations.

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

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

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

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

A. We have a schedule.

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

A. Yes.

Q. How many physician assistants -- strike that.

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

A. Yes.

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

A. Yes.

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

A. One.

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

A. Yes.

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

A. No.

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

Q. I'm sorry?

A. Scientific American Medicine.

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

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

Q. I understand. What about on the

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

A. Yes.

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

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

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

A. No.

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

A. No.

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

A. No.

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

A. No.

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

A. Yes.

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

A. Okay.

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

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

A. I understand.

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

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

A. Yes.

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

A. No.

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

A. Can you repeat the question?

Q. Sure. Did you underline anything or

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

A. No.

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

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

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

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

A. Of course. I discussed with the attorneys.

Q. Okay. Fair enough.

Now, did you bring those depositions with you today?

A. Yes.

Q. These are your copies of the depositions?

A. Yes.

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

A. Yes.

Q. True?

A. Yes.

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

A. I did make.

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

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

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

Q. Have you ever seen that document that's referenced on page 47?
A. Yes.
Q. When is the last time you saw that document?
A. I saw it last week.
Q. As I understand it, that document sets forth certain criteria that you use in terms of making sure that the physician assistant is being appropriately supervised in his or her day-to-day care of patients?
A. It's guidelines set forth for the physician assistant and the physician to follow.
Q. And this is sort of a generic form? It's not prepared specific to any one patient; true?
A. No, it is generic.
Q. And it sets forth the guidelines that you as a physician use in terms of making sure that the physician assistant is being appropriately supervised in her clinical practice?
A. Yes.
Q. Have you ever seen a physician ambulatory medical record review document

specific to Geraldine Medlen?

A. Can you repeat the question?

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

A. Yes.

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

A. I don't recall.

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

A. Yes.

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

A. No.

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

A. I don't recall.
Q. Do you have a recollection of ever meeting Mr. Medlen?
A. I don't think so.
Q. Do you have a recollection of meeting any of the Medlen children?
A. I don't recall.
Q. Now, when you say you don't recall, I don't want to interpret that the wrong way. By that, are you saying to me that you may have met the children and you just don't remember one way or another, or are you telling me when you say I don't recall that you don't believe that you have ever met the children?
A. I don't recall meeting any of them as a patient.
Q. What about outside of a physician/patient relationship, do you recall --
A. I am pretty sure I have never seen them outside of the practice.
Q. After August 4, 1999, did you have any involvement, direct or indirect, with regard to Mrs. Medlen's care at Kaiser?
A. No.
Q. I want to show you what was marked in

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

A. I don't know why.

Q. Should this document have been sent

to you instead of Dr. Mistry?
A. I think so.
Q. And why is that?
A. Because I was the supervising physician for this visit.
Q. And as a supervising physician for this visit, of what importance was it that the physician assistant bring to your attention the results of tests that were done on that visit?
A. The blood sugar was abnormal, the urine sugar was elevated, so these are abnormal lab results.
Q. And of what significance, if any, is that in a diabetic patient that is a high risk amputation patient?
A. The significance depends on the clinical context, the clinical impression after the examination.
Q. Are those labs potentially consistent with an infectious state?
A. Possibly.
Q. Again, it has to be taken in the context of the clinical examination; correct?
A. Yes.
Q. Is it fair to say that Ms. Holmes

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

A. As I told you, it depends on the

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

Q. Why do you say that, doctor?

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

Q. What about the results of the CBC?

A. There was no CBC on this sheet.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. No.

Q. Can we agree that Ms. Holmes should

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. Why is that?

A. Because they are not normal.

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

A. Yes.

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

and available to you, as necessary; true?
A. Yes.
Q. So I'm not going to repeat the history. You are fully familiar with the history and certainly had it reaffirmed to you when you read over the depositions; true?
A. Yes.
Q. In the context of a patient with a history that Mrs. Medlen had as of August 4, 1999, of what significance, if any, are these abnormal random blood sugar and glucose results, urine glucose results and the CBC results?
A. What are the significance?
Q. Of what significance, yes.
A. The sugar was elevated, her sugar control was not good, and there was a mild elevation of white counts.
Q. There are also some results toward the bottom. In addition to the white blood count that shows percentage lymphs and percentage -- it says percentage gran. Do you see those two references?
A. Yes.
Q. First, to find out and in simple parlance, what do those two items that I just

referred to indicate?
A. The elevation of white counts and increased granulocyte percentage usually means it was some kind of inflammation process going on.
Q. What about the other reference, percentage gran?
A. Gran means granulocyte.
Q. And above that lymphocytes?
A. Yes.
Q. Are both of those indicative of some type of inflammation?
A. Yes.
Q. Can they also be indicative of some type of infectious process, as well?
A. Possibly.
Q. Certainly you can't rule out infection based upon those results, can you?
A. You cannot.
Q. And in a patient that is a diabetic patient, are they at increased risk of developing infections where their glucose is not adequately controlled?
A. Yes.
Q. And of what significance is that in a

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. In person?

