Chapter 3 – A 15-year-old girl with a headache

Table of contents:

The story behind the story (how we got this case… and other interesting tidbits):

Bill Bonezzi is a stand-up gentleman who knows his law. I contacted him sometime over the summer (last summer - 2010) - I remember speaking with him while walking around the driveway barefoot, hoping my 2 year old (at the time) would keep playing in the sandbox until I finished the call!

He told me about a good case but I initially thought it was too esoteric; what would be the teaching value? Then he threw in the kicker - the patient actually presented on 9/11. The irony was too good to pass up. I would look at the case and if interesting, it would be a colorful and engaging addition.

We met in Columbus, as he was coming for a meeting. For each case I had some apprehension as I needed the ED chart primarily, and if that was not available, or wasn't able to be found, I couldn't use the case. Well, Bill was in a meeting and stepped into the hallway to give me a armful of papers. He explained about the case and his defense and even agreed to an interview (the real story-behind-the-story) which is included in the chapter. He then ducked back into his meeting and I hustled, like a squirrel with a nut, to my car to check out the goods.

Well 'goods' they were! The case has more risk management/patient safety issues than any in the book (seven) and the funny thing is that I have seen this patient and handled the situation identically, or at least I think I have. A hysterical 15 year old with some supratentorial issues, pressure from the nurses to discharge, a busy day, poor correlation between the nurse and doctor - I *think* I have treated similar patients identically - or have I...

A few final colorful points about the characters' names:

Peggy (the patient) - named after an old friend I met at a festival and corresponded with for years then lost touch. A kind and giving person. She loved primary care and hated specialists. The patient's last name is from a girl who mowed the grass outside a courthouse my friend Steve worked at - he never met her but called her 'Rainy Eyes' because she looked so sad. It later became a song (not a great one...). Peggy's case is so tragic, when writing the chapter, I pictured her with 'rainy eyes'...

Kelly - one of my oldest friends from Kindergarten - we took a road trip to Maine once. When I hooked up with her in Boston, she was dating a Warlock

Bruce - my resident during the medical school OB rotation - a good guy who taught me a bunch

Harry Manning - the pathologist - my uncle - was a radiologist - now 93 in an ECF

Defense ED expert witness - last name is from my good friend Geoff - med school, backpacking, and poker buddy. He is a neurologist - check out October 2011 EM RAP bouncebacks - super smart guy!

WILLIAM J. BIGGS. M.D., (plaintiff ED expert) BEING BY ME FIRST AFFIRMED TO SPEAK THE TRUTH, DEPOSES AND SAYS: ON EXAMINATION CONDUCTED BY MR. LOUIS LATIFF (plaintiff attorney):

Q. You are a medical doctor. Is that correct?
A. Yes.
Q. Do you specialize in any particular field of medicine?
A. Yes.
Q. And what field of medicine?
A. My primary practice is emergency medicine. I also have training and practice medical toxicology, which is a subspecialty of emergency medicine. In addition, I have training and Board certification in intemal medicine end allergy and immunology.
Q. Generally speaking, Doctor. What is emergency medicine?
A. It's the medical practice of dealing with emergency and life-threatening situations.
Q. Where did you attend medical school?
A. University of Miami.
Q. Where did you complete your residency?
A. Rochester, New York.
Q. Can you tell us a bit about your residency training, what it entailed?
A. I began my residency in 1979. It was an internal medicine residency, but at that time, emergency medicine didn't exist as a specialty and we staffed the emergency department and had extensive training in emergency medicine.
Q. Have you been practicing medicine since 1979?
A. Since 1980.
Q. And are you fellowship-trained?
A. Yes.
Q. In what area?
A. Medical toxicology, which is the subspecialty of emergency medicine, for treating poisonings; also fellowship-trained in allergy and immunology at the National Institutes of Health in Bethesda? Maryland.
Q. You mentioned that you're Board Certified in emergency medicine. What is the significance of being Board-certified?
A. That means that I've met the rigorous requirements of having a high level of expertise in emergency medicine. It's manifested by training, practice and passing a rigorous Board certification examination.
Q. You also mentioned that you're Board certified in medical toxicology, is that correct?
A. Yes.
Q. Do those areas of certification coincide with one another?
A. No, but there's some overlap between them.
Q. Now where do you currently practice medicine?

