In The Matter of:

v.

_____

, M.D.

August 9, 2011

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MERRILL LAD
1325 G Street NW, Suite 200, Washington, DC
Phone: 800.292.4789 Fax:202.861.3425

IN THE CIRCUIT COURT FOR BALTIMORE CITY

Plaintiff	Case No.
v.	
Defendant	

Videotaped De Bene Esse Deposition of

, M.D.

Baltimore, Maryland

Tuesday, August 9, 2011

11:45 a.m.

Job No.:

Pages 1 - 103

Reported by:

Videotaped De Bene Esse Deposition of , held at the:

Pursuant to notice, before , Registered Merit Reporter and Notary Public of the State of Maryland.

APPEARANCES

ON BEHALF OF THE PLAINTIFF:

LAURA G. ZOIS, ESQUIRE
Miller & Zois, LLC
Empire Towers, Suite 1001
7310 Ritchie Highway
Glen Burnie, Maryland 21061
410.553.6000

ON BEHALF OF THE DEFENDANT:

ALSO PRESENT: , Videographer

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EXHIBITS

(Retained by counsel)

PROCEEDINGS

(Exhibits Number 1 - 10 were marked for identification and were retained by counsel.)

having been duly sworn, testified as follows:

EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MS. ZOIS:

Q Dr. , just briefly off the video, I wanted to go through the subpoena which your office was served with and go through some of the requested documents. Number one is your current curriculum vitae which I believe we have here today marked as Exhibit 1; is that accurate?

A You do.

Q Do we have any and all reports that were issued regarding the plaintiff, including any drafts?

A You do. There are no drafts.

Q And all the current billings that have been generated in this case, you have provided to me here as Exhibit Number 9?

A Correct.

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Q It doesn't look like this includes your billings for today's deposition?
A It does not.
Q Could you forward a copy of that bill to counsel upon the generation of that bill and have it produced to me before the 15th, do you believe?
A Yes.
Q All correspondence from any representative of the defendant, including but not limited to his attorneys and or insurance company, sent to the deponent regarding the plaintiff in this case.
A I think there's one letter only.
Q The letter that you were sent by counsel is dated March 24th, 2011 and is attached as an exhibit to your deposition as 6; is that right?
A That's correct.
Q This is the only correspondence that you've received from counsel?
A That's it.
Q All documents, records, photographs, medical reports, medical records, or any other writing sent to the deponent for review in this matter, whether or not

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such documents form any part of the deponent's opinions in this matter.
A That's the entire file. The only other thing was I was just showed this morning some records that have been received after I prepared my report, but that's basically the file.
Q So the whole file, everything that's been sent to you by defense counsel is before us today; is that right?
A That's correct.
Q Copies of any medical articles or any medical/legal articles or other writings referenced in any report relating to the plaintiff or relied upon in whole or in part with reference to the opinions rendered or to be rendered in this case.
A No, none pertain.
Q The entire file with reference to the plaintiff or this case, we've discussed that and that's present today, correct?
A Correct.
Q The number of patients deponent has examined for any insurance company or defense lawyer or law firm

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from 2009 to present. My understanding is, talking to you off the record, that you don't have such a list?
A I don't keep a list.
Q Copies of all 1099 forms and/or those portions of the deponent's tax -- deponent's income tax returns for 2009 and 2010 referencing any payments made to the deponent in connection with medical-legal services and medical services generally. Parentheses: Other portions of the tax returns relating to professional expenses, other earned or unearned income and deductions are not requested.
Breaking that down, my understanding is that you don't get copies of the 1099s?
A That's correct.
Q And does your income tax returns for the 2009 and 2010 years make any specific reference in connection with medical-legal services?
A No, I get paid from one source only and it includes all my income.
Q That source is
A The name of the group is , owns the entire

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orthopedic department.
Q So the name of your group is what?
A .
Q ?
A Right. I work in the Center.
Q You are an employee of?
A Center.
Q You're not an employee of ?
A Well, owns . It's a wholly owned corporate entity.
Q So the entity is owned by ?
A That's correct.
Q The tax ID number , is that your tax ID number?
A I have no idea. I think it's .
Q A case list, your current case list has been provided and has been marked for identification as 10; is that right?
A Yes.
Q This case list only goes through March of 2010 but this is your current case list?

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A It is.
Q It just hasn't been updated.
A It hasn't been updated, but this year is really no different than last year in most respects.
Q You're testifying with the same amount of consistency as you did in 2009 and 2010?
A Yes, it hasn't changed.
Q Do you have a fee chart or list of fees associated with services doing defense medical exams?
A I do. I can get it for you.
Q Perfect.
A No, not in terms of defense medical exams, but I can tell you what it is. My office charges anywhere from -- it depends, anywhere from 250 to $475 for a basic fee and then there's a fee of -- if it takes me more than a half hour to review the records, that's charged at a rate of 450 an hour.
Q Is there a fee chart regarding deposition testimony, trial testimony?
A Yeah, I can give it to you. My office charges $1,250 for a deposition, assuming -- that includes my preparation time and assuming that it takes one hour. If

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it's more than one hour, there's an additional charge of $450.
Q Per hour?
A Per hour.
Q So there is in existence a fee chart on a piece of paper or you just know it?
A No, we have a fee chart. For testimony, not for IMEs.
Q Could we get a copy of that before we get started?
A We can, yeah.
Q 13: Copies of all accounts receivable ledgers, statements or other records, including computer-generated ledgers for tax years 2009 and 2010 indicating the amount of income earned for medical-legal services and medical services generally. Identifying information applicable to individual patients or examinees is not requested and may be redacted.
Does use any sort of QuickBooks program that would enable you to go in and determine what portion of income is derived from forensic activity versus patient care?

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A No, but we did a hand audit last year for six months and it's approximately 35,000 a month billing for all nonclinical work. That includes a lot of different things.
Q Okay. Tax returns for 2009 and 2010 for the entity known as , and any ledgers or account receivable data that demonstrates income earned or received for forensic legal and medical consulting relating to Dr. ; other personal information may be redacted. Do those, do tax returns exist for , that demonstrate income earned or received for forensic legal-medical consulting?
A No.
Q But again, the audit that was done?
A We did a hand audit. We did a manual hand audit for six months, five months of last year, and the average is approximately 33-, $35,000 a month and that's billing. Obviously that's not collected and it's not earned but it's billing. That includes all nonclinical activities which is a number of different things.

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Q Does that rate seem to be consistent this year?
A No, it's actually a little bit less.
Q So the --
A I'm getting older.
Q The last time the audit was done was when?
A We did January to May of last year. January, May of 2010. Actually it's been a little bit less this year. I'm getting older.
Q Fair enough. So I think the only thing that we're missing in compliance with the subpoena is the fee chart --
A I can get that. If you want to just open the door and yell out.
(Discussion held off the record.)
(Exhibit 11 was marked for identification and was retained by counsel.)
* * * * *
THE VIDEOGRAPHER: Here begins tape number one in today's deposition of . in the matter of versus . in the Circuit Court for Baltimore City, case number Today's date is August 9th, 2011.

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The time is 11:57 a.m.
The videographer is . This deposition is taking place at , Baltimore, Maryland.
Counsel, please voice identify yourselves and state whom you represent.
MS. ZOIS: Laura Zois on behalf of the plaintiff, .
MS. : on behalf of the defendant, .
THE VIDEOGRAPHER: The court reporter is of Merrill LAD. Would the reporter please swear in the witness.
M.D.
having been duly sworn, testified as follows:
EXAMINATION BY COUNSEL FOR THE DEFENDANT
BY MS. :
Q Good -- almost afternoon -- Dr. .
A We're close.
Q Dr. , are you licensed to practice medicine in Maryland?
A I am. I have been continuously licensed in

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Maryland since 1972.
Q Can you briefly state for the jury what your education and background is?
A Sure. I've lived in Baltimore almost all my life. I graduated from College which is now University in 1962 -- excuse me, 1966 with a bachelor's degree in biology and chemistry. I graduated from School of Medicine in 1970. I received my medical doctor's degree with magna cum laude honors. From 1970 through 1972, I was intern and general surgery resident at in .
I then came back to Baltimore and from 1972 through 1975, I was resident in orthopedic surgery at affiliated program at . I also served a preceptorship with Dr. , studying hand surgery. That was in the final six months of my training. Dr. was the preeminent hand surgeon of our time and was in the process of establishing then what is known today as the at .
I also served as an assistant instructor in the

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Department of at . I've been in private practice of orthopedic surgery since July 1st, 1975. I've been in practice for 36 years.
Q Doctor, have you served with the military?
A I have. I'm retired from Maryland Army National Guard. I retired with the rank of major.
Q Can you tell us what the field of orthopedic surgery means?
A Orthopedic surgery is an extremely broad field which encompasses injuries and diseases of the musculoskeletal system. That specifically means the spine and the extremities. Orthopedic surgery is very broad. It concerns the obvious, such as we're going to discuss today, of fractures and other types of bony injuries.
Orthopedics also includes reconstructive surgery such as joint replacement. It includes the fields of spine surgery, hand surgery, foot surgery, orthopedic rehabilitation, orthopedic tumor surgery, a separate field of children's orthopedics, and a number of other subspecialties within each one of these groups.

