CROSS-EXAMINATION

BY MR. PANTER:

Q. Hello, Dr. Palamara.

A. Mr. Panter, good afternoon.

Q. Pleasure to see you once again.

A. Likewise.

Q. You and I had the opportunity to chat on Friday afternoon, on October 5th.

Do you remember that?

A. We did.

Q. Since that date, certain tings have happened in this case, and I want to know if you know about them.

Do you know about the stipulation that was filed by the people that hired you?

MR. MARTIN: Object to form. Or objection, irrelevant.

MR. PANTER: Oh, it's relevant.

THE ARBITRATOR: I'll allow it.

Q. (BY MR. PANTER) Do you know about the stipulation that was filed by the lawyers that hired you?

A. No, sir.

Q. Let me read it to you, sir. Okay.

"Stipulation of St. Anne's NCHSA regarding decubitus

ulcer. The defendant, St. Anne's Nursing Center, St. Anne's Residence and Catholic Health Services, by and through their undersigned counsel and pursuant to the Florida Rules of Civil Procedure and Florida law, hereby file a stipulation in the state as follows: The defendants stipulate -- these are the people that hired you -- "that the plaintiff, Helen Shaver, developed a pressure sore on the posterior aspect of her left lower extremity during her admission to St. Anne's between April 13, 2010 and April 22, 2010. The defendants further stipulate that the development of the above-described pressure sore was a fault of the defendants."

Did they share that information with you before you took the stand and provided your testimony to this arbitrator?

A. They may have discussed it, not in the same formality that you did.

Q. In what formality did they discuss it with you?

A. Very informally.

Q. Tell me what they said.

A. To the degree that they felt that there was a development of a decubitus ulcer in her left posterior calf.

Q. So they in essence told you, "We're not going to be defending that issue anymore," that that happened and it was negligence?

MR. MARTIN: Argumentative.

THE ARBITRATOR: That is argumentative.

Q. (BY MR. PANTER) Did they tell you that it happened and, "We're not defending that issue"?

A. They indicated, well, thoughts along those lines.

Q. I want to read the rest of the stipulation. I want to be complete with you. "The defendant vigorously denies such sore caused or contributed in any way to the ultimate amputation of the plaintiff's left lower extremity."

That's going to be -- that was your testimony. We're going to talk about that. We're going to have the time ---

MR. MARTIN: Argumentative.

MR. PANTER: It's cross-examination.

THE ARBITRATOR: I know, but just ask the question.

MR. PANTER: It's the way I cross.

THE ARBITRATOR: I know. It may be the way you cross, but ---

Q. (BY MR. PANTER) Let me read the rest of it

to you.

A. Okay.

Q. "The defendants stipulate that the defendants failed to report a PT/INR lab result to Dr. Diaz on or about April 19, 2010 until April 21, 2010, and such failure was a deviation from the applicable standard of care."

Did they tell you they were filing that stipulation?

A. I don't think we talked about that.

Q. But you told me that in your deposition anyway.

A. Okay.

Q. Do you remember telling me that?

A. I do.

Q. Okay. Then they go on -- it goes on. I'm going to read the six paragraphs to you to be complete.

"The defendant vigorously denied that such failure" -- referring to paragraph 3 -- "caused or contributed in any way to the ultimate amputation of the plaintiff's leg.

"As a result -- next paragraph. "As a result of the foregoing stipulation, nursing care and treatment at St. Anne's is no longer an issue in this

matter, and testimony evidence may not be offered regarding same."

Did they discuss that with you?

A. No.

Q. Next paragraph, No. 6, "Thus the only issue in the case is whether such sore caused or contributed to the ultimate amputation and whether failure to report the PT/INR level caused or contributed to such amputation."

Did they read that to you?

A. No.

Q. If we could first -- make this a little easier -- talk about the things that I know we're going to agree upon.

That you're not disputing, these lawyers that hired you, a pressure sore developed at St. Anne's, and that it was their fault?

A. I would like to say that in the definition of a pressure sore, they usually occur from two or three causes. And one is a bony prominence. No. 2 is a malnutrition. No. 3 is an infection.

And they commonly occur over a bony prominence such as a heel, sacrum, back, spine, something like that. Usually they occur from the outside in.

And what we see in Ms. Shaver is that her trouble started from the inside going out.

So consequently while they may have stipulated that, and I certainly am not here in any sort of legal capacity, and I'm not really too sure whether I have any opinion about the stipulations, but I believe that I am here to talk about the science as it relates to Mrs. Shaver and the ultimate loss of her leg.

So I'm not sure exactly how to approach an answer to your question since they seem to be more legalistically oriented than medical.

Q. I didn't write this, just so you know. The lawyers that hired you wrote this, and they used the word "pressure sore," and they stipulated that it was their fault.

A. Fine.

Q. So a pressure sore comes from nonrelieving of a weightbearing part of the body, that's one way it can develop; correct?

A. Correct.

Q. And you know in this instance that Helen was completely immobilized from the tibial surgery; correct?

A. She was not completely immobilized.

Q. Let me ask you this. To your knowledge -- did you go through the records, and were you able to note whether she was able to get out of bed without any -- without complete assistance?

A. I didn't think that she had complete assistance, that I think she had some partial assistance to get out of bed.

And I think I also said in my deposition she had upper body motion, and she had motion of her right leg, and I thought that she did require assistance to get out of bed, but she certainly was not totally debilitated nor dependent.

Q. Do you know to what extent she was able to move and mobilize that left lower extremity during the -- from April 13th to the 22nd she was at St. Anne's? You don't know that, do you?

A. To the extent that it was nonweightbearing, I have no further knowledge.

Q. Okay. Now, you do know that -- and I'm just talking about decubitus ulcer -- that she required a lot of medical care related just to the decubitus ulcer; correct?

A. She required a lot of medical care related just to the decubitus ulcer?

Q. Yes.

A. At St. Anne's?
Q. No. When she left at Baptist.
A. At Baptist?
Q. Yes, sir.
A. Again, the patient had a decubitus, did not have an ulcer.
Q. Okay. Did she require a significant amount of care at Baptist Hospital with respect to the harm and injury to her posterior aspect of her calf?
A. Yes.
Q. You told us what you were reviewing. Did you review the bills in this case?
A. No.
Q. They're in the file there. It's a white file right to your right, sir.
There's a million dollars of medical bills in that white file. It's been admitted into evidence.
Did you make any determination of how much of those bills were related to her medical care specifically regarding the sore on the back side of her leg? Did you do that?
A. I fail to see how it's relevant to ---
THE ARBITRATOR: Just answer the question.
THE WITNESS: No, I did not.
Q. (BY MR. PANTER) Okay. And you also

mentioned you did not review the records of Kindred, correct?

A. That is correct.

Q. So you didn't make any determination as to how much of the care at Kindred related to the sore on the back side of her leg? You didn't review the records; correct?

A. I did not review the record of Kindred.

Q. Did you review the medical bills at Kindred to determine how much of it related to the sore on the back side of the leg?

A. I did not review the bills of Kindred either.

Q. Would you agree that a debridement that she sustained, that she had multiple debridements for the sore on the back side of her leg?

A. I would.

Q. And would you agree that a couple of those were surgical, meaning she was under anesthesia?

A. That's correct.

Q. And would you agree that there were other debridements done at bedside?

A. Yes.

Q. And would you agree ---

A. Well, I don't know that for a fact, by the

way, but I don't think it's really inconsequential, so I would agree with that.

Q. Would you agree that those, even though it's vascular surgery, you have done those at patients bedside; right?

A. Yes.

Q. Are they painful?

A. We're talking about hypothetical case, yes, they can be painful. I'm have no knowledge about Ms. Shaver.

Q. Well, you didn't look at the record to determine the extent of the debridement and whether or not Ms. Shaver was in excruciating pain going through those debridements?

A. I did not see that in the prognosis notes that I reviewed.

Q. You don't know one way or another?

A. I told you when I reviewed the progress notes from Baptist Hospital, I did not see anything written about her having undergone debridements nor the level of pain.

Q. Now, your opinions in this case are based completely on a group of medical records that you reviewed and, of course, whatever experience you have and bring to table; correct?

A. That's correct.
Q. You did not read a single deposition in this case; correct?
A. That is not correct. You know that.
Q. I'm sorry. You read Dr. Salinger's depo and Nurse Julia's depo?
A. That is also correct.
Q. You read the two experts that the plaintiff -- you read their deposition to discern what their opinions were and how they evaluated this case; correct?
A. That's correct.
Q. And those were given to you by the lawyers that hired you; correct?
A. That is also correct.
Q. And did the lawyers ask you to review the other depositions, the fact-finding depositions that were taken in this case with respect to what happened to Ms. Shaver?
A. I reviewed those -- that documentation that was provided to me.
Q. So that' answer is no then?
A. No.
Q. Okay. When you do medical review, it's not unusual for you to review something and maybe ask the

lawyer for materials; is that correct?

A. That is correct.

Q. Did you ask these lawyers to give you the depositions in the case, aside from the two that you looked at, of our expert witnesses? Did you ever ask for that?

A. No, I did not.

Q. And did you ever ask to review the bills in the case?

A. No, I did not.

Q. So first talk about bills is right now; correct?

A. Yes, sir.

Q. Did you know that Helen incurred over a million dollars in medical billing?

MR. MARTIN: Objection. Scope.

THE ARBITRATOR: Scope and relevance.

MR. PANTER: Okay.

MR. MARTIN: I would also point out that the arbitrator has ruled that the liens are to be considered, not the bills. So the extent I don't think they belong --

Q. (BY MR. PANTER) I want to talk a little bit, if we could, about this nonsalvageability issue; okay?

A. Sure.

Q. And you agree that you have to rely on what's in the medical record in forming your opinions?

A. That's correct.

Q. Do you take what's in the medical records -- do you accept what's in the medical records as true or do you decide what part of the record you're going to actually believe versus what part you're not going to believe?

A. The reality is when you look at medical records, you have to take into consideration the capacity ---

(Interruption off the record.)

MR. PANTER: Brittany Panter, I'd like to introduce you. This is Mr. Mullen.

MR. MULLEN: Hi. Nice to meet you.

MR. PANTER: My daughter, she's a third-year law student.

This Matthew Martin, another lawyer from that firm. A lady from the nursing home. This is Dr. Palamara, the witness they hired.

The videographer. Mr. Larry Kuvin is our arbitrator.

The court reporter is Estelle. This is Helen Shaver, our client in this case.

THE ARBITRATOR: Do you have a chair back there?

MR. MULLEN: We usually need to know if a witness walks in the room.

MR. PANTER: I'm sorry.

Q. (BY MR. PANTER) May I proceed?

A. Please.

Q. Where were we?

A. You were talking about the fact when a witness reviews a chart.

Q. Yes. Thank you. Thank you. I appreciate that.

A. I'm paying attention.

Q. I know you are, as I am, as I'm paying attention to every one of your words.

Doctor, when you reviewed this chart, you came up to your opinions based on what you find in the medical records; correct?