A Pitt County Memorial Hospital, which Is a level One trauma center and tertiary care center and we see about 90,000 emergency department visits a year.
Q. Do you practice in the clinical practice for more than 75 percent or your practice?
A. I would say approximately 75 percent of my time is practice and the other 25 teaching, administration and research.
Q. You mentioned teaching. Do you have any current teaching duties?
A. Yes.
Q. Where do you teach?
A. I would say 80 to 90 percent of my teaching is supervising residents and medical students in the emergency department because I do work at a teaching hospital. In addition to that, I give continuing medical education lectures and research lectures in this country and other countries. I teach medical students in the earliest stages of their training with didactic lectures and give lectures for residents and continuing medical education lectures for physicians.
Q. What do you mean by "didactic lectures"?
A Where I am teaching material, rather than teaching at the bedside.
Q. In front of you there's a notebook with some tabs. Could you turn to Tab 25:
A Yes.
Q. What Is that?
A. This Is my Resume, or my Curriculum Vitae.
Q. Does that Resume list, among others, your work history and your memberships in certain professional societies and Board certifications?
A Yes, it does.
Q. Have you also been referenced in medical Journals or periodicals?
A Yes.
Q. Could you estimate for the Jury about how many times you've been referenced, your work has been referenced?
A. I've published more than 50 primary refereed medical research articles, and in terms of other types of referencing, I would say another 50 approximately.
Q. Do you teach medical students, residents and interns?
A. Yes.
Q. And when you're teaching medical students, residents and interns, do you also provide them with any instruction or direction relative to how to care for, treat, examine or analyze a patient who presents into an emergency room complaining of severe head pain?
A. Yes.
Q. Have you testified before as an expert in any medical malpractice cases?
A Yes
Q. What percentage of your time do you testify on behalf of the patients complaining or alleging medical malpractice versus your testimony on behalf of a physician who would be defending against that type of a claim?
A. In the few cases that I've testified. I would say about two thirds were in favor of the physician and about one-third in favor of the patient.
A. Yes.
Q. Could you explain to the jury what is peer review?
A. Peer review is when my colleagues and I review each others work, particularily when there's a untoward event or bad outcome
Q. And how often does that process take place?
A. It's ongoing.
Q. Do you evaluate the conduct or the work of other physicians during this process?
A. Yes,
Q. Is it fair to say that you've participated in hundreds of these peer review processes over the course of your career?
A. Yes.
Q. Are you the reviewer or the person being reviewed?
A. Both.
Q. Now each time that you've testified in cases now back to medical malpractice cases - have you been compensated?
A. Yes.
Q. And have you been compensated in this case for your time?
A. Yes.

a. Does your fee apply, regardless of which direction your opinions turn out?
A. Yes.
Q. You mentioned you've practices for 28 years?
A. That's correct
Q. Now as part of your medical school education, residency training and your private practice, have you become familiar with the symptoms associated will complications arising from brain aneurysms?
A Yes.
Q. And, Doctor, did you examine Peggy Rainy's medical record?
A. Yes.
Q. Did I also ask you to evaluate whether or not any tests on September 11, 2001 could have made the diagnosis?
A. Yes.
Q. Did the analysis extend beyond the knowledge or experience possessed by laypersons?
A Yes.
Q. In formulating your opinion, did you base your analysts on reliable scientific, technical or other information?
A Yes.
Q. Are you prepared today to tell the jury about your conclusion & and opinions to a reasonable degree of medical certainty?
A Yes.
Q. And are all the medical opinions that you intend to give today related to matters beyond the knowledge or experience possessed by laypersons?
A Yes.
Q. Doctor, what is an aneurysm?
A . An aneurysm is like a balloon on an artery. Think of a rubber tire that has a weak spot, and you blow it up and at the weak spot a balloon forms - that's at risk to pop, And that's exactly what an aneurysm is. It's a weak spot on an artery, a high pressure blood vessel in the body, where a balloon has formed and the wall is thinned out and it's at risk to pop or rupture.
Q. When you say a "rupture" what do you mean?
A. If you blew up a tire and you blew it up so big that balloon bursts, it would be a rupture of the balloon. The same thing can happen to an artery. It can pop or burst
Q. Can an aneurysm be deadly?
A. Yes.
Q. Doctor. are you familiar with sentinel bleeds?
A. Yes.
Q. What is a sentinel bleed?
A. When people have an aneurysm, they can have a burst where some blood leaks out and then a clot forms so that there's not a major hemorrhage, but it causes symptoms of headache and neck pain and other symptoms can occur. And that's called a sentinel bleed. By sentinel, it's an event that is a forewarning of something bad to come.
Q. Doctor. is the subject matter of aneurysms and sentinel bleeds, including diagnosing those symptoms and treating them, captured within the field of emergency medicine?
A. Yes.
Q. Doctor, in your career how often do you see a patient where an aneurysm is a concern for what's called a differential diagnosis?
A. Oh, more than once a month.
Q. What is a differential diagnosis?
A. A differential diagnosis is a mandatory part of every evaluation that a physician makes of a patient's complaint. It is not the diagnosis, but it's all the possible thing that could lead to that complaint. For example. if a person complains of chest pains, it could be a heart attack, it could be a muscle spasm In the chest. it could be heartbum. And, so. that listing of all the things that could lead to the complaint are called the differential diagnosis. And that's a vJta1 part of every physician-patient encounter.
Q. Doctor, the law requires that you give an opinion or a conclusion to a reasonable degree of certainty. Are all the opinions or conclusions that you intend to provide today given to a reasonable degree of medical certainty?
A. Yes.
Q. Now if you can answer a question to a reasonable degree of medical certainty please let me know. Doctor, in your opinion, what was the cause of the symptoms that ultimately prompted Peggy Rainy's presentation to the ED on September 11, 20011?
A. I believe she had an aneurysm in a artery to her brain