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I practiced general orthopedics for a long time. I did a fair amount of fracture work. I did a fair amount of hand work. For the last ten years or so of my practice, I did mostly joint replacement and spine surgery. I stopped surgery about five years ago because of arthritis. I still maintain an active clinical practice. I treat patients mostly who have a variety of different types of orthopedic diseases and injuries; I just don't do any surgery.
Q Is there a board certification process for orthopedic surgery?
A There is. At the time that I was certified which was in 1977, the certification process was medical doctor's degree, one year of general surgery training minimum, three years of orthopedic surgery training, and then one year of practice experience. The examination was a two-day event. The first day was an oral exam and the second day was written. I was certified in 1977 and my certification is current.
Q And that's in Maryland?
A Well, it's national.
Q National, I'm sorry. Have you been published

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in the field of orthopedic surgery?
A I have but nothing that pertains to these issues today.
Q Are you affiliated with any local hospitals?
A Yes, I am full-time at . I practice in the right across the street.
Q Doctor, I've marked as Exhibit 1 a curriculum vitae. Is this your current curriculum vitae?
A It is. What it emphasizes is the fact that before I came to which was eleven years ago, I was chief of orthopedics for a long time at the former in East Baltimore. closed in 2000.
I also served as vice-president of the medical staff for several terms. I served on the medical policy board of the Corporation. owned along with a number of other hospitals in our community. Hospital closed in 2000 and that's when I moved to . I've been here for about eleven years.
Q Thank you. Are you a member of any

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professional societies concerning medicine or orthopedic surgery?
A I am. First and most importantly, I'm a member of the American Academy of Orthopedic Surgeons. That is the umbrella organization of orthopedic surgery in the English-speaking world. I'm also a member of the North American Spine Surgeons Association. I'm a member of the Medical Chirurgical Faculty in the state of Maryland, Maryland Orthopedic Society, as well as a couple others.
Q Thank you, Doctor.
MS. At this time I'd like to offer you to Attorney Zois for any cross-examination under qualifications.
VOIR DIRE EXAMINATION BY COUNSEL FOR THE PLAINTIFF
BY MS. ZOIS:
Q Just a couple of preliminary questions, Doctor. Do you plan on commenting on the need for continuing treatment with pain management?
A Indirectly, yes.
Q Indirectly, okay. Are you board certified in pain management?
A No.

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Q Would you agree that there are experts and specialists in the field of pain management?
A Yes, but I will also acknowledge that most orthopedic surgeons are certainly familiar with the medications that are used and so at least to some extent, we all do pain management. It's part of general medicine.
Q But you're not board certified in pain management?
A No.
Q Do you belong to my pain management medical groups?
A No.
Q Do you attend CME courses specifically geared towards pain management doctors?
A I have in the past but I don't now.
Q When's the last time you attended a CME that was a lecture on pain management?
A Couple years ago.
Q How many is a couple?
A Two or three.
Q You're not qualified as an expert in the area

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of anesthesiology or pain management, correct?
A I'm not an anesthesiologist but, like I said, pain management is part of all medical fields and to some extent is part of orthopedics also.
Q Have you ever been offered as an expert in pain management?
A I don't know. I can't answer that. I don't know.
Q Is it fair to say that you have no recollection of ever being offered as an expert in pain management?
A That's fair to say.
Q Is it also then fair to say that you don't recall ever being accepted by the Court as an expert in pain management?
A I have -- I don't know.
Q If you have a patient who's suffering from chronic pain and needs to be on lifelong narcotic pain medication, do you continue to treat them or do you refer them out to a pain management specialist?
A First of all, I disapprove of lifelong narcotic management. But if I have patients who have pain issues that are outside of my experience, I refer them to pain

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management. But I seriously disapprove of what is iatrogenic addiction of long-term, life-time narcotic management. I think it's clearly incorrect and the American Academy of Orthopedic Surgeons is in the process of addressing this issue.

Q But you would agree that there are some people that suffer from severe chronic pain, correct?

A I would agree that some patients have pain issues that need to be addressed on a long-term basis.

Q Do you know what the protocol is for the people that would be considered to be appropriately treated with long-term narcotic medication?

A I have some issues with long-term narcotic usage. I'm familiar to some extent with the protocols because they're in orthopedics also.

Q Are you comfortable with testifying as to the standard of care for pain management doctors when prescribing long-term narcotics?

A No. It's not a field that I'm interested in.

Q Okay. Do you plan on commenting for the need of to have any bariatric surgery?

A Yes.

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Q Have you ever performed bariatric surgery before?

A It's not part of orthopedics.

Q So you've never performed a bariatric surgery; is that correct?

A No.

Q Have you ever attended any CME courses on the topic of bariatric surgery?

A No.

Q Do you belong to any medical associations regarding bariatric surgery?

A No.

Q Are you board certified in the field that would cover bariatric surgery?

A No. Although orthopedics, unfortunately, has a lot of experience with the patient need for bariatric surgery.

Q Do you know the cost of such a surgery?

A I'm not familiar.

Q Are you qualified to perform that surgery?

A No.

Q Do you know the specific risks associated with

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such a surgery?

A Only indirectly.

Q One of the risks of that surgery is death, correct?

A It's the risk of any surgery.

Q And one of the risks of that surgery is pulmonary embolism, correct?

A Yes.

Q One of the risks of that surgery includes it's not going to work, correct?

A That's an individual matter.

Q But you would agree that not every bariatric surgery is successful?

MS. Objection.

A I will agree that every patient who has bariatric surgery does not achieve the desired goals.

BY MS. ZOIS:

Q Do you know what the success rate is of such a surgery?

A It's outside of my experience.

Q Are you qualified to testify in the area of nutrition?

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A No.

Q Are you qualified to render opinions in the area of genetic disorders regarding weight?

A No.

Q Do you know what preexisting health issues can render a person to be disqualified for having bariatric surgery?

A No.

Q Do you know what the criteria are for evaluating the appropriateness of making the recommendation for such a surgery?

A Only insofar as the amount of overweight and body mass index, but otherwise no.

Q What's the body mass index prerequisite for having bariatric surgery?

A I think currently it's 40.

Q Do you know what the other recommendations are or what the other criteria are to qualify for having bariatric surgery other than body mass index?

A Again, it's not something I do so I'm not familiar.

Q So you aren't qualified to testify as to the

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standards of care in a bariatric surgery, correct --
A No, I'm not.
Q Do you know the course and treatment following such a surgery?
A No.
Q Is it fair to say you're not qualified to testify as to the standards of care for preoperative course or postoperative course of a patient considering or having bariatric surgery?
A Only by what my patients have told me but no, I do not have direct qualification.
Q When's the last time you regularly did trauma surgery?
A I did trauma surgery regularly for 25 years. When I moved to , I did it occasionally, and I stopped completely five years ago.
Q So if my math is correct with respect to trauma surgery, you haven't done trauma surgery in eleven years?
A I haven't done trauma surgery on a daily basis in eleven years. I did trauma surgery on an intermittent basis up until the time I stopped surgery completely, which was five years ago.