A. Correct.

Q. Okay. I'll get this predicate out and some of it you rely on and some of it -- for whatever reason, I'm not questioning you, you discount?

A. Correct.

Q. And, for example, just an example of that would be -- and I know you talked about this in your

deposition, you questioned the ability of the people at St. Anne's to accurately make an assessment of Helen's pedal pulse. That's an example of that; correct?

A. Well, I think that that discussion was a little bit different, though. The reality came down to whether they had a responsibility or the capability of making a determination of arterial insufficiency.

And my response to your question was that I did not think that they had that responsibility nor did they have the education to be able to be making a diagnosis of arterial insufficiency.

Q. You're right. And let's talk about that a little bit, because you -- and I asked you that question, do you know about the particulars of this facility, the skill set of those people, and my recollection was your answer was no; correct?

A. Correct.

Q. You just said I don't expect them to have the same level of skill that maybe a lady that works in my office, a nurse that works in my office checking pedal pulses. Would that be a fair example?

A. Within the confines of what you are telling me, yes, it would.

I have no idea about the ability of your

nurse to check pedal pulses.

Q. I'm not talking about my nurse. The nurses in your office, trained by you?

A. Again, it takes a bit of sophistication to be able to make a diagnosis and to accurately diagnose a patient. So I'm a little bit skeptical.

Q. That's okay. So the point being here is did you know that this was called a skilled nursing facility, St. Anne's, this place where Helen was?

A. I accept you saying that.

Q. Did you know that they advertise particular post-rehabilitation for complex orthopedic injuries?

A. No, I did not know.

Q. Do you think that that's important? Do you think when someone, a facility -- a healthcare facility advertises a specialty, a specialty being able to help someone after a post-complex orthopedic injury, that that skill set ought to rise a little bit higher than maybe an ordinary nursing home taking care of 90-year-old people?

MR. MARTIN: Objection. Compound. Facts not in evidence. Argumentative.

THE ARBITRATOR: I think I agree with your objection, but I will let him answer.

THE WITNESS: I think that a nursing home

has the responsibility to perform and discharge those instructions that they have been given by the orthopedic surgeon, and I believe that they should be aware of possible complications that could possibly ensue.

Beyond that, as I said in my deposition, their responsibility is only to call in the medical director to determine whether the patient has deteriorated, whether the patient was not conforming to their expectations.

And to use the words like having specialty care or to give themselves the recognition that they may have an ability a regular nursing home does not have, would not cause me to expect them to have the ability to make a arterial assessment and, again, to do it accurately.

So consequently while I'm accepting what you're saying, by the same token to expect them to function at the level of a Baptist Hospital or to function at the level of a vascular surgeon, I think is unreasonable.

Q. (BY MR. PANTER) And it's interesting, because if you did except accept that and if you did accept the evaluations that were done at this facility on Helen Shaver, you would agree that those findings

are inconsistent with your theory of this case? You have to agree with that, and you've already agreed that in deposition?

A. I have trouble following your logic.

Q. Let me try to make it more clear, then.

A. Please.

Q. The fact -- you say that she, Helen, had progressive ischemic insult resulting from the orthopedic injury, and it was progressive and continuing?

A. Right.

Q. Throughout the time when somebody ultimately decided -- Dr. Eaton ultimately decided to amputate her left leg?

A. Correct.

Q. That's your theory. But if someone found good ischemic blood flow, let's just say that they did something, anything, and they said good ischemic blood flow, that would be inconsistent with your theory of a progressive ischemic problem.

Is that a true statement?

A. No, it's not, not even close. Good ischemic blood flow, what does that mean?

Q. Lack of ischemia and good blood flow and good perfusion. Let me rephrase it. You want to hold

me on that, that's fine.

If someone in the record said this lady has good blood flow, no ischemia, that would be inconsistent with your theory of the case?

A. Had good blood flow with no ischemia, can we just stop at that concept.

Perfusion of the leg is variable, and it can be determined in levels. You could have a four plus pulse, two plus pulse, one plus pulse, and the fact that you have diminished circulation does not mean that the leg is going to die, and it dies in stages.

And I believe that is what happened in her particular case. So I'm not really sure what you're getting at, and how you want me to answer, because what happened to Mrs. Shaver was the fact that she had a partial occlusion of the artery. There was reduced blood flow to the leg.

And I'm not exactly sure what you mean, why their expertise or lack of expertise would have made a difference in the outcome.

Q. Let's do this, Doctor. I would like to ask you about the vascular surgery consult that came by and saw Ms. Shaver and what their orders were. And if you want, I can -- this is the first one. Okay.

I'm going to ask you to look at your

progress notes. And like when I took your deposition, look at whatever records you want. You have them with you today, just like you did in deposition; correct?

A. I do, but you're going to look at Dr. Eaton's op note?

Q. No. We're going to look at the vascular surgical consult that was 4/23, 1:09 p.m., just that one, 1:09 p.m., just after she got to the facility. I'm getting there. We did put it on the screen to help you find it.

THE ARBITRATOR: It's up on the screen. This for the admission of 4/5?

MR. PANTER: No.

THE ARBITRATOR: 4/23.

MR. PANTER: 4/23, sir.

THE WITNESS: All right. What are we looking at?

THE ARBITRATOR: 4/23.

MR. PANTER: Or you can look up on the board.

THE WITNESS: We'll start with the board. It will be faster, 4/20/11?

Q. (BY MR. PANTER) 4/23. This is just minutes after she got there, the next day. Let's talk about these first.

Your testimony I heard you -- if I heard you right when you were answering Mr. Martin's questions, you said she had a nonsalvageable limb when she left Baptist Hospital?

A. That's correct.

Q. Now, I want you to look at the vascular consult.

Do you have any reason to disrespect the vascular consult at Baptist Hospital or disregard them, sir?

A. Which one?

Q. Any of them.

A. Probably not, probably a level of expertise between Dr. Eaton, who is the vascular surgeon at the University of Miami and this PA who did the consult. But anyway, this looks like a progress note.

Q. Did you know that there were five different vascular surgeons in a group that was attending to Helen at various times at Baptist Hospital?

A. I didn't recognize -- I know Dr. Eaton. I know his group, but I didn't see the different names.

Q. Let's look at this one vascular consult. And what does it say about the patient's left foot? Can you read that, or I'll help you.

A. Gangrenous?

Q. Not where it's highlighted.

THE ARBITRATOR: It starts "Patient has."

THE WITNESS: "Patient has nails left foot."

Q. (BY MR. PANTER) Let's talk about this. You can't read that.

A. Pulse ---

Q. Hold on. I want to take one step at a time, if I could. I don't mean to interrupt you.

How about patient has viable left foot?

A. Okay. That's true.

Q. Now, you were just reading nails. You are having a problem reading the record. When you were reviewing, did you have a problem reading the records? They are difficult to read.

A. Well, some of them that are technical are much easier to read, and some of the writing was also better, too.

Q. The writing part, it's all the chart, it's all important, isn't it, Doctor, all of it?

A. All of it is important?

Q. Yes, sir.

A. No, obviously it's not all important. Some things have a greater magnitude and some have less magnitude.

Q. Do you think that a comment with respect to

whether her foot is salvageable or not, it says it's viable, is relevant to the issue of a foot being salvageable or not?

A. At that particular moment in his particular opinion, it might have been salvageable, but it certainly does not be able to predispose future viability.

Q. Just so were are clear, you're a case reviewer in this case. This is a doctor who's attending to the patient at the hospital. Kind of draw this picture for Mr. Kuvin, who knows this well, but this doctor who wrote this note is sitting or standing at Helen's bedside; correct?

A. Yes.

Q. He's evaluating her, he's touching her probably; correct?

A. Correct.

Q. He's there. He can check everything. You are looking at the records, and this is inconsistent with your opinion, because you said it's nonsalvageable, and this doctor, when she comes to Baptist, leaving St. Anne's after ten days of neglect, admitted to by your lawyers, says she has a viable left foot?

MR. MARTIN: Objection. Argumentive.

Compound.

THE WITNESS: Can I answer?

THE ARBITRATOR: Do you want to?

THE WITNESS: Yes.

THE ARBITRATOR: Okay. Overruled.

THE WITNESS: The reality is, though, that we die in stages. You saw the progression, the necrosis of the left leg even after the debridement.

And while the foot may have been viable at that point, and I think that everyone thought that they were viable -- that it was viable at that point, the events had been set in motion that was going to cause say her to lose her leg.

And I would like to see the rest of that note, because you've only got the one portion of it.

Q. (BY MR. PANTER) I'll bring you both pages.

A. It is the next page. I'm not even sure it's a doctor.

Q. Oh, yes, it is. Here, sir, here you go.

THE ARBITRATOR: Somebody signed it.

MR. PANTER: Here's two pages.

Q. (BY MR. PANTER) So this doctor, this note, this vascular surgical note doesn't say nonsalvageable, does it?

A. No, it doesn't.

Q. And do you think if a doctor examining a patient thought it was nonsalvageable, that they would write that in the chart?

A. They probably didn't know, nor would I have known at that particular point, that the leg was nonsalvageable but by virtue you have to look back and kind of see where everything was going.

Q. So these ---

A. I will give them back. I need the exercise.

Q. That's good. Thank you so much, Dr. P.

A. Sure.

Q. Bottom line, with respect to this note, your opinion is different than this vascular surgeon who was attending to her the day after she left St. Anne's?

A. Correct. Well, at that particular moment, that was his opinion.

Q. Right. And if we go to page 2, what was the plan? I have it highlighted. There's two parts to the plan, one and two.

A. Arterial study and then decubitus -- who knows -- both legs.

Q. How about ---

A. Precautions, heel protectors. And whose signature is that? Were you able to identify that?

Q. Do you know Dr. Tsoukas, one of the partners of Dr. Eaton?

A. No. Dr. Tsoukas is a partner of Dr. Eaton?

Q. Was, yes, sir. Do you know who Dr. Tsoukas is? T-S-O-U-K-A-S.

A. Oh, yes.

Q. So ---

A. Is he a vascular surgeon or heart surgeon?

Q. He's part of Vascular -- Baptist Vascular Surgical Institute.

A. I know Dr. Eaton very well. I used to be president of the Florida Vascular Society. He never attended our meetings. So I'm not sure he's actually a vascular surgeon.

MR. MULLEN: Just answer the questions they're asking.

Q. (BY MR. PANTER) Now, this doctor thought decubitus precautions were important; correct?

A. Correct.

Q. And decubitus meaning preventing pressure ulcers?

A. Correct.

Q. Okay. What is the purpose of decubitus precautions for both legs, heel protectors and air mattress?

A. To prevent decubitus ulcers.

Q. You had asked before about the doctors at Miami Vascular Specialists. I have here Caldman, Noel, Rua, Tsoukas, Eaton.

Does that help refresh your memory?

A. Yes. I know them all very well, except for Dr. Tsoukas.

Q. All right. Thank you.

A. T-S?

Q. T-S, yes.

Would you agree with the fact that that vascular surgeon, Dr. Tsoukas, believed that the measures to prevent the pressure ulcers of the left lower extremity or all her extremities for that matter would be a benefit to Helen?