Q. Doctor, in your opinion to a reasonable degree of certainty, did the care provided by Dr. Hanninger in the emergency room physician on September 11, 2001 meet the applicable standard of care for emergency room physicians?
A. No.
Q. In your opinion, Doctor, had the bleed been diagnosed on September 11th 2001, could neurosurgical or neurological Intervention have saved her life?
MR. BONEZZI: Objection; move to strike.
A. Yes.
Q. In your opinion, Doctor, what specific neurosurgical or neurological intervention could have been undertaken to fix the leak?
MR. BONEZZI: Objection.
A. As an emergency physician. I would have immediately referred her after making the diagnosis, to either a neurosurgeon or an interventional radiologist. Think of that big balloon on the tire. One thing would be to tie something around the base.

[pages omitted]

Q. Is the history taken adequate for an emergency room physician?
A. No.
Q. Why not?
A. First, the history of the present illness is totally inadequate. It does not meet the standards that one needs to do when you do for someone who presents with a headache. The review of systems is inadequate and inconsistent with other data. The physical exam records the blood pressure one time, and it's a crisis blood pressure. This is never addressed or repeated. One big deficiency is this record does not record a differential diagnosis, which is… which is a major feature of every encounter. And the discharge condition isn't given. There's no re-evaluation. There's nothing about response to treatment. It's an inadequate record.
Q. What is the nature of the history of present illness that you have cause for concern for?
A. The standard for history of present illness that every medical student is taught early in their training is that there are seven items that have to be addressed, and these items aren't addressed, and if they had been addressed, I think the outcome would be different. These items are the location of the pain. That is addressed. The character, throbbing. That is addressed. The onset and the time course. Is it sudden onset? That's a major thing that isn't addressed. The mitigating factors or precipitating factors, we know from the run sheet that this was precipitated by coughing, and that isn't addressed [by the doctor]. So, you know, by not addressing these important elements, the consideration of the cause of her headache was not there.
Q. Now note that on the history portion there is a statement that says "started after a coughing spell"
A. Okay. I'm sorry. So that was addressed. I'm sorry-
Q. You also mentioned the lack of a differential diagnosis in the chart,
A. Yes
MR. BONEZZI: Objection.
Q. Why is charting a differential diagnosis important?
MR. BONEZZI: Objection
A. It's generally considered a --the standard methodology of a physician to arrive at a diagnosis. You gather data and then you formulate a differential diagnosis and then you eliminate those diagnoses that you can from the data. That's the way we're taught it, you know, early on in medical school. You have a chief complaint: you take your history of the present illness and the other aspects of the history, the review of systems, past medical history, social history and family history; you perform a physical examination; you formulate a differential diagnosis; and that leads you to further testing and examination to arrive at the correct diagnosis. That's the way we do things.
Q. Now there's a blood pressure noted on the chart?
A. Yes.
Q. And what is it?
A. 174 over 94.
Q. Is there any aspect of Dr. Hanninger's chart that addresses the blood pressure or its cause?
A. I did not see that in the record.
Q. Is that problematic?
MR. BONEZZI: Objection.
A. Yes.