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Q So you no longer perform surgeries now at all?
A I don't do any surgery anymore.
Q And that you stopped performing surgeries five years ago?
A Yeah, after 30 years in the operating room, basically my hands wore out.
Q I'm a little unclear as to when the last time you regularly performed trauma surgery?
A I stopped taking call in 2001 I moved to But I still did plenty of trauma surgery because patients would come to the emergency room and ask for me. And I stopped completely, of course, in January 2006 when I stopped surgery completely.
Q So I think the answer to my question is the last time you regularly did trauma surgery was eleven years ago?
A Yes, but I did surgery on at least a fairly regular basis up until the time I stopped completely. But, you know, up until then, it was an everyday business.
Q You mentioned you were board certified in orthopedics. Did you pass the test the first time you

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took it?
A No, second attempt.
Q When's the last time you were recertified?
A I'm grandfathered. There was no recertification.
Q So you took the boards in 1976?
A That's -- '77.
Q '77 --
A I beg your pardon, '76.
Q So you took your boards in 1976, didn't pass the first time but passed the second time?
A That's correct.
Q And currently orthopedic surgeons are required to recertify every ten years; is that right?
A That's only if you were certified after '85.
Q So since 1985 orthopedic surgeons have been required to recertify every ten years?
A Yes.
Q Have you ever considered going back and recertifying?
A There's no need to.
Q When would have been the last time you did an

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ankle and foot reconstruction like this one?
A Probably about five or six years ago. These are common. I did hundreds of these. I mean, during the winter months, you would do three or four a week.
Q What percentage of your current patients in private practice now have an injury like this that you see on a regular basis?
A Infrequent. I see some but it's infrequent.
Q Would you agree that in order to give expert testimony, an expert should be competent?
A Yes.
Q Would you agree that operating on the correct body part is an element of being competent?
MS. . Objection.
A Yes.
BY MS. ZOIS:
Q Would you agree that operating on the wrong body part would be incompetent?
MS. : Objection.
A Yes.
BY MS. ZOIS:
Q For example, if a doctor operated on the left

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knee instead of a right knee, that is something that could be considered incompetent?
MS. : Objection.
A Yes.
BY MS. ZOIS:
Q Dr. , have you ever operated on the wrong knee before?
A Yes. There was a situation a few years ago when my team set up the wrong leg, even though I consented the patient and marked it, and they set up the wrong knee.
Q So you operated on the wrong knee, correct?
A Yes. After we looked inside, we discovered it was the wrong knee.
Q What about the neck, have you ever operated on the wrong level of a bone in the neck?
MS. Objection.
A Yes. The neurosurgeon identified the wrong level and basically it's a surgery done through a keyhole. He identified the wrong level.
BY MS. ZOIS:
Q But you were doing that surgery with him --

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A I was with him.
Q So you operated on the wrong level --
A Yes, it was his responsibility but I was with him.
Q So you're claiming it was the neurosurgeon's fault, not yours, even though you operated on the wrong level?
A Yes, it was his error in identification.
Q You were sued for both of those operations?
MS. Objection.
A Yes.
BY MS. ZOIS:
Q You settled both of those cases?
A Both were settled --
MS. : Objection.
BY MS. ZOIS:
Q What about [phonetic] versus are you familiar with that case?
A Yes.
Q A patient that had a problem in his knee?
A Yes.
Q That was present before you operated on him?

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A He had an undisclosed neurologic injury that was undeterminable because of the nature of the arthritis in his knee.
Q So your position is it was undeterminable but you settled that case, correct?
A That is correct.
Q What about versus , what happened in that case?
A Patient died of --
MS. : Objection.
A -- of a blood clot, pulmonary embolus, after relatively minor knee surgery. He died because of the inappropriate care that he was given in the intensive care unit afterwards by the internist.
BY MS. ZOIS:
Q But you settled that case too, right?
A My name was on the chart; I had no choice.
Q All the cases that we've talked about, you've settled out of court, right --
MS. : Objection --
A That's correct.
MS. ZOIS: Nothing further on the

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qualifications issue, but I would move to strike any testimony from Dr. with respect to any testimony regarding pain management issues or bariatric surgery.
MS. : At this time I would like to offer Dr. as an expert in the field of medicine and orthopedic surgery.
MS. ZOIS: No objection as to orthopedics but my previous stated basis for pain management and bariatric surgery are on the record.
FURTHER EXAMINATION BY COUNSEL FOR THE DEFENDANT
BY MS.
Q Doctor, you became involved in this case at our request, at my request?
A That is correct.
Q And what is your understanding of what you were asked to do?
A I was asked to evaluate Ms. regarding the nature of her injuries.
Q That evaluation, is that called an independent medical evaluation?
A Yes.
Q What does that term mean?

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A It means that it's an evaluation independent of treating physicians. It's part of general medical practice. As a practical matter, what I do is no different than with any patient I see in consultation. I take a history from the patient, I examine the patient, I review medical records, I may review x-rays or take x-rays if necessary and then prepare a report.

The only difference is I don't treat the patient, although sometimes I will make suggestions regarding what I think would be appropriate care. Sometimes I make the suggestions in writing and sometimes, as I did with Ms. I'll tell her what my suggestions are.

Q When did you see Ms. ?

A I saw her on April 25th, a couple months ago.

Q At that time do you take a history of the plaintiff?

A I did.

Q What did Ms. relate to you in the history portion of your exam?

A She described that she works as a custodian. She described the injury which occurred on October 27,

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2007 which was about three and a half years after I saw her. She had sustained a fracture of her right ankle. She was treated at and underwent what is called open reduction and internal fixation; that is, plate and screws are used to secure the fracture. She also had some infection issues afterwards which she explained to me which necessitated further procedures.

She had brought with her some x-rays which I reviewed which showed the fracture had healed nicely but -- but there was an issue regarding one or two of her screws which were a bit prominent.

She was taking quite a bit of medication when I saw her. She was taking oral narcotic medications as well as using what is called a transdermal narcotic patch called Fentanyl.

She was also taking Lyrica which is a medication used for nerve pain. She indicated the pain was mostly on the outer side or lateral side of her ankle. She felt that she was limited in her ability to walk, and there was also some numbness on the outer side of her ankle.

She described her general health as good. She

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was taking medications for pain management, but she gave me no history of any other medications which she was taking. Her history otherwise was unremarkable.

Q Doctor, you mentioned open fracture. What does that term mean, "open fracture"?

A Fractures in general fall into two basic categories, a closed fracture or an open fracture. The difference very simply is that an open fracture, the integrity of the skin is broken and there's communication there for the bone through the skin. That fracture is by its very nature somewhat more difficult to treat.

Open fractures are usually the result of a greater level of trauma than a closed fracture. Otherwise, the treatment is pretty much the same. It involves secure fixation to enable the bone to heal.

Q Do you know why Ms. fracture was open?

A Ms. sustained a relatively common injury which is a fall from a standing position. That's distinctly different than an accident that occurs from a fall from a height or, for instance, in a motor vehicle collision where there's more force involved. Ms. 's fracture was open most likely because of her size.

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There's considerably more lever --

MS. ZOIS: Objection; move to strike.

A There's considerably more lever force exerted on the ankle. This is part of the orthopedic basic fund of knowledge of orthopedics called mechanism of injury.

BY MS. :

Q During that examination, did you take a physical examination of Ms.

A I did.

Q What did that physical examination reveal?

A First of all, I observed that she was in no apparent distress. She gave her height at five feet, six inches, and her stated weight was 340 pounds. She stated it was about the same weight that she was at the time that the accident occurred and that she'd been heavy for a long time.

She had well-healed scars on the inner and outer aspects of her ankle. Screw heads that I could easily palpate, that I could easily feel on the outer side of her ankle. I could not feel a screw on the inner side. I -- range of motion was limited. Basically she had motion -- plantar flexion which is the ability to

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bring the foot down. Her other motions were basically zero.

She was wearing what is called a Jobst stocking, it's a compression stocking to control swelling. I removed the stocking. I was surprised that Ms. had not been instructed on use of the stocking. I showed her how to put it on in an easy way when we were finished.

I also noted that she had what are called paresthesias. That's a numbness and tingling sensation on the outer aspect of her foot.

Q Doctor, in front of you is I'm presuming a number of medical records that have been provided to you. Did you review all those medical records?

A I did.

Q Can you briefly tell me in that what records you reviewed?

A There are a lot of records here. Most of them are from . I reviewed her basic operative note which was prepared by Dr. . Dr. and I have trained together; I've known him nearly all my professional life.

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There are a number of records pertaining to the treatment which she had subsequently which involved treatment for an infection which had developed. There was one record from Dr. about a month or so after surgery where there was some concern about her personal hygiene which leads to concerns that her wound may have been contaminated.

There are also a number of issues addressing physical therapy which had been done afterwards. There were records from Dr. who was her primary care physician at the office. At the time that she saw Dr. , she was taking nonnarcotic medications.

I also reviewed records from Dr. who was an independent examiner who also had examined her. Dr. saw her on a number of different occasions. And I reviewed records from Dr. who also saw her for an independent evaluation. I saw his comments also.

Among the records also was a functional capacity assessment study. The most recent one was done on September 1st, 2010. She was found capable of working

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at a light-duty job. She was not able to stay on her feet for extended periods of time. There were complaints of nerve pain in her ankle.

There are a number of records from Dr. at . Dr. was treating her for pain management. There are also records regarding referrals for bariatric surgery to address her morbid obesity.

Although there were obviously a great number of records, including her operative note, those represent the most important records that I did review.

Q Thank you. Upon your review of the medical records and physical examination, did you form an impression as to a reasonable degree of medical probability as to what condition plaintiff sustained?

A I did.

Q What is that opinion?

A It is my opinion, first of all, that Ms. had sustained an open fracture of her right ankle, this would be considered a bimalleolar fracture which means that two of the three bones in the ankle were involved. Although a distinct description was not given, it was probably a type I open fracture, although I'm not

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positive of that. It doesn't really make a whole lot of difference because the fracture healed. She underwent typical treatment which is plate and screw fixation.