A. Yes.

Q. Was there any indication in that note which were put down -- that's okay -- any indication in that note that they were recommending an amputation at that time?

A. At that time, no.

Q. Now, on April 23rd, what were the results of the testing done in a peripheral vascular lab?

Do you know that, sir?

A. I believe she had an ABI of .41.

Q. Did that same result also reflect no significant arterial occlusive disease?

A. I don't know what it referred. I can tell what it means, though.

Q. Let's talk about the ABI. We know that that stands for arterial brachial index; correct?

A. Correct.

Q. We don't have to repeat what that test is because we had Dr. Salinger to explain it to all of us in this room, but you also know that her ABI after the revascularization surgery went from .41 to .99, which is normal?

A. Correct.

Q. Okay. That is a good thing?

A. It's a good thing to a degree.

Q. Okay. Well, a lot of what we were talking about is to degrees, because .41 doesn't reflect complete occlusive disease, it's moderate; correct?

A. .41 in a diabetic is considered to be very serious.

And as I have already pointed out in my testimony, the fact that she had diminished perfusion of the anterior compartment and she also had diminished perfusion of the area around the upper calves cause a disruption of the collateral blood

supply.

Q. Let me ask you this, Doctor, on the vascular consultation note, which we'll put up on the screen for you -- I think we can -- page 746 to 748, dictated by Dr. Chan, a PA, and later signed by Dr. Tsoukas, do you know what the reason was for that consultation?

A. No.

Q. How about if I tell you that it was for decubitus ulcer in left lower extremity?

A. Okay.

Q. Would you agree with that?

A. I believe, yes.

Q. All right.

A. I believe that's what he wrote.

Q. And do you know what his plan was at that time?

A. Revascularize the leg.

Q. What about also a neuro consult? Do you remember that?

A. No.

Q. If I tell that you it was, it was part of the plan to do the neuro consult, would you agree with that? Do you want me to show you the record?

A. I believe you.

Q. And were they also recommending once again

decubitus precautions?

A. Yes.

Q. That's important -- it was important for this patient at Baptist Hospital, it was very attuned to that necessity for her medical care; correct?

A. Part of it. Part of the medical care, certainly not the most important.

Q. Does that note from Dr. Chan that we just discussed indicate there was a risk of limb threat anywhere in that note that was signed by Dr. Tsoukas?

A. Patient currently with risk of limb threat and motor and sensory function loss to the left foot.

Q. And would you agree that risk of limb threat is not the same thing as writing nonsalvageable, no hope?

A. At that moment I believe that they believed that they did have a hope of salvaging the leg.

Q. Apparently ---

A. At that time I think that they believed that they did have hope for being able to salvage the leg.

Q. And that, once again, is another vascular surgeon and his PA with an opinion that's inconsistent with yours, it says nonsalvageable from the day she left Baptist the first time?

A. And my opinion is based upon the review of

all the records and has the benefit of hindsight.

Q. Okay. Were you aware of the notes and the consultations that talked about -- and it's on page 761. It's another consultation by the Baptist Cardiovascular Institute doctors that talked about the loss of motor -- it's on page 761, David. It talks about the loss of motor and sensory, that they are out of proportion to the fact that the PT pulse existed.

Were you aware of that and it might be a nerve injury?

A. No. It would not surprise me.

Q. And they were talking -- and it's on the bottom right, they talk about nerve injury. About three lines above 761, where it says nerve injury.

A. Yes, sir.

Q. You kind of testified that Helen did indeed have a nerve injury, you believe that probably was one of the problems?

A. That's correct.

Q. Because when Mr. Mullen was asking you questions, you said ischemic and nerve. It's kind of hard to differentiate between it because she never had a complete occlusive ischemic disease?

A. That's correct.

Q. And nerve injuries can be treated

differently than occlusive ischemic diseases; correct?

A. Nerve injuries are very difficult to treat.

Q. For example, foot drop is a nerve injury?

A. It is.

Q. And people get on with foot drop. They wear, there are different braces. I have pictures of them, I can show you. But I know that you know about -- you must have patients with foot drop, and some of them are worse than others.

It's another one of those degree things; correct?

A. Correct.

Q. And some people can get a kind of a $199, maybe a $49 foot drop splint and go on their merry way and have a reasonable quality of life and ambulate reasonably well?

A. They can. The difficulty is that she had an insensate foot as well.

THE ARBITRATOR: A what?

THE WITNESS: Insensate, without feeling. And that usually predisposes to ulcerations and ultimate loss of the extremity.

Q. (BY MR. PANTER) Okay. And she had a lot of comorbidities, you went through all those; correct?

A. Correct.

Q. And when she came to St. Anne's, they knew about those comorbidities; correct?

A. I believe they did.

Q. And they should have; right?

A. We have looked at the record together and, yes, we did see that those comorbidities were clearly listed.

Q. And when you are at a facility -- do you know what a care plan is?

MR. MARTIN: Objection. He's not giving nursing testimony.

THE ARBITRATOR: Yes. I think you're going beyond ---

MR. PANTER: I was going to go to causation. That's what he's here about.

Q. (BY MR. PANTER) Does a facility have to attend to various comorbidities?

MR. MARTIN: Same objection.

THE WITNESS: Yes.

THE ARBITRATOR: That's a good question.

Q. (BY MR. PANTER) Do you know the mechanism in which they do that at a nursing home?

A. No, I wouldn't, the mechanism of how they do it in a nursing home, I don't have any knowledge of that.

Q. It has to be a document somewhere, would you agree? And that's why I was asking about a care plan.

THE ARBITRATOR: But he said he doesn't know, so let's not get into that.

Q. (BY MR. PANTER) The information must be communicated to the care provider in some manor. You would agree with that?

A. Yes.

Q. If they are not given the information, then they can't address those comorbidities?

MR. MULLEN: Objection. Scope.

THE WITNESS: It's not -- the director is not given the information, then they can't address the comorbidity, is that your question?

Q. (BY MR. PANTER) Yes. If the care providers aren't provided with the information, for instance, related to comorbidities ---

A. Care provider being the doctor?

Q. It could be a nurse. It could be a doctor. In this facility ---

A. The subject of your sentence is who's the care provider, CNA or what?

Q. Let's talk about an RN.

A. An RN.

Q. If an RN is not given any information about

the patient, then it's going to be difficult for her to assess, treat and pay attention and be aware of any problems with respect to the comorbidities?

MR. MARTIN: Objection. Scope.

THE ARBITRATOR: I agree. Sustained.

Q. (BY MR. PANTER) Okay. Let's then move on to another issue, Doctor.

What surgical intervention was planned for the evening of April 23rd?

A. April 23rd, that was Dr. Eaton's procedure?

THE ARBITRATOR: Yes.

Q. (BY MR. PANTER) Do you know? Let me catch up here. Vascular ---

A. Vascular consult, left leg ischemia at the time of fracture.

Q. Let me bring it over to you.

A. What activity was planned?

Q. What surgical intervention was planned? How about this, rather than bring it over to, you how about if I tell it was revascularization of the left leg by Dr. Eaton.

A. Well, that was his consult. Is that your question?

Q. No.

THE ARBITRATOR: His plan, what was he going

to do.

Q. (BY MR. PANTER) Let me show it to you. So I was asking what ---

A. This is the preoperative anesthesia note, I believe.

Q. Yes. What were they planning on doing? That's all I'm asking.

I have it highlighted for you.

A. Revascularization of the left leg.

Q. Okay. That's my question.

THE ARBITRATOR: Your answer seemed ---

THE WITNESS: That was what was written, not by Dr. Eaton, but apparently by the person who evaluated Mrs. Shaver prior to the operation.

Q. (BY MR. PANTER) Okay. Does the medical record indicate any discussion of amputation at this time?

A. No.

Q. Okay. And do you know if this procedure was completed, the one I just showed you, which they were planning a revascularization of the left leg?

A. Yes. Four days later it was completed.

Q. Not on that day; right?

A. That's correct.

Q. And do you know why it was canceled?

A. I believe because she had a high INR.

Q. And do you know now she came to have a high INR, which is PT/INR?

A. Yes, because she was given Coumadin at St. Anne's.

Q. So do you know how much Coumadin she was given at St. Anne's?

A. I don't remember the dose.

Q. Do you know if she was overdosed with Coumadin?

A. Remember that it was, I think, 5.7 INR at that time.

Q. Let me review it with you to help refresh your recollection.

She had an order by Dr. Diaz at the facility that says don't call me -- or don't call me if the INR is between 2 and 3; correct?

A. Correct.

Q. And the INR on that -- that was a therapeutic range, she was getting two milligrams a day; correct?

A. Correct.

Q. It's an important anticoagulation drug for her comorbidities that she had, it was reasonable to have that drug; correct?

A. Correct.

Q. And it was also reasonable and important for it to be monitored appropriately by the St. Anne's facility; is that correct?

MR. MARTIN: Objection. Scope.

THE WITNESS: That's correct.

Q. (BY MR. PANTER) And back on this question, so, Doctor, when her PT/INR was taken on 4/18, do you remember what it was at the facility?

A. No, I do not.

Q. How about if I refresh your recollection? I do. It was 3.7.

A. Okay.

Q. How about the next day at that time, did they call Dr. Diaz?

A. I don't know whether they did or not.

Q. Assuming that they didn't, you can read the depos, didn't you see the record where it said they called him on 4/21? Do you remember that page of the record?

A. No, I don't.

MR. MARTIN: Objection. Scope. This goes to nursing care.

This has nothing to do with what the ultimate INR was. It's also argumentative.

THE ARBITRATOR: I think it goes to causation.

MR. PANTER: Absolutely.

Q. (BY MR. PANTER) Now, I'm going to ---

MR. MULLEN: Your expert already testified it does not.

THE ARBITRATOR: Let me hear it.

Q. (BY MR. PANTER) I'll help refresh your recollection. They've made the call on 4/21. What happened the day before that on 4/20? They gave her another dose of Coumadin, didn't they?

A. They may have. I accept your word that they did, but I don't think you'd be asking the question if they did not.

Q. And on 4/21, they gave her another dose of Coumadin before they called the doctor?

A. They did.

Q. And now after giving her two extra doses of Coumadin, both of those were breaching the standard of care; correct?

MR. MARTIN: Objection to scope.

Q. (BY MR. PANTER) Both of those were breaches of standard of care; right?

THE ARBITRATOR: That objection I'll take. Sustained.

Q. (BY MR. PANTER) You know, your lawyer has already admitted that this facility was negligent for this -- what we're talking about these facts right here, don't you?

MR. MARTIN: Objection.

Q. (BY MR. PANTER) Now you know that because I told you?

A. Yes.

Q. They didn't tell you, I told you; correct?

MR. MARTIN: Objection. Argumentative.

THE ARBITRATOR: Again, argumentative and repetitive.

Q. (BY MR. PANTER) Okay. But In any event, after she got two extra doses of Coumadin, in violation of the doctor's order, what was her INR?