Q. Yes.

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

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

A. Yes.

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

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(Thereupon, YANG Deposition Exhibit 2 was marked for purposes of identification.)

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

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

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

A. Yes.

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

A. Yes.

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

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

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

A. No.

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

A. No.

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

saw those results before today's deposition?
A. That was when the attorneys sent me the copies.
Q. Did you ever talk to Ms. Holmes about those results in terms of why she didn't send them to you?
A. No.
Q. Why she didn't bring them to your attention?
A. No.
Q. If those lab results had been brought to your attention as the supervising physician, what would you have done?
A. I probably will talk to Nancy Holmes -- it depends on the clinical history -- and I probably would ask Nancy Holmes to call the patient.
Q. Why? What is it about the results that would have caused you to do that?
A. Because of some abnormality in the lab.
Q. And you know what the term differential diagnosis is, don't you?
A. Yes.
Q. Would you have had some things in

your mind as potential differentials for causing those abnormalities?

A. Yes.

Q. What would have been within your differential?

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

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

A. Possible.

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

A. Yes.

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

A. Yes.

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

A. Yes.
Q. When should the results of the random glucose, the urine glucose, the blood sugar, the CBC, when should those results have been presented to you as the supervising physician?
A. If it was ordered stat, this should be available within two, three hours.
Q. Can you tell from looking at the chart or looking at anything in this case how they were ordered?
A. Chest x-ray was ordered stat, but for other tests, I'm not sure.
Q. Who was it that determined that the chest x-ray should be ordered stat?
A. It was me.
Q. And who was it that was responsible for determining whether the chest x-ray should be ordered stat or on a nonstat basis?
A. It was me.
Q. Who was it that was responsible for determining whether the blood work and the urine test was to be done on a stat basis?
A. It was me also.
Q. And is it fair to say that there is no indication in the record how you wanted those

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

A. I recall the lab was also ordered stat.

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

A. Yes.

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

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

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

A. I don't recall.

Q. Let's just assume hypothetically that

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

A. Yes.

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

A. Yes.

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

A. I don't.

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

A. Yes.

Q. Can we agree that they were not?

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

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

MR. KILBANE: Objection. Go ahead.

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

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

A. Yes.

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

and contact the provider; true?
A. Yes.
Q. In this case, you don't know whether or not the lab was required to pick up the phone, because you don't know what their parameters were; true?
A. I don't know.
Q. You said that had you been provided with the lab work, the CBC, and the results of the urine, I think you told me the first thing you would have done is contacted Nancy Holmes?
A. Yes.
Q. And then depending upon the clinical circumstances, might you have had Nancy contact Mrs. Medlen?
A. Yes.
Q. For what purpose?
A. To tell her about the report and evaluate a list on the phone about the patient's condition.
Q. Now, there is an indication that Mr. Medlen called the following day on August 5 wanting the results and also indicating that his wife was febrile and was having certain symptoms. Do you know in this case why that

information was not brought to your attention on August 5?

A. I don't know.

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

A. Yes.

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

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

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

MR. KILBANE: Objection. Go ahead.

A. Immediately?

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

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

A. Personally, I act within 24 hours.

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

MR. KILBANE: Objection. Go ahead.

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

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

A. True.

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

A. I don't know.
Q. It should have been; true?
A. Yes.
Q. And depending upon the information that you gathered from looking at the labs and talking to the patient, one of the ways that you might have treated this patient was to have her come to the emergency room or come to internal medicine to be reevaluated; true?
A. It depends on the evaluation on the form first.
Q. Sure. But we know that no evaluation took place, according to what you can see in the records; true?
A. True.
Q. There doesn't appear to be any indication -- and correct me if I am wrong -- there doesn't appear to be any indication that anyone got back to Mr. Medlen on August 5 to give him information or to respond to his wife's symptoms; is that correct?
A. That's true.
Q. And that's not good care, is it, doctor?
A. That is not adequate care.

Q. On August 4, 1999, did you physically examine Mrs. Medlen?
A. No.
Q. On August 4, 1999, did you even meet Mrs. Medlen?
A. No.
Q. The diagnosis of fever of unknown etiology that's noted on Exhibit 2, was that your diagnosis or was that Nancy Holmes' diagnosis?
A. It was Nancy Holmes' diagnosis.
Q. Would you agree that before one can arrive at a fever of unknown etiology or fever of unknown cause that you have to search for an explanation for a febrile illness?
A. Yes.
Q. Frequently a fever of unknown etiology or fever of unknown cause is a diagnosis of exclusion, is it not?
A. Yes.
Q. Would you agree that there were test results pending at the time that diagnosis of fever of unknown etiology was noted by Ms. Holmes?
A. Yes.