It was important to note on the x-ray that she brought with her that there was no posttraumatic arthritis. In other words, despite the relative severity of the fracture, the joint was, the integrity of the joint was not disrupted. The fracture had healed.

I was concerned about the fact that she had persistent nerve pain, and I made some suggestions regarding further study in that regard. I was also concerned that she had a screw on the lateral side that was prominent and somewhat tender, at least prominent, and I thought it would be reasonable for that to be removed.

I also thought this patient would -- should consider bariatric surgery as she was morbidly obese.

MS. ZOIS: Objection; move to strike based on previous issues addressed.

BY MS. :

Q Based on the history, examination and medicals, did you form an opinion as to the treatment received by

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Ms. ?
A I did.
Q And what is that?
A Ms. had extensive treatment, and basically I agree with the treatment which she received by the orthopedic surgeons and the rehab physicians who were treating her.
Q Based on the history, examination and medicals, do you have an opinion as to the surgical procedure that was performed on Ms. ?
A Yes.
Q What is that opinion?
A She had a typical, what's called open reduction internal fixation, plate and screw fixation. It was very nicely done. The fracture healed. Most importantly, the joint was not involved.
Q Do you recall how long it took for the fracture to heal?
A Typically -- well, her fracture healing was somewhat delayed by the fact she had developed a soft tissue infection. I believe at the six-month mark, her fracture was noted to be healed completely and that's

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typical of this type of fracture.
Q I guess you answered my next question. The typical recovery period for someone with Ms. 's injuries, about six months?
A It's usually about six months. It takes six months for patients to get just about as good as they're going to get. An occasional person will need a screw removed or some of the internal fixation devices removed, and if that's necessary, there's obviously an additional brief period of incapacitation. Most patients will have basically recovered in about six months.
Q In your review of the medical records and your history with the plaintiff, were there any factors that caused Ms. to have a slower than normal recovery?
A Yes.
Q What are those factors?
A This patient's obesity is a real problem. This is a problem in orthopedics in general. It's a problem with Ms. in particular. She had a soft tissue infection also which to some extent may have been due to her obesity, but the amount of weight that she puts on her ankle slowed her recovery.

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MS. ZOIS: Objection; move to strike.
BY MS. :
Q I think you indicated that Ms. was referred to physical therapy, correct?
A Yes.
Q Is that typical of someone with this type of injury?
A Yes, most patients at about the six-week mark, when they no longer need formal casting, will begin physical therapy for range of motion, and usually at the three-month mark when their fracture is healed more, will need physical therapy to help strengthen up.
Q How long would someone with a normal fracture undergo physical therapy?
A Usually anywhere from three to four months or so.
Q You indicated previously that you reviewed Dr. 's reports?
A Yes.
Q Do you share the same opinion that plaintiff reached a plateau with regard to her recovery and it was questionable that she would improve without a significant

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weight loss?
A I do. I agree with Dr. 's opinion.
Q Why is that?
A Dr. has expressed a well thought-out opinion and I agree with his assessment. This is certainly within the realm of my personal experience also over many years as an orthopedic surgeon.
MS. ZOIS: Objection; move to strike.
BY MS. :
Q You indicated in the history Ms. gave you a weight of approximately 340 pounds. Does excess weight affect the healing process with a bimalleolar fracture?
A Only indirectly. The bones heal at their own rate and the bones are going to heal at their usual rate. But it's fair to say that if you're putting more weight on it once the weight-bearing process begins, that it may take longer to heal. It's certainly going to be more painful.
If you have a very large amount of fat around a fracture where an incision has been made, the likelihood of breakdown of the wound is much higher. Fat does not have the same vasculature as muscle and skin does, and

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patients who are very heavy often have wound breakdown problems. This is something we commonly see in orthopedics.

Q Is it true that Ms. own physicians, Dr. and Dr. indicated that she was morbidly obese?

A Yes.

Q What does that term mean?

A It means roughly that a patient is more than 100 pounds overweight. Ms. weighed 340 pounds; her height is five foot six, five foot six. Her average body weight, appropriate body weight would be something in the 140 to 160 pounds. It's fair to say that she's almost 200 pounds overweight.

Q Does someone who is obese have the same life expectancy as someone who is not obese?

A No --

MS. ZOIS: Objection; move to strike.

BY MS. :

Q And why is that? What is your opinion and have you reviewed any medical data that substantiates your opinion?

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A I did review some medical data specifically for that question. On average, about eight years is the diminished life span due to concurrent illnesses is accepted for women --

MS. ZOIS: Objection; move to strike.

BY MS. :

Q And -- strike that. Your report notes and the reports of Ms. 's physicians that she was seen for swelling or edema. What is edema?

A Edema is basically a soft tissue swelling.

Q Is that a related condition from this accident or could it be caused by other circumstances or factors?

MS. ZOIS: Objection to the form of the question.

A It could be either. It's not uncommon to see some persistent swelling after a fracture. This is far more common in patients who are obese because their venous circulation is not as good.

Q You noted previously, and I think you state on the record, that Ms. did not suffer from any posttraumatic arthritis?

A That's correct.

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Q What is posttraumatic arthritis?

A Posttraumatic arthritis is arthritic changes. In other words, the destruction of the joint that can occur after an injury. The x-ray which she brought me that was relatively recent had shown that the joint was intact. If the joint is intact at this point, then we know that posttraumatic arthritis is not going to occur. Plus the fact in Dr. operative note, he does not describe any damage to the joint at the time that he did her surgery.

So even though she had a fairly severe injury, the integrity of the joint was preserved.

Q Doctor, could you state in your opinion the need for any future surgery?

A Yes. I think she needs two things. I think, first of all, she needs to have at least the screw on the lateral side that's bothering her removed. One could discuss with her whether all the screws would be removed at the same time, but either way it's a relatively minor procedure.

I am also concerned that she has some nerve compression on the lateral side of her ankle, and I

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suggested nerve studies and if they do show that she has compression, then an operation to decompress the nerve would be recommended.

Q Is it your opinion that a major weight loss would improve Ms. condition as well?

MS. ZOIS: Objection.

A I think a major weight loss would help significantly.

BY MS. :

Q And why is that?

A Most patients who have bone and joint pain, joint pain in particular, will feel significantly better with weight loss and the reason is obvious: They're putting less weight on the injured area.

MS. ZOIS: Objection; move to strike.

BY MS.

Q Based upon your examination and your history with Ms. , you indicated that she's taking a number of medications for that pain?

A Yes.

Q Do you recall what medications those are?

A Yes. She's taking oxycodone which is a

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narcotic in large doses, 50 milligrams four times a day. She uses a 50-microgram Fentanyl patch. Fentanyl is a very potent narcotic. She takes Lyrica, 225 milligrams twice a day. That's a large dose of Lyrica. Lyrica is a medication used for nerve pain. She takes medications for unrelated conditions also. But she was taking those three medications.

Q Her medical records also indicate a Quinine -- I don't know if I'm saying that right -- sulfate?

A Yes.

Q What is that?

A Quinine sulfate is used for charley horses, used for leg cramps particularly at night.

Q Her medical records also indicate that she is taking trazodone?

A Trazodone is a medication commonly used to help patients sleep.

Q Do you prescribe one or all of these medications in your practice?

A Occasionally I will prescribe Fentanyl. I often prescribe Lyrica, although not in the dosage that she has. I won't prescribe oxycodone or OxyContin in

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anywhere close to these dosages.

Q Why is that --

MS. ZOIS: Objection; move to strike.

A She's taking dosages that by the very nature are producing what is called iatrogenic addiction. In other words, she's more likely than not addicted to prescription drugs. That is a situation that I will not get into with my patients.

MS. ZOIS: Objection; move to strike.

BY MS. :

Q You've been an orthopedic surgeon for a number of years. Is it typical for a person with Ms. 's condition or injury to be taking several narcotics at a high dosage nearly four years after an injury?

MS. ZOIS: Objection.

A It's distinctly uncommon.

MS. ZOIS: Objection; move to strike.

BY MS. :

Q Do you have any opinion as to whether or not these narcotics would affect Ms. 's ability to perform daily living or perform her job?

MS. ZOIS: Objection; form. Objection;

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foundation --

A It's hard to say but I think it's fair to say taking these amount of medications, I would be very hesitant for her to be climbing ladders or engaging in any type of work which would put her at personal risk.

MS. ZOIS: Objection; move to strike.

BY MS. :

Q Do you have an opinion as to whether Ms. might decrease her dosage of the pain medication if she were to lose weight?

A I think it's highly likely.

MS. ZOIS: Objection; move to strike.