A. 5.7.

Q. And that's why they had to delay doing a revascularization surgery; is that correct?

A. That is not correct.

Q. You told me before that they didn't do the vascular surgery because the PT/INR was too high, 5.7. That's what you said to this arbitrator; isn't that true?

A. May I clarify that?

THE ARBITRATOR: The answer is "yes" or

"no."

THE WITNESS: The answer is yes to your question.

THE ARBITRATOR: Then you can clarify it if you choose to.

THE WITNESS: There are ways to reverse Coumadin.

Q. (BY MR. PANTER) Okay.

A. If they wished to have done so.

Q. And in any event, they waited until it was a therapeutic range, and they did the surgery on what date?

A. The 27th.

Q. Okay. And you told me in deposition that delay is not a good thing generally; correct?

A. That is correct.

Q. And delay with a revascularization surgery with an ischemic problem is also not a good thing?

A. That's also correct.

Q. And for Helen Shaver, delay in getting revascularization surgery is not a good thing?

A. Not a good thing, but it would not have altered the outcome.

Q. It didn't help he,r, it didn't improve her chances of a better outcome waiting longer, did it?

A. It did not improve her chances of a better outcome.

Q. Now, I want you to see the vascular surgical note on 4/23. It's on our page 1351. And this a vascular surgical consult by Dr. Eaton.

Do you recognize it as such?

THE ARBITRATOR: What's the Bate number?

MR. PANTER: 1351. I'll bring it over to him.

THE ARBITRATOR: There it is.

Q. (BY MR. PANTER) I want you to please highlight the part where it says neuro findings ---

THE ARBITRATOR: Matt, do you have our Bate numbers?

MR. MARTIN: No. They're not Bate stamped.

THE WITNESS: That's better. Thank you.

Q. (BY MR. PANTER) Now, you claim that she had a continuing ischemic problem, that's part of your theory of this case; correct?

A. That's correct.

Q. And you respect Dr. Eaton, you told me that already?

A. I do.

Q. Would you read out loud the last three lines before the angiogram. We're trying to highlight it,

but it's just too high. It's a paragraph where it starts neuro findings.

I would like to you read that out loud, i.e., the next paragraph.

A. Foot is paralyzed.

Q. It starts off with neuro findings.

A. Between the two of them, they're technologically deficient. I can read it.

Q. Go ahead and read that, sir.

A. "Neuro findings date to surgery and are likely direct injury" -- "direct nerve injury and not ischemia."

Q. Once again, Dr. Eaton, the respected vascular surgeon, believed at this time that the problems that he was noting were not ischemic?

A. It doesn't mean that she did not have ischemia. It just meant that she has nerve damage secondary to direct nerve injury.

I'm not sure how the two concepts are mutually exclusive.

I would like to go back to the top line. If patient wants to wait for angiogram, in view of what we were talking about a few minutes earlier about delaying the surgery.

THE ARBITRATOR: Let him ask the question.

MR. PANTER: Okay.

MR. MULLEN: Did he want to expand his answer?

THE ARBITRATOR: No. There's no pending question.

MR. PANTER: I'm going to cross-examine him. I'm going on. He's taking a break for a second, a thought process.

Q. (BY MR. PANTER) Is there any mention in Dr. Eaton's vascular surgical note about amputation at this time?

A. No.

Q. Is there any indication he recommended amputation at this time?

A. No.

Q. On April 24th, I want you to look at the next progress note, and tell me when you you're done.

THE ARBITRATOR: Before we get to that, was there something you want to expand on this note of April 23rd?

THE WITNESS: Well, Mr. Panter made mention that there was a delay in performing the operation -- I guess the angiogram, because of her high INR. And I'm looking at the top line. The patient wants to wait for angiogram. I just kind of wonder what the

patient's contribution was to the delay.

THE ARBITRATOR: He can't answer that question.

MR. PANTER: I have a question for him because of his statement.

THE WITNESS: Okay.

Q. (BY MR. PANTER) What does Dr. Eaton say about the angiogram on page 1351 at the bottom of the note? And I will bring it to you.

A. I like projecting it.

THE ARBITRATOR: Yes. Project the bottom.

THE WITNESS: I can see it. Angiogram, PT -- PT closer to 2, 3.

Q. (BY MR. PANTER) But he's waiting because it's 5.7 as a result of St. Anne's overdose of Coumadin. Is that a fact?

A. Well, he's waiting for ---

Q. Is that a fact? You can answer and then you can explain it. Is that a fact?

A. Yes.

THE ARBITRATOR: Do you want to explain it?

THE WITNESS: Yes.

THE ARBITRATOR: Do it.

THE WITNESS: I don't really know if it is a fact, what his thinking was at that particular point.

Depending upon the urgency of the ischemia, the severity of the ischemia, if we needed to move along we would go ahead and move along by reversing it with fresh frozen plasma or vitamin K or both.

And I think that Dr. Eaton's thinking at that particular time was that the leg was not so severely ischemic that he had to address the issue immediately are.

Q. (BY MR. PANTER) Let's look at the next day. I think we're following the sequence on this issue of salvageability, April 24th.

By the way, in preparation did you review these vascular surgical handwritten notes? Did you take the time to go through them all?

A. Yes, I did.

Q. Let's talk about it. Let's look at the note of April 24th, 2010, and let's talk about Dr. Eaton's evaluation at that time where it says left foot.

And I would ask David to highlight it. It's about -- do you see where it is -- yes, that is it.

April 24th. And how does he describe Helen's left foot at that time?

A. Remains viable. I don't think that's Dr. Eaton's note, whoever wrote that note.

Q. It's Tsoukas.

A. Warm temperature and capillary refill.

Q. You said it wasn't Eaton, but that's actually more interesting, because now we have Eaton. We've got Tsoukas. You've got multiple vascular surgeons, skilled, by your own admission, who are all saying we've got a viable foot here and saying it's not ischemic and things that are quite different than your progressive, ischemic, nonsalvageable theory. Agree?

A. No, I really don't, because I think that you're looking at the end result, and I'm saying we're probably walking down the road toward the end result. At that particular time, there was viability of the foot.

And I think this rather brief note also ignores the fact that she had a dying anterior compartment and also had dead muscle in the posterior calf.

Q. Well, these doctors were looking at her. They knew what the problems were in her anterior calf. And by the way, when she left the facility, while you were at the anterior calf, she had to come out, they had to take the staples out. It seems she got to Baptist because of an infection that she got at the facility; correct?

MR. MARTIN: Objection. Argumentative. Compound.

MR. PANTER: Well, he mentioned the anterior calf. It may be compound.

THE ARBITRATOR: See if you can rephrase it.

MR. PANTER: I can.

THE ARBITRATOR: Make it a little less argumentative.

Q. (BY MR. PANTER) You mentioned the anterior calf.

A. I did. And you used ---

THE ARBITRATOR: Let him finish his answer.

Q. (BY MR. PANTER) Well, my question to you is this, that she had a wound from those staples that was not attended to for at least six days at this facility. You know those facts, don't you?

A. No, I do not.

Q. You don't remember reading Julia's deposition.

A. Julia's deposition?

Q. The nurse?

A. I do remember her.

Q. And remember there was no doctors order up and until she got there at 4/13, not a single doctor's order with respect to wound care until the 17th? Do

you remember that?

A. No, I do not.

Q. Then I guess you don't, but maybe you haven't done your homework.

MR. MARTIN: Argumentative. Move to strike.

THE ARBITRATOR: Move it.

Q. (BY MR. PANTER) What about on the 18th, they waited one more day, is that the first day they provided any wound care for her anterior calf?

MR. MARTIN: Objection. Scope.

THE WITNESS: I have no idea what day it was. I do remember that they were applying Bactroban to it.

Q. (BY MR. PANTER) You think they were applying Bactroban to it?

A. Yes. Because you made mention of that in my deposition, and I corrected that, because you said Bactrim, and I said Bactroban.

Q. And I corrected you. Wasn't that on her sternum, the wound she still had from the cardiac surgery? That's where the Bactroban went.

A. No. Actually, our discussion was about whether they had ever taken the knee immobilizer off. You showed me a picture where they did. And, in fact, you mentioned of the fact that they were applying

Bactroban to it. You said Bactrim, and I said Bactroban.

So consequently, at that particular point, you had made the fact that the leg had been examined. So I don't know whether I can accept what you are telling me at face value.

Q. I want to show you the order, which is page 91 of our records, treatment record from the facility, about Bactroban.

A. Okay.

Q. And just so the arbitrator sees the reality here is where was that Bactroban, according to this treatment record, applied? And I can highlight it for you or I can point it out.

Anything about Bactroban being applied to the surgical wound from her orthopedic surgery?

A. It says right above it, apply Santyl Bactroban daily, cleanse with normal saline -- what it says -- first of all, Bactroban is listed twice, apply Santyl, Bactroban daily, cleanse with normal saline prior to skin prep around wound, place Vaseline over it.

Then on the next line, Santyl Bactroban covered with four by fours -- four by four and fabric tape daily to chest wound.

So I'm not too sure whether they're the same order.

And then further on down, it says apply A and D ointment and lower extremity -- to lower extremity bilateral and dry heels daily.

Then the final line is cleanse left leg surgical site with normal saline, apply four by four and fabric tape, monitor SS, skin infection, bleeding precautions.

Q. Is there anything there about Bactroban being applied to the surgical wound?

A. Actually, Bactroban came from your comment during my deposition.

Q. Look at the doctor's order, physician order No. 2. Read that one as well.

MR. MARTIN: Objection. Scope. Relevance.

THE ARBITRATOR: Yes. I'm having a problem with relevance.

MR. PANTER: Well, everything is relevant because it goes to his credibility.

THE ARBITRATOR: No, not everything is relevant. I'm having a problem with this area. What has the chest wound got to do with anything in this case?

MR. PANTER: Nothing. The point is that the

treatment that -- the only wound care she got was to her chest.

She got no wound care to her leg for five days at that facility, not ---

THE ARBITRATOR: I think that's already been established.

MR. PANTER: He's not agreeing to that. He's trying to argue that there's been some kind of wound care that was provided to her lower leg.

MR. MARTIN: He's not giving nursing opinions.

MR. PANTER: All right. Thank you.

Q. (BY MR. PANTER) So, Doctor, then do you agree that there was no wound care to Helen's left lower surgical area?

MR. MARTIN: Objection. Scope. Relevance.

THE WITNESS: I frankly don't know whether that was or wasn't.

Q. (BY MR. PANTER) All right. Doctor, was an angiogram performed when the INR reached the 2 to 3 range?

A. I thought the patient had a CT angiogram performed.

Q. What were the results of the angiogram performed a 4/26?

A. Left popliteal artery occlusion.
Q. And the occlusion we're talking about was two to three centimeters; correct?
A. Correct.
Q. And what procedure did Dr. Eaton perform on April 27th?
A. Performed an intimectomy and subsequently an atherectomy.
Q. And would you agree that his intimal artery -- his left popliteal intimal -- his left artery -- his left popliteal artery intimal flap removal was a successful procedure, Doctor?
A. Yes, it was.
Q. And ---
A. At least partially. I need to clarify.
Q. Well ---
THE ARBITRATOR: He needs to clarify. He said he needs to clarify.
THE WITNESS: I need to clarify. At least it was partially successful, yes, sir.
Q. (BY MR. PANTER) And he restored patency to the popliteal artery; correct?
A. He restored patency to the popliteal artery, tibial and peroneal arteries, sir.
THE ARBITRATOR: I'm sorry. He restored

what?