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

MR. KILBANE: Objection. Go ahead.

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. True.
Q. Can we agree that you should have personally evaluated Mrs. Medlen?
A. No.
Q. Can we agree that the physician assistant utilization plan requires that all established patients with new conditions must be seen and personally evaluated by a supervising physician prior to the initiation of any treatment?
A. This is a guideline of Kaiser.
MR. KILBANE: You just asked him if that's what it said; right?
MR. MISHKIND: I am reading from it, but I asked whether all established patients with new conditions -- strike that.
Q. We have already established that Mrs. Medlen was an established patient; true?
A. Yes.
Q. And she presented with a new condition on August 4, 1999?
A. Yes.
Q. And the physician utilization plan indicates that all established patients with new conditions be seen and personally evaluated by a

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

A. Yes.

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

A. True.

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

A. Yes.

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

A. Yes.

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

A. She referred patients to me.

Q. Did you personally examine

Mrs. Medlen?

A. No.

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

A. Yeah, I was available.

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

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

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

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

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

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

A. Yes.

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

A. I don't recall.

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

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

Q. Got it.

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

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

Q. Do you have any explanation in this

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

A. No.

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

A. No.

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

A. My tentative diagnosis would be flu syndrome.

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

A. No.

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

A. Yes.

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

When did you plan to see this patient again?

A. When did I plan to see the patient

again?

Q. After the August 4 visit.

A. It depends on the clinical course.

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

A. To treat as a flu syndrome.

Q. And what does that mean?

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

Q. So that was the treatment plan?

A. Yes.

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

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

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

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

three days.

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

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

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

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

Have I read that accurately?

A. Yes.

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

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

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

Q. Pretty clear language, isn't it?

A. Yes.

Q. You were the supervising physician; true?

A. Yes.

Q. This was a new condition; true?

A. Yes.

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

A. True.

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

A. I didn't.

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

MR. KILBANE: Objection.

A. No, we didn't initiate any specific treatment plan.
Q. You were treating her for a flu-like syndrome; correct?
A. Yes.
Q. You had a treatment plan initiated for a flu-like syndrome; correct?
A. Treatment, yeah.
Q. You would agree with me that this language isn't just a guideline. This is something that if you are going to have a physician assistant seeing the patient, you as the supervising physician, in order to provide safe and reasonable care for a patient, must comply with; true?
A. Yes.
Q. And you didn't comply with it; true?
MR. KILBANE: Objection.
A. I act not inconsistent with this sentence.
Q. I'm sorry, tell me how you did not act inconsistent with that sentence.
A. Because we didn't initiate any treatment plan, other than regular over-the-counter medicine.

Q. Why didn't you see this patient when she presented with a new condition?
A. We didn't initiate any planning.
Q. Why didn't you see her? What was preventing you from examining this patient on August 4, 1999?
A. I evaluate the patient after Nancy Holmes' presentation and evaluation.
Q. Where were you?
A. In the facility.
Q. On the floor?
A. Yes.
Q. There is nothing physically that was preventing you from coming and seeing this patient with a new condition; true.
MR. KILBANE: Objection. Asked and answered.
A. There was nothing preventing me.
Q. Tell me what the physical examination included with regard to the lower extremity of this patient.
A. In the chart?
Q. Yes.
A. It was not mentioned.
Q. The upper extremity -- there was an

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

A. Yes.

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

A. The upper extremities were not mentioned.

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

A. Alert and oriented times three.

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

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

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

A. Yes.

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

A. Upper extremities means arms and hands and fingers.

Q. Maybe I misstated it and I apologize.

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

A. Yes.

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

A. Yes.

Q. Some of the exam was normal; correct?

A. Yes.

Q. And there was some mild abnormalities?

A. Yes.

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

A. Yes.

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

A. Correct.

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

A. Yes, I vaguely recall.

Q. Tell me what you vaguely recall her telling you.
A. She told me the patient's symptoms and her examination, and her impression was flu syndrome.
Q. Did she also tell you that this was a diabetic patient with a history of diabetic foot ulcers?
A. Yes.
Q. Did she also tell you that that was a patient that was a high risk amputation?
A. I don't recall.
Q. Should she have told you that in order to give you sufficient history so that you could make clinical decisions?
A. Yes.
Q. Do you have diabetic patients that you treat?
A. Yes.
Q. And do you have diabetic patients that have peripheral neuropathy that you treat?
A. Yes.
Q. Do you have diabetic patients with peripheral neuropathy that present with recurrent diabetic foot ulcers?