BY MS. :

Q What is your opinion for that?

A Most patients who are morbid -- many patients who are morbidly obese have a lot of bone and joint pain. It's not uncommon and the reason is obvious. We see it all the time in orthopedics. If you can get patients to lose weight, they will usually feel better.

Q Doctor, in your meeting with Ms. can you tell us what her current work situation is she told you?

A Yes, she was working. She did have some

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restrictions at work, and basically I agree with the restrictions that she has. But she's working full-time in her capacity as a custodian.

Q Does Ms. suffer from an impairment due to this injury?

A She does.

Q What is that impairment and how is that determined?

A She has what is called a permanent partial physical impairment. Basically it's a term that reflects a patient's limitation in their ability to work. In my opinion, she has a 35 percent impairment at this time of her right foot and ankle.

Q Does any portion relate to any other conditions not related to this injury?

A Yes, it does. This patient would have had much less of an impairment if she were of a smaller body size. It is my opinion that about half of this impairment reflects the fact that her overall course was altered by the fact that she was, that she is quite large.

Q Doctor, will Ms. need continual follow-up care with her orthopedic surgeon?

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A I think once the issues of the prominent screws and the possible nerve compression are addressed, she will not need ongoing orthopedic care.

Q Will Ms. need continual follow-up care with her pain management doctors?

MS. ZOIS: Objection.

A I think the best thing one could do for Ms. would be to help her to be weaned off narcotics, and then she would not need ongoing pain management.

MS. ZOIS: Objection; move to strike.

BY MS. :

Q Doctor, in your practice in patients suffering from the same type of fracture that Ms. did, do you have a lifelong or a long-term care plan with those patients regarding follow-up visits?

A No. I've treated hundreds and hundreds of patients who have had fractures similar or identical to the one which Ms. had. These types of injuries are extremely common in orthopedics. Every orthopedic surgeon has treated countless patients of this sort, and I can't recall a single patient who had ongoing chronic pain issues after an injury such as this.

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Generally at six months or a year, the patients are discharged and you never -- they never will need your care again, at least not for this type of injury.

MS. : Thank you, Doctor. I think those are all the questions I have right now. I'll turn you over to Attorney Zois.

FURTHER EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MS. ZOIS:

Q Doctor, how long have you been doing medical-legal work?

A Probably for 25 years.

Q Just so the jury is clear, legal-medical work is where you're asked to evaluate an injured person, correct?

A Yes.

Q So you're not treating the patient, correct?

A That's correct.

Q You're not picked by the Court, correct?

A Not in this instance.

Q You're picked by the attorney representing a claimant, right?

A In this case I was.

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Q And you were picked by the firm of in this case, right?

A Yes.

Q Now when you're doing an evaluation for a firm or a company like , Incorporated, they ask you to render your opinions in the matter, right?

A That is correct.

Q When you were sent your letter of March 24th, 2011 from the firm of , you knew they were defending this case; is that right?

A Yes.

Q And you get paid by the company or the insurance company or the firm that hires you to render these opinions; is that right?

MS. : Objection.

A Usually that's correct.

BY MS. ZOIS:

Q Over the years -- I'm sorry, it was 26 years you've been doing this?

A 25, more or less.

Q So for the last 25 years in doing your medical-legal work, it's typically for people that are

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defending claims; is that right?

A Yes, most but not all.

Q Would you say it's about 90 percent of the time you're testifying for the company defending the claim?

A Actually I've done a bit more plaintiff's work recently, but over the years it's been about 90 percent.

Q Over the last 25 years, it's been about 90 percent for the defense; is that right?

A Yes.

Q Currently, you only work two days a week; is that right?

A I have clinic two days a week. I work four days a week but I have clinic two days a week.

Q When you say clinic, you mean in the office --

A I see patients.

Q You see patients two days a week, right?

A Yes, I have two long days of clinic. All day Monday and all day Wednesday.

Q Long day, is that an eight-hour day?

A No, it's 7:30 to about 4:00 or so.

Q So eight and a half?

A Yeah, more or less. Without a break.

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Q So two eight, eight and a half hour days. Of those two days, is it fair to say that a quarter of the percentage of your time is doing legal-medical work?

MS. : Objection.

A Quarter or less. It's something in that range.

BY MS. ZOIS:

Q And you do about six exams a week for --

A About six a week --

Q We can't talk at the same time; the court reporter is going to shoot us both.

A I'm sorry.

Q So you're doing about six exams a week for legal-medical work; is that right?

A At this time, correct.

Q That's about, based on my math, 300 exams a year?

A Approximately or a little bit less. I don't work 50 weeks a year.

Q My understanding is you charge $475 for an exam?

A Some are charged less but that's what the charge was for this one.

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Q What do you charge one of your normal orthopedic clients or patients?

MS. : Objection.

A For ordinary consultations usually about 200, 250. It's a decidedly less expensive examination. It takes much less time.

BY MS. ZOIS:

Q Do you charge an additional amount for reviewing records beyond your exam?

A If it takes more than a half hour, I do.

Q How much time did you spend with ?

A Face to face?

Q Yes.

A I don't keep a record of that but typically -- usually it's a half hour, maybe a little bit less.

Q Of that half an hour, how much of the time do you spend taking a history versus doing a physical exam?

A Almost all of it is history. Orthopedics is largely history and imaging review. I could show you how to examine her in five minutes.

Q So do you think you spent five minutes examining her?

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A Probably something in that range. I also spent some time showing her how to use her Jobst stocking. I was really surprised that her treating physicians had not shown her how to do it.

Q And you know Dr. , right?

A I do.

Q You would consider him to be an expert in the field of orthopedics, wouldn't you?

A Dr. is a good orthopedic. He and I trained together; I've known him all my professional life.

Q What have you charged so far in this case? I know that you provided --

A Yeah, I provided you with a bill. In round numbers it's about $2,000. That reflects, as you've noticed, that there was a very large quantity of documents for review.

Q Right, and just for the record, the bill is 9 and it looks like the amount of $2,525. But is it fair to say that that does not include your time here today for this deposition?

A Yes.

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Q What do you charge for a deposition?

A It's $1,250 assuming that it's one hour or less, and that includes preparation time which in this case actually was fairly extensive because of the age of the records. If it goes longer than an hour, it's an additional $450.

Q Do you also have a fee chart for testifying in court?

A When necessary I do.

Q Your fee chart we've looked at earlier which is marked as Number 11; is that correct?

A Yes.

Q How many depositions do you do a month?

A About two, maybe three. I do between -- deposition and testimony. It comes out to about 30 a year.

Q We have marked as Number 10 a list of your deposition testimony which goes back to January of 2005 but is only current through March of 2010; is that correct?

A Right, it hasn't been updated yet.

Q Can you tell me how many depositions you've

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given in the last six weeks?
A I don't know offhand. It's been a couple I'm sure, but I don't remember. I know I did ... I did none last week. The week before, I think I did one. I really don't recall.
Q We're here today for this deposition so that would be one.
A Yes.
Q On July 28th you testified in a case for ; is that correct?
A I may have. I don't recall specifically.
Q was the plaintiff's attorney.
A Yes.
Q Does that help ring a bell?
A I know him.
Q Actually was defending part of that case, right?
A They were there.
Q is in this case as well, correct?
A Yes.
Q Before that, at least as far as I know, on July

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7th, you were also defending a case?
A That could be.
Q The plaintiff's attorney was in that case?
A Yes.
Q So we know of at least three in the last six weeks. Are there any other cases you can recall testifying in in the last six weeks?
A Not that I recall. But that would be about right. I do about three a month, two to three a month.
Q Now , I notice in the last two cases that you testified before ours, they were a defendant in that case or at least the insurance company was involved. My understanding is you see about one case a week; is that right?
A That's --
MS. : Objection.
A -- about right.
BY MS. ZOIS:
Q Have you ever done a hand audit of how much is earned for doing the legal-medical forensic work monthly?
A I've done a hand audit of how much is billed.