THE WITNESS: Patency to the popliteal artery.

THE ARBITRATOR: So the blood flow was increased.

THE WITNESS: The blood flow was increased.

Q. (BY MR. PANTER) And that's the reason he did that surgery, correct, to increase blood flow?

A. The reason for the surgery was to increase the blood flow to the leg. That is correct.

Q. And I thought I heard you earlier talk about the tibial artery being completely occluded.

Did you say that or not?

A. The anterior tibial artery was diminutive, and only patent, a very small vessel.

Q. Diminutive is different than complete occlusion; correct?

A. That is correct.

Q. I thought I heard you say it was completely occluded. Maybe I stand corrected.

But you never said earlier that it was occluded, did you?

A. I don't recall whether I said it was completely occluded, but certainly it was not serving the purpose that was intended, which was to perfuse

the anterior compartment.

Q. She had no discoloration in her toes; correct?

A. Correct.

Q. Now, did -- I'm sorry. Give me the doctor's report that we're looking at.

Still looking at Dr. Eaton's operative report, if you need to look at it, that's -- I have it in my hand.

I don't want it to be at a disadvantage to you. I want to make sure you have it if you need it.

A. It's on the screen.

Q. I don't know which page will be relevant to you for these questions, but I have a few questions.

Did Dr. Eaton's operative report reflect compartment syndrome anywhere in the report?

A. No, it did not. Well, I'm sorry. I don't think it was, because they -- or needed to, because at the time that he went in there, there was so much necrosis of the posterior calf, that the compartment syndrome had likely decompressed itself.

I think we need to make a distinction between a compartment syndrome and dead muscle.

Q. Okay. And she had dead muscle, myonecrosis; correct?

A. That's correct.

Q. And you agree with me that you can get death of muscle from pressure, which can cause ischemia? That's one way it can happen. It can happen other ways as well; correct?

A. That's correct.

Q. Okay. And in Dr. Eaton's report, the same report, he also reflected that Helen -- it's on the second page, I'm not sure where it is, but I know that the doctor knows, you and I talked about this, she had a rubious foot; correct?

A. Correct.

Q. And excellent signal in the region of the posterior tibial artery; correct?

A. Correct.

Q. That's a good result of that part of the surgery; correct?

A. Well, it's -- I have to qualify that. I mean, there's more to the leg than just a posterior tibial artery and the area that he was perfusing, but he certainly achieved the result of perfusing the foot.

Q. Let's talk about the whole limb, then. Okay. The day after surgery, what did Dr. Eaton write in his postop day report No. 1, page 1375, about

Helen's limb? What did he write? I'm sorry. It was Tsoukas.

A. The popliteal artery repair -- complains of local pain, left lower extremity. Vital signs stable. Afebrile. Left foot warm. Positive Doppler. PT, PTT -- I'm sorry. Posterior tibial and posterior tibial. I'm not sure what he meant by that. I don't know what that other word is.

Anyway, going a little bit further, something DC. Post wound.

A little bit higher than that.

Mild -- popliteal wound was mildly erythematous or ecchymotic. It was ecchymotic.

Hemoglobin was 7.7. Hematocrit, 23.8, down from 9.3.

I don't know. Status -- action plan, status post -- I have who idea what that is. Well perfused limb. Will order ---

Q. Hold on. I want to talk about the well-perfused limb. That's what I was going after.

A. Okay.

Q. After the popliteal artery intimal flap was removed, that limb was well-perfused. That's a good thing; correct?

A. If that's the part he's looking at.

Q. He says the whole limb, he doesn't say the foot, he says the whole limb, well-perfused limb.

What does a limb mean to you?

A. The limb, the way it's written over there, would mean the area that goes from the left groin down to the toes.

Q. Okay. And obviously he knows there is a problem in her whole left leg. She had surgery. It's the groin to her toes, and it was a good perfused limb.

That's not nonsalvageable, is it?

A. At that point, they didn't think it was.

Q. They didn't write nonsalvageable, let's amputate, let's do that, did they?

A. I think at that point, they thought they were going to be able to save it.

Q. Let's go further on and look at Dr. Eaton's note on May 3rd. I don't have it on the screen.

But do you know what Dr. Eaton said, vascular surgical consult on May 3rd, about the bypass?

A. No, sir.

Q. What if I told you he said bypass is patent? Is that a good thing?

A. It wasn't bypass, but, yes.

Q. That's what he wrote.
A. I realize that.
Q. I mean, I didn't make that up. Do you want me to show it to you?
A. No. I believe you.
Q. What does he mean by that, then?
A. It means that the left lower extremity is well perfused.
Q. That's not consistent with a nonsalvageable limb either, is it?
A. It's only looking at one part of the picture.
Q. He's looking at the limb, the whole limb, and he's certainly considering ischemia. That's something as a vascular similar surgeon you would be considering every time you look at a patient with any kind of limb problem; right?
A. From the prospective of what you're saying, it's true. He did a very good job reperfusing the lower part of the limb.
Unfortunately, as we're about to see here, she had difficulties more cephalad.
Q. How did her ABI, which we talked about before, the arterial brachial index on her left lower extremity on May 3rd compare to the preoperative

findings?

A. It's significantly improved.

Q. Let's be specific. It went from .41 to .99, which is normal?

A. That's correct.

Q. Would you agree that that finding is contrary to a diagnosis of ischemia?

A. Yes, sir.

Q. Another note on May 6th, if we go a little further, by Dr. Chan, signed by Tsoukas, what does that say about the viability of the leg? Do you remember that, or should I tell you -- share the note with you? It's on page 1405.

A. If you could project it, it will make it a little bit easier.

Q. That's it. It is a PA at this time.

What does that indicate in the last line about viability of Helen's leg?

A. Status post wound -- no. Vascular surgery post operative day 9.

Left popliteal artery ---

Q. To help you, I'm just asking you to go to the last line and read what he says about the viability of Helen's left leg.

MR. MULLEN: Doctor, if you need to read the

whole note first before you answer any questions, you're entitled to do so.

MR. PANTER: I'm asking him. He can do whatever he wants when he's done doing what I'm asking.

I'm asking to read the last ---

MR. MULLEN: Excuse me, Mr. Kuvin, I think he's allowed to read ---

THE ARBITRATOR: He is. But I agree with Brett, ask your question.

Q. (BY MR. PANTER) My question is, I want you to look at the last line of that note, sir, and read what it says out loud about the viability of Helen's leg on May 6th, 2010 at 1:30 p.m.

A. Left leg viable.

Q. Now, is there anything else you want to read in note? You're certainly welcome.

THE ARBITRATOR: That you feel is important.

Q. (BY MR. PANTER) Is there anything else that you would ---

A. Wound debridement today. Back dressing in place. Left foot is pink and warm.

Q. Pink and warm is another good finding with respect to perfusion viability; is that correct?

A. That's correct.

Q. So now we're going to go May 8th, and I want to ask you if you know of a vascular surgery progress note written by Dr. Chan. a PA again, documented the left leg status was unchanged, and there was adequate perfusion.

I can show you where that is or I can bring it to you. But the note says left leg viable, will follow.

THE ARBITRATOR: That's May 10th.

Q. (BY MR. PANTER) This is May 8th, and I have it highlighted in yellow for you.

So I would ask you to read the highlighted section out loud to our arbitrator, what it says about Helen's viability of her left leg on May 8th, 2010?

A. Left leg viable, will follow PRN.

Q. Okay. Is there anything there about an amputation?

A. Not at that point.

Q. Anything there about her leg being nonsalvageable?

A. No, not at that point.

Q. Anything there about her having a perfusion problem?

A. No, sir.

Q. Anything there about an ischemic problem?

A. Not about ischemia. That's for wound debridement.

Q. Okay. Thank you.

A. Left leg vascular status unchanged, adequate perfusion.

Q. If you're a vascular surgeon or vascular surgical PA, would you agree you're going to look at Helen's leg for ischemia every time you see her?

A. Yes.

Q. Would you agree that you would reasonably expect if there was ischemia noted, that it would be documented in the medical chart?

A. Yes.

Q. As late as May 8th, is there any documentation by any physician examining Helen's leg stating it's not salvageable?

A. No.

Q. All right. I would like to transition, if we could, to another issue about evolving ischemia in this case, if that's okay with you, Doctor.

A. Yes, sir.

Q. All right. On page 543, and I'll -- thank you. We have records here, and some of these were shown by the lawyer for the facility at 11:24, 4/13, just before her discharge at St. Anne's, and I would

like you to tell us what is documented with respect to her pedal pulses?

Can you find them? I have it in yellow here or -- yes, actually ---

A. Give me a second.

Q. I'm going to help. I forget I have this.

What does it say there?

A. Capillary refill less than three seconds, radial and pedal pulses strong and palpable. Skin warm to touch.

Q. Now, do you question, whoever the person is from the cardiovascular unit who wrote this note, question their accuracy?

A. Yes.

Q. Okay. And do you know who it is?

A. No.

Q. Do you know what their experience was?

A. No.

Q. Do you know if they're in a cardiac unit?

A. The cardiac monitor. These type of people do this all the time. That was a statement, not a question.

Q. Okay. Well, is it your testimony in front of this arbitrator that you can't compare the nurses to the -- at a hospital to the nurses you would expect

to get -- would be taking care of you at a facility such as St. Anne's?

MR. MARTIN: Objection. Scope.

THE ARBITRATOR: I think the ---

THE WITNESS: Brett ---

Q. (BY MR. PANTER) Do you remember your earlier testimony saying that you would not expect the same type of skill set of people to be at a nursing home that would be at Baptist Hospital? Do you remember testifying to that?

A. Yes, sir.

Q. Now, not only are you critical of the accuracy or the ability of people at St. Anne's to discern pedal pulses, but now you're also critical of the nurses at Baptist Hospital and saying that they are wrong when they write pulses strong and palpable; correct?

MR. MARTIN: Objection. Argumentive. Scope.

MR. PANTER: It's not argumentative.

THE WITNESS: Well, what you're saying is true.

Q. (BY MR. PANTER) Is it true?

A. I don't know how to approach the question, quite honestly, because we know she's got a blocked

popliteal artery. How could she possibly have 3 plus pedal pulses? Obviously, it's wrong.

Q. Well, you say that there was a blocked popliteal artery, because there was an intimal flap surgery that was done on April 28th, but we -- there could be a reasonable argument that the injury took place and she didn't become symptomatic until days afterwards.

Would you agree that that can happen medically, you can have an injury and not be symptomatic for some time afterwards?

A. Yes, sir.

Q. And there can be in medicine, injuries that don't become acute for some time after the actual event?

MR. MARTIN: Objection. Overbroad.

THE WITNESS: Yes, I do.