A. Yes.
Q. And when you have that type of patient that presents with fever, chills, body aches, would you agree that the physical examination of that patient should include the lower extremities to ascertain whether or not the ulcers in a diabetic patient with peripheral neuropathy and recurrent diabetic foot ulcers are infected?
A. Can you repeat your question?
Q. Sure. Would you agree that a physical examination of the lower extremities when you are seeing a patient that's diabetic, has peripheral neuropathy, that has recurrent diabetic foot ulcers and presents with fever, chills and body aches, that a physical examination should be done which would include the lower extremity to determine whether or not the ulcers are, in fact, infected?
A. Yes.
Q. And no such examination was done on this patient; correct?
A. It was not documented.
Q. Well, you know of no evidence that her lower extremities, including the ulcers on

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

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

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

A. There is no documentation.

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

MR. KILBANE: Objection. Asked and answered.

A. No, that is not always true.

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

A. That would include.

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

A. Yes.
Q. That would be a reasonable and prudent thing to do; correct?
A. Yes.
Q. There is no documentation in the record that Nancy Holmes did that on August 4; true?
A. No documentation.
Q. And you can't say to me that Nancy Holmes told you that she examined her feet; true?
A. I don't recall.
Q. Doctor, do you have an opinion in this case as to whether or not Mrs. Medlen's infection clinically would have been noted on August 4, 1999 had a lower extremity examination been done, including an examination of her diabetic feet?
A. I cannot say one way or the other.
Q. Is it fair to say you just don't have an opinion to a reasonable degree of probability?
A. I don't have an opinion.
Q. So I take it you will not testify at trial that had the test results been acted on

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

A. I don't have an opinion.

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

A. I don't have any opinion.

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

MR. KILBANE: Objection.

A. Can you repeat the question?
Q. Sure. Absolutely. Labs are done, urine is processed, and the information is reported back to you on August 4, or early August 5 -- let's say August 4, and you had examined the patient on August 4, and felt that her fever, her chills, her body ache, and the test results were consistent with a diabetic foot ulcer on a diabetic patient that was developing or had an infection in that diabetic ulcer, what would the treatment have been at that point in time on August 4, if all that information was available?
A. If my impression was a foot infection after the examination, the treatment would be to start IV antibiotics, and depending on the situation, I may send her directly to the hospital.
Q. Now, the IV antibiotics, is that something that you can administer here at Kaiser - Snow on an outpatient basis?
A. One dose maybe we can administer, but more than that, we cannot do it.
Q. And you would have to assess the patient based upon the response to that one dose

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

A. Yes.

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

MR. KILBANE: Objection. Go ahead.

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

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

A. Yes.

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

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

MR. KILBANE: Objection.

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

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

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

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

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

Q. Well, the standard and routine would

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

A. Yes.

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

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

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

A. I do not recall.

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

A. No.
Q. You didn't have any contact with the Medlens at the hospital, The Cleveland Clinic?
A. No.
Q. Did you ever talk with Nancy at any time about what happened on August 4, 1999 after August 4, 1999?
A. No.
Q. In a diabetic patient that has a history of foot ulcers, that's a high risk amputation patient, what would you need to see in a physical examination of the feet to at least suspect the possibility of an infection when the patient presents with fever, chills, body ache?
MR. KILBANE: Objection. Go ahead.
A. I would expect to see swelling of the part of the foot, redness, and even drainage from the ulcer, if there is an ulcer there.
Q. Do you necessarily have to have drainage if there are early signs of an infection?
A. It may not be there.
Q. And do diabetic patients that have diabetic neuropathy always appreciate the

swelling and redness of their feet?
A. It usually would be noticed.
Q. And it should be noticed in an examination, as well?
A. Yes.
Q. Diabetic patients that have diabetic neuropathy don't always have the same kind of sensory appreciation for pain and swelling in their feet; true?
A. They may not feel the pain.
Q. And they may not appreciate the swelling, as well; true?
A. Swelling, they can see the swelling. They may not feel the swelling.
Q. Do you always have swelling if the infection is earlier in the acute stages?
A. Early stage you may not see the swelling.
MR. MISHKIND: Doctor, I have no further questions for you.
MR. KILBANE: We will read it.
- - - - -
(Deposition concluded at 11:35 a.m.)
(Signature not waived; 28 day stipulation.)
- - - - -

AFFIDAVIT

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

PAGE	LINE	REQUESTED CHANGE

DAVID YANG, M.D.

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

Notary Public

My commission expires .

CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named DAVID YANG, M.D. 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 as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

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

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

Vivian L. Gordon

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

My commission expires June 8, 2004.

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EXAMINATION OF DAVID YANG, M.D.