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Q Billed?
A Billed and earned are very different things.
Q Have you ever done a hand audit of how much you've billed?
A Yes, I have.
Q What is that monthly bill?
A It comes out to about 33,000 -- something between 30 and 35,000 a month. The average is about 33.
Q When were you first contacted by , defendant in this case?
A In March.
Q What date particularly?
A March 24th.
Q So you were hired at the end of March. When were you contacted by them, do you know?
A I have no idea. This was stamped, the letter is dated March 24th. It's not stamped in until the date she was actually seen which was April 25th.
Q The first entry on your bill appears to be April the 6th; is that correct?
A Yes.
Q You generated an opinion report in this case,

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which is 15 pages long, on April 25th; is that right?
A Yes.
Q On April 25th, that was the date that you actually examined Ms. ?
A That is correct.
Q Did you form any opinions about this case before your examination of Ms. on April 25th?
MS. Objection.
A No.
BY MS. ZOIS:
Q Do you know that you were named by the defendants as an expert back on March 8th of 2011?
A I don't know that.
Q Would it surprise you to learn that you were designated as an expert in this case before actually rendering any opinions?
A It would surprise me.
Q Do you want to see a copy of the expert designation?
A I'll take your word for it.
Q So it's fair to say you didn't have any information to render opinions back on March 8th of 2011;

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is that right?
A No. Her chart was, as I say, dated March 24th and our computer stamp is April 25th.
Q Just so the jury is clear, you weren't picked by the Court to render opinions in this case; you were picked by ? Is that correct?
A That is correct.
Q You talked a little bit about the mechanism of injury in this case, and I notice that you were provided with some photographs of the area where the accident took place, but do you know how deep of a hole it was that she fell in?
A I asked her. And she basically said it was a hole, it was dark and she wasn't sure.
Q So you don't really know how deep it was?
A Well, I don't know exactly.
Q Right. And --
A We know she stepped in a hole. I don't know exactly.
Q Do you know the manner in which she stepped in the hole?
A Well, we know from the way it broke what

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happened. She twisted her ankle into inversion and plantar flexion. That's how you get this fracture.
Q Do you know what she fractured her foot on? Do you know what she landed on?
A Well, we know what the fracture is so it tells us -- gives us an idea.
Q No, specifically the substance that she landed on. Do you know what substance she landed on?
A No.
Q Do you know what her foot positioning was, how it was twisted when she landed?
A Yes. We know it's into inversion of plantar flexion. That's how you get this fracture.
Q Do you know what the force of the impact was? Have you done any calculations as to the force of the impact?
A Well, we know that she was very heavy and that was a lot of the force.
Q I'm asking you. Have you done any calculations --
A No.
Q -- as to the mechanism of injury regarding the

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force and velocity of where she landed and how she landed?
A No.
Q Can we agree that the area in which she landed is not a sterile environment?
A Yes.
MS. : Objection.
BY MS. ZOIS:
Q So she landed in --
A There are no sterile environments.
Q Fair enough. But this was a hole in a floor with cables and wiring, correct?
A Yes.
Q Did you review any of Ms. prior medical records before rendering any opinions in this case?
A I don't believe they were provided.
Q So the answer is no, you didn't review any prior medical records --
A No.
Q Are you aware of any medical conditions that she had before October 27, 2007?
A No.

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Q Did you review all of the available x-rays?
A I reviewed what was provided.
Q What was provided?
A She brought with her an x-ray.
Q So you reviewed one x-ray?
A Well, she brought an x-ray which showed the healed fracture. The fracture -- the x-ray was recent. I didn't record the date, I apologize. Let me see if it's in my handwritten notes. I didn't record the date, I apologize for that. But since it was recent, I did not take an additional x-ray.
Q Was it recent as of 2011?
A You know, I don't recall. I know it was recent. It was in less than a year's time that I saw her. Otherwise, I would have likely asked her to have an x-ray.
Q So you haven't seen the postfracture x-ray before the hardware was put in?
A You mean the fracture before the hardware?
Q Yes.
A No.
Q Did you talk to the attorney on this case

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before you wrote your report?
A No.
MS. : Objection.
A I never do that.
BY MS. ZOIS:
Q Was one of the things they asked you to do in this letter to you of March 24, 2011 to comment about the impact of her weight and what her weight had to do with her medical recovery, her current condition, and her need for future medical treatment?
A Yes.
Q So they actually asked you to come out and talk about that issue as it relates to this injury?
A Yes, it certainly is a realistic question.
Q You know Dr. , right?
A Yes.
Q Did you call and talk to him about his care in this case?
A No, it wouldn't be appropriate, plus the fact his care was excellent. There were no issues.
Q So you've reviewed the records of her treating doctors at , correct?

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A Yes.
Q So you reviewed Dr. records? Right?
A Right.
Q You agree that all his care was appropriate, correct?
A Sure, no question.
Q You reviewed all Dr. records?
A I have.
Q And , voted best hospital of the year for the 22nd year in a row, correct?
A Yes.
Q You would agree that all the doctors at are primo doctors. correct?
MS. : Objection.
A I absolutely do not agree with that.
BY MS. ZOIS:
Q Okay. is, according to U.S. News and World Report, the best hospital in America, is it not?
A Yes.
Q And it has for the last 22 years?
A It has been for a long time; that's where I did my training.

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Q You have your 15-page report in front of you, correct?
A Yes.
Q Do you document her weight anywhere in your 15 pages of your report?
A Yes. She stated her weight at 340 pounds.
Q Other than her stated weight, do you document how her weight may have fluctuated or where she started at the time of this accident?
A Well, I asked her and she said she weighed about the same amount at the time of the accident.
Q Okay. Did you do any research of the medical records to see whether or not her weight fluctuated from the time of the accident up until the time you saw her?
A No.
Q So let's try and go over some of the things we agree on. We agree that she had a fracture in her ankle and foot, correct?
A That is correct.
Q I think your testimony earlier was that two out of the three bones were involved?
A Yes. By the way, I should have mentioned the

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fracture, she had a base of the fifth metatarsal fracture which was screwed, but that fracture is really not of any clinical significance compared to her other injury.
Q Right, but she has a screw in her foot --
A She does.
Q Would you agree that the fracture was a complex, difficult fracture to fix?
A Well, let's put it this way: For a board-certified orthopedic surgeon, it's an everyday event.
Q Let's look at your report on page 3, fourth paragraph. You state: Fixation was accomplished despite the fact that the fracture was fairly difficult. Is that fair to say, that that's shown in your report?
A Yeah, there's a moderate degree of difficulty in doing these.
Q Okay --
A But again, this is bread and butter orthopedics.
Q How many pieces of hardware does she have in her foot?
A She's got a couple of plates and a number of

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screws.
Q How many pieces of hardware does she have in her foot?
A I think she has two plus about ten screws.
Q She actually has 13 pieces of hardware in her foot.
A Okay. She's got a lot of hardware. But again, that's the way we do these.
Q You said that you thought it was a grade I fracture?
A Yeah, I'm not sure that I have good documentation. There's one place where it's described as a grade III open fracture. I'm not sure that that's correct. I didn't see an accurate description of what it looked like.
Q You read her preoperative note from correct?
A Yes.
Q In there they've described it as a grade III fracture.
A They called it a grade III. I'm not sure that that was correct. It's fair to say, and we all agree

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that it was an open fracture, and the treatment really doesn't make any difference whether it's a grade I, II or III.
Q I'm sure the treatment doesn't but the size of the open wound between a grade I and a grade III is a significant difference; wouldn't you agree?
A It may not be. Grade III basically means that bone is protruding.
Q Well, on page 3 you indicate: I note that the fracture was described as being a grade III open injury, correct?
A That's what they called it.
Q Typically those openings are measured, correct?
A Sometimes.
Q Well, they were measured in this case, weren't they?
A I don't think I documented it.
Q So you're unaware that the opening was measured and that it was about six inches?
A If that's what it was measured, I'll accept that.
Q If that's the case, then this clearly would be

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a grade III open injury, wouldn't it?
A Well, it's either a two or three. We can agree on that.
Q We can agree on grade III?
A We can agree that it's either grade II or grade III. Grade III means that the bone -- that you can see the bone. It doesn't --
Q You haven't --
A You can have a long wound and not see the bone.
Q Grade III means you can see the bone?
A Means you can see it.
Q So if these records would indicate the bone was exposed, that would be a grade III, correct?
A If the bone was visible, yes.
Q Contained within these records, are you telling me that you didn't read closely enough to determine whether or not there was exposed bone?
A I'm sure I did but I don't recall.
Q Just so we're clear on the treatment, you, I believe, testified when asked by counsel that all of the treatment was fair, reasonable and necessary and causally related to the October 27th, 2007 fall; is that right?

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A I think I specified that the surgery which she had, the subsequent surgery that she had, and the physical therapy, and the internal medicine treatment she had were all reasonable and related to this injury.
Q So her total medical expenses of $151,039.54 are related to the October 27th, 2007 incident, correct?
A Well, if you notice, I had issues -- can I see your list?
Q Sure, marked as 3 --
A -- making sure we're talking about the same thing, that's all.
Q Sure.
A No, we're fine.
Q As far as her off-duty status, did you review Dr. 's recommendations for when she could go back to work and at what level and how many hours and that sort of thing?
A I know that Dr. wanted her to go back to work at light duty and then diminished capacity.
Q Do you agree that for the time periods Dr. kept her out of work, that that was appropriate?

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A In her case, it probably was. The amount of time that she lost from work was much longer than most patients should have after an injury of this sort.