THE ARBITRATOR: Can I interrupt this for a moment? Because I want to zero in on something, Brett and Matt, because I'm the one that's going to have to make a ruling in this case.

Doctor, let me ask you this question, because it's troubling me. It's your opinion, within reasonable medical probability, that the leg was not salvageable, period?

THE WITNESS: Yes, sir.
THE ARBITRATOR: From the get-go.
THE WITNESS: But we didn't know that.
THE ARBITRATOR: But in hindsight?
THE WITNESS: Yes, sir.
THE ARBITRATOR: Okay. Then how do you equate that with the leg being viable with all good things happening later?
THE WITNESS: The lower part of the leg was well perfused, and Dr. Eaton did a good job, but the problem is it was rotting up top and rotting in the anterior compartment and caused everything else to start to die.
THE ARBITRATOR: Why wouldn't that have shown up in these records somewhere?
THE WITNESS: It became more aware of it -- the pictures that Matt showed early on kind of reflected the deteriorating process. The leg was just kind of dying because of the progressive necrosis.
And while he had done a very good job in perfusing the foot, the rest on the leg was dying up top.
THE ARBITRATOR: Third question, what we have been going through is all this stuff that occurred in May of '10. Okay.

She then goes to Kindred, and then she goes back to Baptist in July. And that's, what, two months later, something had -- did something happen during that two months?

THE WITNESS: No. It's a progressive process.

The whole thing was set in motion by virtue of the fact that she had the fracture. She had the diabetes. She had the hypertension. She had the obesity and everything else.

It was a progressive process. It was dying piece by piece. Every time they went back to it to take else off, something else died. They did everything they possibly could.

And if I were Dr. Eaton or if I was Tsoukas, or I was the PA, I would have been writing the same notes, because it looked like we were going to be able to save the leg.

The problem was that the dye had already been cast, and it wasn't coming back.

THE ARBITRATOR: So bottom line, you're saying that these doctors were looking at this thing, and you, in hindsight, rather than foresight?

THE WITNESS: You hope you're able to turn a process around, and they weren't able to do that, nor

would I have done it.

Eaton is a good guy. He did everything he possibly could, but the fact is that the problem that she was having in her leg was in the upper calf and the anterior compartment, that was dying, progressively.

THE ARBITRATOR: Okay. I'm sorry to interrupt. I just -- that was banging around in my head.

Q. (BY MR. PANTER) Let me show you the operative report.

And are you familiar with Dr. Eaton's operative report when he actually did the amputation?

A. I read it.

Q. And you know in that report itself, he said she, in fact, has a palpable pulse in her foot; correct?

A. That's correct.

Q. And with perfusion, you would expect to -- with lack of perfusion and big ischemic problems, the foot would be the first part to reflect that symptomatically; correct?

A. Usually.

Q. And in this case there were no problems with Helen's foot?

A. No.
Q. Am I correct?
A. Except it was numb, but, yes.
Q. That's nerve related, the numbness could very well be nerve related. You've already testified to that; correct? That would explain that?
A. Yes, sir.
Q. Okay. Wouldn't you agree that your statement would give some credence to the accuracy of the nurses then or you're still taking a position that the nurses are -- I don't want to say incompetent, but inaccurate in their abilities?
MR. MARTIN: Scope.
THE ARBITRATOR: Yes, scope. And I sustain.
Q. (BY MR. PANTER) Okay. Let me go on. Do the medical records anywhere from Baptist, we're talking about now, April 5th to April 13th, anywhere reflect absence of pulses in her left foot during that admission?
A. First of all, I would like to go back and correct what you said, because it was inaccurate.
The fact is that the 4/13 note that you had up there was prior to the revascularization, and then you were saying that the foot was warm, pink with good pulse.

It was after revascularization, so we're not comparing the different time events.

Q. That was before she went to the nursing home, I was ---

A. 4/13 is when she came back to St. Anne's.

Q. The earlier note -- I think that note we were talking about was 4/13, just before she went to Baptist where they said they had good pulses.

A. Which obviously was incorrect.

Q. That's where we're at.

A. Now, could you rephrase the other question that you want me to answer?

Q. I don't have a question pending.

THE ARBITRATOR: I don't think there's a question.

MR. PANTER: You sustained an objection. That's why I was going ---

THE ARBITRATOR: I sustained the objection, so there's no question pending.

Q. (BY MR. PANTER) According to the records, did Helen Shaver have pedal pulses upon admission to St. Anne's?

A. I believe it was documented that she did in one of the records.

Q. Not in one, in three different places -- do

you want me to show them all to you or will you concede that to me? We go can through them all. I tell you what, I will.

A. Please.

Q. Let me show you -- and I will come over there. We have, for the record, page 35, which is the patient's resident admission evaluation, and I have it highlighted for you.

Does that reflect for the arbitrator all pedal pulses intact?

A. It does.

Q. Now, I want to show you, which is page -- page 37, which is an initial progress note of 4/13, 7 p.m., and I have it highlighted.

Does that say all pulses intact and equal, capillary refill?

A. Less than.

Q. Less than 3.

A. Correct. It does.

Q. And finally, page 39, this is part of the skin integrity admission, and is that -- I don't have it highlighted, but I will show you, pedal pulses present and equal?

A. It does. And that was on the 13th.

Q. All on the 13th?

A. That was the day that she was returned to Baptist.

Q. No. You have your dates wrong, sir.

A. I'm sorry. You're correct. I apologize. You're right. You're right. You're right.

Q. This is the first day she was at Baptist -- I mean, at St. Anne's?

A. Correct.

Q. And all these different nurses were all wrong with respect to her pedal pulses, that's your testimony; correct?

A. That is my testimony.

Q. Now, on April 19th, in that same facility, do you know what the documentation was with respect to Helen's pulses?

A. If I'm looking at my correct notes, it says abnormal pedal pulse.

Q. And in your deposition you agreed that that documentation that we're talking about was reflective of vascular compromise.

Do you still agree with that?

A. I do.

Q. Okay. And was there any treatment -- did anyone call the doctor that you know of from St. Anne's when the first documentation existed with

respect to abnormal peripheral pulses and vascular compromise?

MR. MARTIN: Objection. Scope. Goes to nursing care.

THE ARBITRATOR: Repeat that question back.

MR. PANTER: I asked him if anyone called the doctor when they noted abnormal peripheral pulses, because it goes directly to causation.

MR. MARTIN: It goes to nursing issues, as to whether the nurses should have ---

THE ARBITRATOR: I have to agree with Matt. I don't want to get into the nursing care with him.

MR. PANTER: It's related to medical care, did a medical doctor -- was a medical doctor informed about this?

THE ARBITRATOR: And the answer to that let's say hypothetically, is no.

MR. MARTIN: Regardless, the doctor is unemployed by the defendants, nor are we responsible for their ---

THE ARBITRATOR: Yes. Where are you with that?

MR. PANTER: They didn't call the doctor.

THE ARBITRATOR: Let's assume they didn't.

MR. PANTER: They needed to call the doctor.

THE ARBITRATOR: They didn't, so ---

MR. PANTER: Okay. I'll just move on.

THE ARBITRATOR: Okay.

Q. (BY MR. PANTER) Any let me ask you this. Is there any indication in the medical record that Dr. Diaz was informed of these abnormal peripheral pulses?

MR. MARTIN: Same objection.

THE ARBITRATOR: Same thing.

Q. (BY MR. PANTER) If you were the doctor attending to Helen Shaver, would you expect to be called?

MR. MARTIN: Same objection.

Q. (BY MR. PANTER) (Continuing) -- of a nurse noting abnormal peripheral pulses?

THE ARBITRATOR: Good try. Same. Sustained.

Q. (BY MR. PANTER) All right. Does the record ---

THE WITNESS: Do the Burgess exercise, up and down on your toes ten times.

MR. PANTER: Do you want to take a couple-minute break?

THE ARBITRATOR: No. Let's keep going.

Q. (BY MR. PANTER) Does the record include the

findings of daily -- including the findings of daily assessment of Helen's peripheral vascular pulses at St. Anne's?

MR. MARTIN: Objection. Scope.

THE WITNESS: Yes. Oh, I'm sorry.

THE ARBITRATOR: That's all right.

Q. (BY MR. PANTER) Does it, daily? Is there a daily assessment of her peripheral pulses?

MR. MARTIN: Scope.

THE ARBITRATOR: It's scope.

Q. (BY MR. PANTER) Let me ask you this. Would you agree that a systemic inspection of her skin can identify impending problems early?

A. Yes.

MR. MARTIN: Objection.

THE ARBITRATOR: Wait a minute.

MR. MARTIN: Overly broad. Vague. There's no time line, and to the extent he's referencing St. Anne's nursing.

THE ARBITRATOR: Overruled.

Q. (BY MR. PANTER) Do you know if wound care was ordered by Dr. Montane on April 9th --

MR. MARTIN: Asked and answered.

Q. (BY MR. PANTER (Continuing) -- of her anterior leg.

A. I never asked that question.

THE ARBITRATOR: Let him answer.

MR. MULLEN: About an hour and a half ago.

Q. (BY MR. PANTER) Was wound care ordered by Dr. Montane?

A. I don't know for a fact, but I suspect it was.

THE ARBITRATOR: Yes, we did talk. I'm sorry.

MR. PANTER: If we did and I asked it a second time, then I apologize to everyone in the room. I didn't remember that.

Q. (BY MR. PANTER) I want to talk to you a little bit, if I could, about the compartment syndrome that you mentioned, if that's okay with you.

A. Sure.

Q. Is there any mention in the medical record of the existence of compartment syndrome prior to the surgery performed by Dr. Montane on April 8th?

A. No.

Q. Would you agree that nerve injury is a possible result of a complex fracture?

A. Yes, sir.

Q. I want to ask you to look at a progress note by Dr. Montane. It's page 433 from the surgery on

4/7. And first of all, I want to talk to you about an issue.

Would you agree that an orthopedic surgeon as well as you is generally competent to diagnose and treat compartment syndrome?

A. Yes, sir.

Q. Would you agree that one of the ways to diagnose compartment syndrome is by physical exam?

A. Well, I agree that one way to diagnose a compartment syndrome is by physical exam.

Q. Yes.

A. I believe that that would not be as complete an examination as a physician would have to perform to make an accurate diagnosis.

Q. Okay. Well, I'm not -- my question was, is one of the -- let me rephrase the question.

Is one of the components in the diagnosis of compartment syndrome a physical exam?

A. Yes.

Q. And Dr. Montane had the ability to do a physical exam, and you did not, obviously?

A. Yes.

Q. By the way, you never requested a physical exam of Helen shaver; correct?

A. Meaning me?

Q. Yes, sir.
A. Ms. Shaver has never been my patient, so I have never requested a physical examination of Ms. Shaver.
Q. Do you know, if that was something you felt relevant, that the rules allowed that you just ask the lawyers, and she comes to your office, and you do a physical exam, and you're allowed that if you want?
MR. MARTIN: Objection. Relevance.
THE ARBITRATOR: Yes. Sustained. I don't understand what there would be to examine anyway.
Q. (BY MR. PANTER) Is skin tension one of the things -- one of the parameters that doctors look at with respect to diagnosing a compartment syndrome?
A. Yes, sir.
Q. I want you to look at Dr. Montane's orthopedic report the day before surgery, and we'll highlight what he noted with respect to skin tension. I want you to read that.
A. Normal skin tension.
Q. Is that the first time you've seen that particular specific note that I just had you read?
A. No. I read it before.
Q. And when you read it and you were evaluating the fact that you felt she had a compartment syndrome,

and that Dr. Montane was late to treat it, did you consider the fact that he examined her the day before and wrote no skin -- normal skin tension?

A. He writes above that, left knee swelling present that extends to midleg.

Q. Does he also write no skin tension?

A. He does write it, yes, sir.

Q. Does he write anything about possible compartment syndrome or anything of that nature?

A. No, he does not.

Q. So would it be -- would you reasonably expect that if he felt that compartment syndrome was a real and present risk to Helen Shaver at that time, that he would have put that in his orthopedic physician progress note?

A. Yes, sir.

Q. But he didn't do that; correct?

A. He did not do that.

Q. Would you agree that, assuming the finding of normal skin tension is accurate, that that's not consistent with compartment syndrome?

A. It is not a descriptive that I would use in making a diagnosis. I would talk about tension of the underlying compartments.

And usually you feel whether it's firm or

rigid.

I would never really describe skin tension as a component of compartment syndrome.

Q. That's the way he wrote it.

A. As far as it goes, I accept what he writes. But, again, if I were trying to describe a person with a compartment syndrome, I probably would use terms in terms of the muscle tension.

Q. Is there anything about muscle tension being a problem with this patient in his note?

A. No, he did not mention that word.

THE ARBITRATOR: Do you have any opinion as to whether or not there was, in fact, a compartment syndrome?

THE WITNESS: Absolutely, he did, because when he did the operation -- as I described, when he opened the fascia, the muscle just burst out. And it doesn't do that. It's kind of like opening up a lobster. When you open the thing up ---

Q. (BY MR. PANTER) So then Dr. Montane was negligent, is your testimony, in not getting to this compartment syndrome that you say existed on 4/7, earlier then?

A. All I can tell you is it existed at the time of his operation on the 8th, and it was probably there

at that point too, to some degree.

Q. Well, you said when I deposed you that she had a compartment syndrome that wasn't operated on soon enough by Dr. Montane?

A. Correct. I did say that.

Q. And now I'm looking at the orthopedic note that immediately precedes that day, and by his physical exam there's nothing about compartment syndrome, nothing about that; correct?

A. That's correct.

Q. So you're saying that you don't agree with the fact that the compartment syndrome from the traumatic injury may have occurred sometime after this orthopedic exam and the time he actually did the surgery, you think it existed earlier?

A. I do think it probably existed from the time of her injury.

Q. Okay. That's where we getting at. So your opinion is inconsistent with Dr. Montane's physical findings on exam? That's all I'm getting at.

A. Yes, sir.

Q. Okay. Fair enough.

Now, I want to also look at the medical record of Dr. Montane, who performed the surgery on April 8th.

Okay. Now, I think you and I would agree that there is a mention of the existence of compartment syndrome after the surgery was performed; correct?

A. That's correct.

Q. And would you agree that the operative record from Dr. Montane is the very first mention of compartment syndrome in this record?

A. Yes, sir.

Q. And not only would you agree with that, but all of the exams don't reflect anything that there was compartment syndrome for this woman before the surgery. There's nothing there.

But you have come to the opinion, and that's what you're here for, that you've come to the opinion that compartment syndrome was a problem from the time she broke her leg; is that correct?

A. That is correct. And I can't really speak to the totality of the records, because I don't remember them all, but I can tell you that probably the fact that the situation, the pathology was getting worse over the period of time of April 5th and April 8th, that the clinicians who were examining her probably did not consider that as one of the differential diagnoses.

Q. So they were negligent in -- because doctors must consider all differentials diagnoses, especially compartment syndrome is a serious thing?

A. It is. But what you're saying is doctors must consider. That's a rather sweeping statement.

Q. You're saying ---

MR. MULLEN: Let him finish, please.

THE ARBITRATOR: Yes, finish.

THE WITNESS: It is a rather sweeping statement.

I think it was probably fairly low down on their -- maybe the second or third rung on their diagnostic differential.

The point is that it is very difficult to make that diagnosis when somebody has a fracture because of the muscle trauma, because of the hematoma. The leg has a tendency to swell, and it's very difficult to differentiate between just the swelling and the hematoma from the fracture than it is to differentiate that from actual compartment syndrome.

THE ARBITRATOR: Let me ask a question. I'm trying to get to the bottom line here. If hypothetically the doctors from the get-go failed to diagnose a compartment syndrome, had they done that properly, assuming they did something wrong, would

that have in any way prevented the amputation of the leg?

THE WITNESS: It may have.

THE ARBITRATOR: It may have. Okay.

Q. (BY MR. PANTER) But it's your theory that she had this compartment syndrome at the time she fractured her leg, and it's your theory that the doctors, that was not in their differential diagnosis, and it's your theory that they missed it, and the records are to the contrary; correct? All that?

A. No, it's not correct.

Q. The records that say no muscle -- or no skin tenseness, you had already testified to, that that's to the contrary of a compartment syndrome finding?

A. I'm learning. The reality is when you say the records, the skin tension, correct, does not indicate presence of a compartment syndrome. The operative record most certainly does.

Q. I'm going to get to the operative record now. I want to ask you about the operative record, and it's perfect timing.

The operative record, there is no dispute that the muscle bulged out and she had a compartment syndrome, and a fasciotomy was done to relieve that; correct?

A. Correct.

Q. I think our dispute is when it became -- when she had a compartment syndrome, when it actually occurred; correct?

A. Correct.

Q. And you would agree that you can have a trauma and have a compartment syndrome sometime later, it doesn't have to occur at the same exact moment that you have your injury; correct?

A. It is -- well, the way to answer your question force me to say that it does not have to happen -- you ask very general questions or very sweeping questions that are hypothetical, and I will answer your question hypothetically, yes, that can happen.

Q. Let me ask this. Did Dr. Montane's operative report note the presence of any necrotic muscle?

A. I believe it did.

Q. Let's look at the operative report. Any part. He has to see the whole thing. I want to be fair to the doctor.

THE ARBITRATOR: While he's reading, gentlemen, do you have any other witnesses?

MR. MARTIN: No.

MR. PANTER: Here's my problem, only those two -- off the record for a moment.

(Discussion held off the record.)

THE ARBITRATOR: Back on the record.

Q. (BY MR. PANTER) Have you reviewed the operative report that we were talking about with Dr. Montane?

A. Yes, I did. And there was no mention of necrotic muscles.

Q. Okay. Now, I would also like you to look at Dr. Montane's postop report on page 350, sir.

Have you reviewed that report?

A. Yes, I have.

Q. Do you remember it?

A. Do I remember it?

Q. Yes.

A. No, sir.

Q. You came here today. I don't know how much you remember or don't remember. I'm not being disrespectful at all. I just want to know if you remembered it or not.

A. I think memorizing the entire 6,000 pages is -- probably supersedes the responsibility of an expert witness.

Q. That's why I put it up on the screen for

you.

THE ARBITRATOR: Guys, let's not -- all right.

Q. (BY MR. PANTER) What does the doctor who operated on this patient, Helen Shaver, put in his postop note with respect to compartment syndrome?

A. No evidence of compartment syndrome. I can't -- can you blow it up?

No evidence of compartment syndrome.

Q. And your testimony is you disagree with that, that not only did the compartment syndrome begin at the time of the fracture but it continued and progressed for some period of time?

A. Absolutely. And this note was after the revascularization.

Q. This is after the fasciotomy surgery where he relieved the compartment syndrome and notes the day after that -- not the day after, the afternoon afterwards, he says no evidence of compartment syndrome.

And you, as the witness for the defense in this case, disagree with that statement and say Dr. Montane's note is incorrect, that this woman, Helen Shaver, had a continuing progressive compartment syndrome along with other problems; correct?

A. Let me be as strong as possible. I disagree categorically.

Q. That's fine. I'll move on.

And you would agree that Dr. Montane was the one at that time who had the ability to evaluate, palpate, do a physical exam of Helen Shaver; correct?

A. I do agree that he had all of those abilities.

Q. And I also want you to look at the following day, the orthopedic consultation on page 353.

Do you remember that or not?

A. Go ahead. I may.

Q. We have already established that a lack of tenseness is -- how do I say it -- antithetical? Is that the proper -- antithetical to compartment syndrome?

A. Not consistent with, or inconsistent.

Q. And in this note, Dr. Montane, the orthopedic surgeon who did the fasciotomy, who has been attending to Helen every day at the hospital, writes what about the tenseness of her leg?

A. Not tense.

Q. Okay. Now, let's go to the next day, if we could.

The next day where Dr. Montane examined her

again, April 10, did read that note in preparation of testimony, or not?

A. I did.

Q. And when you read this note, knowing that it was antithetical to your opinions, you were still ready to give the opinion to the arbitrator that Helen had a continuing compartment syndrome; correct?

A. That's correct.

Q. And just so we're very clear, the orthopedic note two days after surgery, said what about the tenseness or lack thereof of Helen Shaver's left extremity?

A. Leg swollen, not tense.

Q. All right. And then I would like to continue, if we could, the next note that we could find was April 12th.

THE ARBITRATOR: I think you proved your point, to me anyway.

MR. PANTER: Okay. Then I'll go on to another issue.

THE ARBITRATOR: Okay.

Q. (BY MR. PANTER) I would like to address, if I have your permission, Doctor, to address the issue of myonecrosis.

A. Very good.

Q. And I would like to focus on Dr. Montane's operative report of May 6th. This is when he's doing the debridement at Baptist after Helen left the facility, St. Anne's.

Are you familiar with that?

A. Yes, I am.

Q. And the preoperative diagnosis was what, sir?

A. Decubitus ulcer.

Q. And I'm not sure. Do you actually agree that she had a decubitus ulcer, or not? I wasn't sure of your previous testimony.

A. I believe that she had skin injuries that is consistent with epidermal death.

THE ARBITRATOR: What does that mean? Is it or isn't it a decubitus ulcer? That was his question.

Q. (BY MR. PANTER) Yes.

A. There's a term "decubitus," which is used by the medical profession to describe skin abnormalities. So insofar as that generalized term is used, I would agree that it is a decubitus.

Q. Would you agree that the procedure is to debride the skin, subcutaneous tissue and muscle on her left leg?

A. Would I agree -- what was the question?

Q. That they were debriding her skin, which was in the subcutaneous tissue in the muscle on her left leg.

A. What day was that, sir?

Q. This is the surgical debridement that Helen went through a May 6, 2010.

A. Okay. The question is, do I agree that they did it, or what?

Q. That they were debriding her skin, subcutaneous tissue and muscle on her left leg.

A. I agree that she had it done.

Q. Okay. Does Dr. Montane's note describe that he first debrided the skin that contained necrotic tissue?

A. Yes, sir.

Q. And necrotic tissue is dead tissue; correct?

A. Necrosis means cellular death, yes, sir.

Q. And you agree that there was an area of that necrosis that extended all the way through the subcutaneous tissue?

A. I do.

Q. And is it fair to say, according to this note, the area of necrosis extended from the skin through the subcutaneous tissue?