Q But we're talking about For recovery, do you agree with the time periods that Dr. kept her out of work?

A Yes, assuming is a unique patient, yes, I agree with what he did.

Q Well, every patient is unique, aren't they, Doctor?

A Well, up to a point, yes.

Q She currently has to wear medical stockings daily; is that right?

A She wears a Jobst stocking.

Q She wears a brace to work; is that right?

A She has an AFO type of brace which she wears.

Q She has 13 pieces of hardware in her foot still today --

A Yes.

Q -- and ankle? She reports having chronic pain in her foot and ankle still today; is that right?

A That's what she says.

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Q She reports having chronic numbness in her foot and ankle; is that right?

A Yes.

Q She reports having swelling in her foot and ankle; is that right?

A Yes.

Q She reports having nerve pain in her foot and ankle; is that correct?

A That is correct.

Q There was a documented study that did show that she did have nerve damage; is that accurate?

A If it's done, I haven't seen it. It was not sent to me. I --

Q Did you see reference to it in the reports?

A I made reference to the fact that I thought she needed to be tested because I was concerned that she'd had a nerve injury.

Q Did you see reference to the fact that she had an EMG nerve conduction study test which revealed that she did have a nerve injury?

A You know, I don't recall.

Q Okay. Well, if you look at page 7 of your

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report, you indicate: Evidence of nerve injury was found to both the distal, tibial and peroneal nerves?

A Hold on one second, please.

Q Page 7, first paragraph.

A Okay, that was in '08. Yeah, I thought she needed to be retested.

Q Okay. So she was tested and it did appear that she did have nerve damage, correct?

A Well, no, because ...

Q No?

A You can't tell from that because they didn't test the opposite leg for comparison. Patients will have nerve conduction abnormalities simply on the basis of obesity, so you can't tell from this. I had made a much more specific recommendation when I saw her to be tested for -- to be tested again.

Q Just so we're clear, your report does say though evidence of nerve injury was found to both the distal, tibial and peroneal nerves --

A Right --

Q That's in your report, correct --

A Yeah, I was quoting the neurology clinic --

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Q That was what the neurology clinic at at found on May 13, 2008, correct?

A Right, three years ago. It goes on to say they were partial and it was considered likely that nerve regeneration would occur in the future. That's why I was concerned because she still has symptoms.

Q You were aware she was a custodian before October 27, 2007, right?

A Yes.

Q And you know that she held that job for some period of time before this incident?

A I usually ask that question.

Q Did you?

A Let me see.

Q I'll help you. It's on the first page of your report, "She has been doing this work since 2005."

A Yeah, because usually I ask that question, yeah.

Q So you're aware that she was working in her capacity as a custodian for about two years before this incident --

A Yes.

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Q Right? You haven't seen anything to indicate that she had any problems or difficulty in performing her job before October 27, 2007?

A I have not been provided with any documents which would indicate that she was having any problems.

Q And you're unaware of any restrictions that she had before October 27th of 2007, correct?

A Yes.

Q So as far as you know, she was perfectly capable of performing her job with no restrictions even though she was heavy?

A At that time, that's correct.

Q During the course of her recovery, would you agree that some of the doctors said they didn't think she'd ever be able to get back to doing that job; isn't that fair to say?

A Yeah, I think that was a realistic concern.

MS. ZOIS: Just to clean up where we were going with her work before, I would offer into evidence 3 which outlines the past medicals and also the accumulation of her lost wages in this case which was $62,576.80 for the time that she was off of work.

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BY MS. ZOIS:

Q So you agree that the time missed from work was medically necessary and appropriate, correct?

A For it was, but it was considerably longer than most patients would have lost from work.

Q And she went back to work full-time three years after the accident; is that right?

A That's approximately correct.

Q But she tried to go back earlier than that, didn't she?

A Well, there was some recommendations about going back to work part-time with restrictions and so forth.

Q And she did what her doctors instructed her to do, didn't she?

A As best as I can tell.

Q You would have to agree that being a custodian is somewhat of a physically demanding job? It's not a sedentary desk job, right?

A It's not sedentary.

Q And she got back to work, right?

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A She did get back to work.

Q You would agree that that's pretty impressive with her injury that she was able to get herself back to work; is that right?

A I would have expected her to be able to go back to work, but all the same I'm glad she went back to work.

Q I think you commented on it in your report --

A I did --

Q I think you used the word "commendable"?

A Yes.

Q She worked hard to get back to work? She actually went to a work hardening program to get herself back to work; is that right?

A Yes. It's a recognized method of treatment that we use for patients who have difficulty getting back to work.

Q That can be a painful experience? You push yourself; is that right?

A Well, by its very nature, it's a matter of increasing your tolerance of activity. That's what work hardening is.

Q Again, just so we're clear, she didn't have any

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restrictions on her work that you're aware of before October 27, 2007?

A Not that I'm aware.

Q Now she's back to work with restrictions?

A She had some restrictions.

Q Do you know what her restrictions are?

A I think she has restrictions regarding ladders, climbing. I think at one point -- I'm not certain if she has restriction regarding how long she was allowed to be on her feet. I did think that she should not use anything higher than a low stepladder. I don't think she should climb.

Q Doctor, you agree that she has a permanent injury as a result of her October 27, 2007 injury, correct?

A I do.

Q Now my understanding of where we disagree, in part, is that you attribute part of her permanency to her weight; is that right?

A That is correct.

Q What disability rating would you have give her on October 26th, 2007?

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A That's an interesting question. I'm not sure if there is -- this is something that is a bit out of my field. I'm not sure if there's a disability rating that applies specifically and only to morbid obesity. It's obviously a risk factor for a patient and it obviously limits most patients who have it, it limits their activity level. But I would have to check the book to see if there's a specific impairment assigned to that specific disease.

Q You used the AMA Guidelines to come up with your 35 percent, right?

A Yes.

Q A lot of doctors can use the same guidelines and come up with different numbers; is that correct?

A Up to a point, that's correct.

Q Well, Dr. , for example, he gave her a 65 percent permanency rating?

A That was his opinion.

Q He didn't give her any -- he didn't take away from any of her permanency because of her weight, did he?

A He did not.

Q Dr. is actually in this building with you; is that correct?

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A Yes, he's upstairs.

Q So different doctors can use the same guidelines and come up with different numbers?

A I think you have to look at the facts but yes, there is some leeway in opinion.

Q Typically, your numbers are lower than that of treating doctors or plaintiff experts; is that right?

A Not always and in this case, I agree completely with Dr. who had also seen her probably for the state.

Q So Dr. was a defense exam, correct?

A I'm not sure who hired or who requested Dr. I've seen him do work for a number of different sources.

Q Yet you attribute half of her permanency to her injury and the other half you don't give her because she's heavy, right?

A Well, very simply --

Q Can you tell me where in the AMA Guidelines it says that you cut a person's permanency in half if they're heavy?

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A It's not in the guidelines but there are additional factors that have to be considered in evaluation of a patient.

Q How about the factor to be considered that she didn't have any problems doing her job on October 26, 2007; do you consider that a factor?

A Sure, granted, she didn't at that time. But this lady, even though it is commendable that she went back to her job, the fact is that her result was clearly impacted by the fact that she was morbidly obese. This is a common problem in orthopedics. We treat patients who are morbidly obese all the time, and we simply can't expect the same kind of result that we can in patients who don't have this medical problem.

Q You would have to agree with me though, Doctor, that if you examined her foot and ankle on October 26, 2007, and she had no problems with her foot and ankle before that, that you could not give her a disability rating according to the AMA Guidelines, correct?

A If her examination was confined to a foot and ankle, that is correct.

Q Doctor, I know we talked about this before, but you would agree that every patient is different, correct?

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A Yes.

Q Every patient has their own unique set of circumstances, right?

A Right, up to a point, that's correct.

Q Some people heal more quickly than others?

A Up to a point, that's also correct.

Q Some people have other medical issues that might impact their recovery that others don't?

A That is true.

Q What's the weight cut-off for then where you wouldn't attribute half of her disability to her weight? What would she need to weigh for you to opine that all of her permanency rating is attributable to this accident?

A If she weighed 200 or less, I wouldn't have thought about it. In fact, even at her current weight, if she had recovered in the usual amount of time --

Q We just discussed every patient is different, correct?

A Right, but let me finish my answer, please. If she had recovered in the usual amount of time and had no

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residual issues, she would have had no impairment due to her weight. But she does have residual issues that clearly result, at least in part, to her weight. I'm not denying the fact that she had a significant injury because she did, and she had a lot of medical care and it was well warranted and well done. But she has another factor which was a direct impact on the slowness of her recovery.

Q So if she weighed 200 pounds and had the same care and treatment that she did following this incident, you would not attribute any of that disability to her weight?

A More likely than not, she would have been back to work in six months with no residual issues.

Q That wasn't my question.

A And she would have had no impairment due to anything except the accident.

Q That wasn't my question. My question was if she weighed 200 pounds, had this fall, had this fracture, this hardware, this injury and the recovery was the same, you wouldn't attribute any of her permanency to her weight?

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A That's correct. But also I would have expected her clinical course to have been very different.

Q But everybody's different, right?

A We are different up to a point.

Q Do you know what her weight was on October 26 or October 27th?

A Well, she told me it was about the same.

Q Did you look at the records?

A As best as I recall from the record, it was about the same.

Q We can agree that this type of injury will cause a person to be immobile, correct?

A For a period of time. Relative -- immobility is relative.

Q Are you sure it's 50 percent attributed to her weight? Could it be 70/30, could it be 60/40? Where do you get the 50/50?

A Well, I've given my opinion.

Q How do you get the 50/50?

A My estimate.

Q Could it be 60/40?

A It could be much more if her impairment is due

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to her weight.

Q Oh, so it could be 70/30?

A Could be. It could be either way but --

Q So it's all possible then. Are you testifying, just so the jury is clear, are you testifying within a reasonable degree of medical certainty her permanency is 35 percent and it's reduced in half because of her weight? Is that within a reasonable degree of medical certainty?

A Yes, I've given you my best opinion.

Q Now you stated in your report -- I'm going into this line of questioning assuming that I lose on a motion to exclude your opinion on the issues of the bariatric surgery and what she should or shouldn't do with respect to her weight.

But you've stated in your report that she's very much in need of a bariatric surgery; is that right?

A Yes.

Q The surgery though is in no way related to this accident; is that correct?

A That's correct.

Q But you've never performed one of these

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surgeries?

A It's not what orthopedists do.

Q And you've never attended a CME course on this topic, correct?

A Morbid obesity is part of the problems that orthopedists address, but no, it's nothing I treat, it's nothing I have specific education in.

Q You don't belong to any medical associations for bariatric surgery?

A No, an orthopedist wouldn't.

Q And you're not board certified in any field that would cover bariatric surgery?

A Same answer. It's not part of our field.

Q But you think she needed this surgery?

A I think it's common sense.

Q Do you think everyone who's heavy needs bariatric surgery?

A I think when you consider the fact that her life span is clearly reduced as a result of having -- being morbidly obese, and the fact that she has a significant problem as a result of it, that if she is not successful in losing weight on her own, then bariatric

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surgery is a reasonable alternative.
Q My question --
A And at least is something that should be considered.
Q My question was, does everyone who is as heavy as she is need bariatric surgery?
A The answer is no, but I gave you examples of why I think that it would be valuable for all patients and to a lesser extent for her.
Q How heavy does a person have to be in your opinion to need bariatric surgery?
A I believe the definition of the Bariatric Society is a body mass index of 40.
Q Do you know what her body mass index is?
A I didn't calculate it.
Q So you don't know what her body mass index is, correct?
A No, but she's clearly almost 200 pounds overweight.
Q Do you know why is heavy?
A I asked her about other medical issues and she didn't describe any, so I can't tell you.

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Q So you don't know why she's overweight?
A I don't have an answer.
Q You don't know maybe she has a thyroid problem, a genetic disorder?
A Well, I asked her these questions and I assumed that she had reasonable medical care. I know her primary care doctor, Dr. at , he's a good doctor, and I'm sure if there was a medical cause for obesity that he would have gone into it with her.
Q You don't know what her caloric intake is every day, correct?
A It's not something I would do. It's not something an orthopedist does.
Q We went over this already, but just to be clear, you don't know what testing needs to be done before having bariatric surgery, right?
A Again, no. It's not something I do.
Q You can't tell us what all the risks are associated with this surgery, can you?
A No.
Q And you don't know the costs associated with

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this surgery?
A No.
Q You don't know what the success rate is for this surgery?
A I know it varies widely, but I don't know the success rate.
Q Let's assume Ms. is not willing to accept the risks associated with this surgery which we discussed earlier include death, infection, pulmonary embolism, and she tries to watch what she eats instead, and let's afford [sic] she can't afford this elective surgery. Do you think the fact that she has 13 screws in her foot and ankle may eliminate some possible exercise programs she can do?
A No. The fact that she has hardware in her ankle is of very little clinical concern.
Q What about the chronic pain, the numbness and the swelling? Do you think that may eliminate her ability to exercise?
A Well, I've indicated that I thought that she needs to have her hardware issues addressed through a minor procedure, and she has some swelling which is

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controlled with a stocking. I wear the exact same thing and I do my exercises.
Q Do you think you're qualified to tell her what exercises would be in her best interest?
A If I were her treating physician, I would talk with her about that.
Q Do you think that the fact that she has chronic pain and swelling and discomfort and works an eight-hour job where she's on her feet doing physical labor might have some impact on her ability to work-out after work?
A I think that's a very individual point. Some patients work a full day and then will go to the gym. Some patients will work-out on their days off. I think working out and working on exercise is something that you have to want to do.
MS. ZOIS: No further questions.
FURTHER EXAMINATION BY COUNSEL FOR THE DEFENDANT
BY MS. :
Q Doctor, just briefly. Today's the first time we've met, isn't it?
A That is correct.
Q I've never – we've never had depositions

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together, you've never --
A I don't believe I've ever talked before today.
Q You were referenced to Dr. who gave a 65 percent impairment. Dr. performed an IME for Ms. , is that your understanding?
A Yes.
Q And did almost what you're doing here today on behalf of , Dr. performed on behalf of Ms. at some point prior to your IME, correct?
A Yes, that's correct.
Q You were asked about the reasonableness of all of the -- if I may -- the medical treatment. You agree that all of her medical treatment was reasonable, and I think you specifically agreed that you agreed that the surgery was performed correctly and properly and reasonably, medically necessary; that the follow-up treatment, including physical therapy and the following up with orthopedists was medically necessary; and that all of that should have been done roughly in a normal patient about six months?
A Yes.
Q I think you also testified that she -- you

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would recommend that she have the hardware reviewed and that may require a possible surgery, future surgery which is outpatient surgery?
A It's a minor procedure done under outpatient, yes.
Q And that she have a nerve conduction study or something like that done again?
A Yes, I was concerned about her current condition.
Q If there's something that shows up on a nerve conduction study, does that require surgery or how does that get treated?
A It depends. It may require an operation which hopefully would diminish her need for medication.
Q So in your opinion, the possibility of two future surgeries, which are relatively outpatient or minor procedures, should be done to Ms. ?
A I believe so, yes.
Q And I think you also opined that the need for continual orthopedic follow-up, treatment and pain management, I guess as continuing lifelong or over the next several years, is unnecessary if certain things are

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done, for example, the hardware surgery and possible nerve conduction surgery --
MS. ZOIS: Objection; move to strike.
A Yes, that would certainly eliminate the need for further orthopedic care. Most patients who have this type of injury do not need ongoing orthopedic care.
MS. ZOIS: Objection; move to strike.
BY MS. :
Q Doctor, all of the opinions you've provided today are based on your reasonable -- based upon reasonable medical certainty to the best of your knowledge; is that correct?
A That is correct.
MS. : Thank you.
THE WITNESS: You're welcome.
FURTHER EXAMINATION BY COUNSEL FOR THE PLAINTIFF
BY MS. ZOIS:
Q Just one last question. I understand that you've never met Ms. before -- struggling with that a little bit. I understand that you haven't met her before, but as recently as three weeks ago, you testified for another member of her firm at ,

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correct?
A Who was that? I don't believe she asked any questions. She was just there because she was the third party.
Q So another attorney was present --
A She was present.
Q -- and was involved in the case?
A Yes, she was present but didn't say a word --
Q And was defending the case?
A Well, she was a third party.
Q She was a lawyer --
A She represented --
Q -- for a defendant in the case, correct?
A As a third-party defendant, correct.
MS. ZOIS: Okay. No further questions.
MS. I have no follow-up.
THE VIDEOGRAPHER: Here ends today's deposition. Going off the record, the time is 1:13 p.m.
(The video record was concluded).
(Discussion held off the record; exhibits retained by counsel for the defendant).
MS. ZOIS: Off the video, on the record, I

would move for admission 1, 3, 5, 6, 8. For admissibility to the Court but not to the jury, 9, 10 and 11.

(Signature having been waived, the videotaped de bene esse deposition of was concluded at 1:15 p.m.)

CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

I, Registered Merit Reporter, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for or related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 10th day of August, 2011.

My commission expires:
April 11, 2014

_____

NOTARY PUBLIC IN AND FOR
THE STATE OF MARYLAND