A. That's correct.

Q. And would you agree this note also notes minimal muscle necrosis?

A. It does say that.

Q. And does the note indicate the muscles themselves look red and there was normal bleeding?

A. The note says that.

Q. Do you agree with that finding or do you disagree with that finding?

A. I have to accept what Dr. Montane wrote in his note.

Q. So in this instance you accept what he wrote in this note, but in the other instances you don't accept what he wrote in his note?

A. Yes. That's exactly correct.

Q. Okay. Did you read Dr. -- I don't know how to pronounce it, and we talked about this, neither of us could pronounce it, Dr. McKenzie, who is another orthopedic surgeon who did another debridement surgery.

A. Okay.

Q. Vascular surgeon. I'm sorry. Thank you. Plastic surgeon. Thank you.

Did you read that report? That was May 10th?

A. Yes, I did.

Q. Okay. And did Dr. McKenzie mention any necrotic muscle at all?

A. No, he did not.

Q. Now, if on May 10th, during the debridement procedure, the surgeon made no mention of myonecrosis, is it reasonable to assume that the extensive myonecrosis developed between May 10th and July 29th?

A. Could you repeat the question, please.

Q. Yes. This doctor mentioned no myonecrosis.

A. Right.

Q. So, therefore, is it reasonable to assume that the myonecrosis developed between May 10th and July 29th, which was the date of the amputation?

A. Probably it was in the course of becoming increasingly necrotic, yes, sir.

And he also described it in his note that there was minimal bleeding, I believe --

Q. Okay. And ---

A. (Continuing) -- which is consistent with my theory.

Q. And does he also suggest the possibility that the lower leg wound with the large eschar wound was caused by Coumadin toxicity, because the INR was quite high?

A. He did.

Q. He did that; correct?
A. Could you show it to me, please?
Q. You want me to show it to you?
A. Yes.
Q. Okay. It's on the front page about four lines down from the indications.
MR. SAMPEDRO: I highlighted it for you, Doctor. I'll blow it up.
THE WITNESS: Soon after she was also found to be on Coumadin, toxic, and possibly lower leg wound with large eschar wound was caused by Coumadin toxicity, because her INR was quite high at the time, also. She also developed an ecchymosis -- is that right -- occlusion of her left popliteal artery.
Q. (BY MR. PANTER) That's what I want to ask you. Now ---
A. I would like to explain that a little bit.
Q. That's fine. Keep reading if you want.
THE ARBITRATOR: You want to explain?
THE WITNESS: Yes. It's inaccurate.
MR. PANTER: It's what?
THE ARBITRATOR: He said, "It's inaccurate."
Q. (BY MR. PANTER) So that's inaccurate again. So once again now you have Dr. Montane who is inaccurate; correct?

A. Right.
Q. The nurses, who are the nurses at Baptist are inaccurate; correct?
A. Yes, sir.
Q. The nurses at St. Anne's, who are inaccurate; correct?
A. That's correct.
Q. A lot of multiple vascular surgical consults who are inaccurate?
A. No, I didn't say anything about the vascular surgeons.
Q. All right. So let's move on. Dr. McKenzie, a plastic surgeon, who is inaccurate? You just said that.
A. Well, this note is inaccurate.
THE ARBITRATOR: In what way?
THE WITNESS: Coumadin toxicity refers to bleeding. She had an eschar. It was not because of Coumadin toxicity.
No. 2, he also predicates the fact that she developed an occlusion of the left popliteal artery, seemingly as a result of Coumadin.
Coumadin kept the artery open. So that note contains inaccurate information.
Q. Let me ask you this. Hematomas come from

Coumadin toxicity; right?

A. Yes.

Q. And she had a hematoma when she left St. Anne's, and she arrived at the emergency room at Baptist, hematoma right at the scar where the staples were?

A. That wasn't a hematoma. That was necrosis of the skin. That was not secondary to hematoma.

Q. She didn't have a hematoma as well?

A. No, sir. I didn't see one mention of hematoma anywhere in the record.

Q. Give us a second. We'll get it.

A. Okay.

Q. I want to show the infectious disease consultation when Helen arrived at Baptist Hospital. Maybe this will refresh your recollection and I'm going to show it to you, but it says that presenting -- and I highlighted it and I will highlight it so I can show it to you -- presenting with left wound infection, and there was significant hematoma in the area.

And I will show this to you and see if that refreshes your recollection with respect to the previous testimony you just provided.

I highlighted it for you. And there's the

front page. You can see where it came from. It's infectious disease.

A. This is on 4/8?

Q. No,sir. Read the note. It's 4/23.

A. 4/23.

THE ARBITRATOR: That's when she went to Baptist?

MR. PANTER: Yes, sir.

THE WITNESS: In my humble opinion, I think he should have used the word "ecchymosis." It would have been more accurate, because the hematoma is a collection of blood underneath a covering, like underneath skin or underneath fascia.

And there's no possible way in looking at the outside of the leg could he have been able to make that determination.

Q. (BY MR. PANTER) Okay. So this is just one more doctor that's wrong? This is now the infectious disease doctor at Baptist Hospital is incorrect in his charting that Helen had a hematoma, that you've already agreed, can come from Coumadin toxicity; correct?

A. He doesn't say where the hematoma is. If he's just looking at a leg, you can't see a hematoma looking at a leg.

Q. It says on 4/8/2010, now presenting with left wound infection, there is a significant hematoma in the area.

So do you think that hematoma is somewhere else in her body?

A. I have no idea. Unfortunately, he doesn't really specify where it is. And I think that would make a lot more sense if he used the word "ecchymosis".

Q. Okay.

A. We looked at the pictures, and the pictures were more consistent with ecchymotic changes than a hematoma.

Q. Okay. Do you think that the ability of this infectious disease doctor to see it live, in person, puts him in a little bit of a better position than you, to determine if it is a hematoma or ecchymosis?

A. I would say obviously being there, that would be much better -- he should have much greater accuracy.

But when you try to put the whole thing together and try to interpret what he says, it kind of doesn't make sense.

I don't think there was any indication he was trying to mislead, but looking at it, to me it

doesn't make any sense.

Q. There's another doctor ---

THE ARBITRATOR: You've already said that.

MR. PANTER: I did. I apologize. I'm sorry.

Q. (BY MR. PANTER) Okay. I have a lot of questions on Coumadin toxicity, but I'm going to make it narrow and ask you, there's no question in your mind that Coumadin -- that Helen came to Baptist Hospital with Coumadin toxicity, that is a fact; correct?

A. We use the description of Coumadin toxicity meaning having an elevated PT/INR.

A reality of Coumadin toxicity means that you have a complication as a result of it, but -- so I will except what you're saying as being Coumadin toxic, because that is the vernacular that we currently employ.

Q. Is it a potential complication of Coumadin toxicity to develop hematomas?

A. In the general sense, that is correct.

Q. Okay. Do you remember if Dr. McKenzie, who is the doctor that we just reviewed, the plastic surgeon who did the second debridement, documented possible left lower leg wound with large eschar wound

caused by Coumadin toxicity?

A. That was his opinion, yes, sir.

Q. Well, do you disagree with that opinion as well?

A. Caused by Coumadin toxicity?

Q. Yes.

A. I would disagree with that.

Q. So another aspect of Dr. McKenzie's analysis, diagnosis is incorrect according to you?

A. I would disagree with that. It's his opinion.

Q. Let me ask you this. You would agree that the decubitus ulcer was a contributing cause to Helen's losing her -- having to have her leg amputated; correct?

A. In a very minor way.

Q. Well, you testified -- let me read part of your testimony, then. Give me a second, please. I'll get to it.

A. While he's doing that, could I ask a question?

Q. Not really, unless it's to go to the bathroom.

A. I can wait.

THE ARBITRATOR: You need the men's room?

THE WITNESS: I will wait till after 4 o'clock.

MR. PANTER: If you have to go to the restroom, I understand that, you can go anytime you want.

THE WITNESS: I'm a big boy. Thank you.

MR. PANTER: I'm not. He knows ---

MR. MARTIN: Let's get through this.

Q. (BY MR. PANTER) Would you agree -- when I ask you this question, would you agree that -- I'm sorry. It's on page 87.

Would you agree that even in the case of the development -- wait. Sorry. I apologize. Yes.

The question was this, would you agree that even in this case, this case, Helen Shaver's case, the development of the decubitus ulcer was a contributor, was a contributor to her ultimate loss of her leg? Do you remember giving the answer, "I think that was the catalyst"?

A. Yes.

Q. Now, let me read on further. When we say catalyst, that would be, to me, a contributor; is that correct?

A. That is correct.

Q. And I looked up -- I took some time to look

up the word "catalyst," and I used Webster, and I want to -- this is a definition I have, and I want your opinion on this.

A catalyst ---

MR. MARTIN: Objection. Can't you ask him what he meant instead of reading Webster's definition?

THE ARBITRATOR: Yes. I don't understand.

Q. (BY MR. PANTER) I don't have to mention it. I'll ask you this question.

THE ARBITRATOR: I know we all know what the word "catalyst" means.

Q. (BY MR. PANTER) Would you agree that catalyst means an agent that provokes or speeds significant change or action?

A. That's correct.

Q. Would you agree that the loss of her leg, the deterioration of her leg was significant action?

MR. MARTIN: Object.

THE WITNESS: Would I agree that the loss of leg was significant action? It doesn't make any sense, does it?

THE ARBITRATOR: You're the witness.

MR. PANTER: Okay.

THE WITNESS: It doesn't make any sense to me.

Q. (BY MR. PANTER) Nevertheless, you have testified under oath that it was -- the decubitus ulcer was a contributing cause to the loss of Helen's leg and a catalyst?

A. I made those two -- I made those two statements, yes.

THE ARBITRATOR: Then how does that comport with your opinion that her ulcer had nothing to do with the loss of the leg?

THE WITNESS: Yes, sir. The catalyst was meant in a sense that it brought about the early recognition of something that was going on with the leg, and she was transferred back to Baptist Hospital so, if anything, it sped up her getting to keep the treatment that she needed.

And, No. 2, the actual, quote, unquote, decubitus that she sustained played a very, very, very minor role in the ultimate loss of the leg.

And I would like to point out again that Dr. Salinger also agreed if she did not have any arterial inefficiency, she would not be an amputee right now.

Q. (BY MR. PANTER) You just told our arbitrator that it sped up the process, the decubitus ulcer; correct?

Is that ---

MR. MARTIN: Objection. Misstates his testimony.

THE WITNESS: I'll say yes.

MR. PANTER: Okay. And I will end my cross-examination at this time.

THE ARBITRATOR: Thank you.

Mr. Martin.