Q. Why?
A. As I've said, we have three recordings of blood pressure. That alone is problematic because another set of vital signs should have been taken before discharge. That's the standard of care. But all the values are very abnormally high for a 15-year-old, and this is an abnormality that should be addressed. And the standard of care is to rule out end organ damage from the high blood pressure. And this wasn't done.
MR. BONEZZI: Objection; move to strike.
Q. Is there any mention of any stiff neck or neck pain?
A. Yes. Under examination. It says neck supple. No tendemess.
Q.. In your opinion, is that adequate charting in respect to the neck pain?
MR. BONEZZI: Objection.
A. Yes. And I could comment that the stiff neck that develops from a subarachnoid hemorrhage is generally delayed.
Q. Is charting the chief complaint significant?
A. Yes
Q, Is there anything noting that Peggy complained of stiff neck as a chief complaint?
A. No
Q. Is noting the condition on discharge relevant to charting in your evaluation?
MR. BONEZZI: Objection
A Yes.
Q. Why is that?
MR. BONEZZI: Objection; move to strike.
A. In emergency departments it's very important to do a summary assessment of what occurred, what was considered, why one came to the conclusion one came to, What the response of treatment was, how did abnormal vital signs change, I mean, this is the standard.
Q. And, Doctor. Do you suppose that if a patient denies that the headache that the patient is complaining of is the worst headache of her life, does that fact in and of itself relieve the emergency room physician from further inquiry into the cause of the headache?
A. NO, it does not. As we said, there are seven elements, and severity of pain is just one of those seven elements.
Q. What should the ER physician do?
MR. BONEZZI: Objection to the form of the question.
A. An emergency physician evaluating a patient with a headache has thefolowing responsibilities. People who come into and ER with a headache fall into 2 categories. One Is the headache can be a manifestation of a serious life-threatenlng condition, Things like meningitis, aneurysm rupture, encephalitis. a viral infection of the brain tissue, intracerebral hemorrhage, a subdural hematoma, a brain tumor. There are some dangerous life-threatening causes that lead a person to come to an emergency department complaining of a headache. The other category of patients are patients who have non-fife threatening. causes. things like a migraine headache, a tension headache, a sinus headache, even though these can have complications that can be life-threatening. and it's the duty of the emergency physician to consider all of those causes in the two categories and to ask the questions and formulate a history that allows one to know; "This is a headache that we can give a pain pill to and make the person more comfortable" or "This is a headache that we can.." that we need to do further testing and evaluate," And the types of questions that one has to consider that are were documented to have been here In the rest of the record are not addressed in the doctor's record.
Q. Doctor, if you give a patient a pain reliever and the patient thereafter feels better, does that mean that the headache was not caused by something more serious?
A. Absolutely not. I've had patients who I've sent to the CT scanner because of the character of their headache, who came back, and I gave them pain medicine before they went. They came back and they said, "My headache is totally gone, I can go home." And I said, ·Well. let me check your CT scan, and they've had a subarachnoid hemorrhage or some other serious condition, So all sorts of pains respond to pain medicine, including brain tumors and subarachnoid hemorrhages,
Q. Now, if Dr. Hanninger had gone through steps to make the diagnosis, what would he have done next?
A. He would have considered a subarachnoid hemorrhage or an intracerebral hemorrhage, given the blood - crisis blood pressure as possible causes of the headache, and she would have ordered a STAT CT scan of the head.
Q. Before we move forward on that line, doctor, you mentioned CT scans. What Is a CT scan?
A. CT stands for computerized tomography. And what this means, tomography means it's a series of slices of X-rays through the brain. and then the computer constructs a picture of the inside or the brain from the X-ray signals. So it's a type of Xray and the X-ray machine looks like a big donut and the patient's head slides through the donut

while the X*ray detectors and producers swirl around their head and the computer constructs a picture of the inside of the brain.
Q. Were CT scans available in 2001?
A. Yes
Q Should Dr. Hanninger have ordered a CT scan?
A. Yes.
Q. What would the CT scan have shown?
A. The CT scan has a 95 percent sensitivity to see a subarachnoid hemorrhage.
Q What if the CT scan hadn't shown it?
A. If the CT scan does not show a subarachnoid hemorrhage and it's a high-suspicion case, then the standard of care is to perform a lumbar puncture, which is sensitive to detect virtually 100% of subarachnoid hemorrhages.
Q. Is it your opinion, Doctor, that Dr. Hanninger's failure to order a CT scan for Peggy Rainey was beneath the standard of care?
A Yes.
Q. Is it also your opinion that Dr. Hanninger's failure to order a lumbar puncture fell beneath the standard of care?
A, Yes.
Q. Doctor. You are also aware that Peggy had apparently taken Primatene Mist for asthma?
A. Yes.
Q.. Now can taking Primatene Mist increase your blood pressure?
A. Yes.
Q. Can you explain to the jury how that might have been?
A, Well the Primatene Mist contains a drug that is delivered to the lungs and causes dilation of the breathing tubes. If it gets into the body, it can increase the heart rate, it can increase the blood pressure. It has been associated with strokes and hemorrhages in teenagers who have had a rapid surge in their blood pressure. It's really a drug that's not recommended.
Q. In your opinion, did the Primatene Mist in Peggy's instance cause her elevated blood pressure?
A. I don" know. It could have. It's a possibility. It's in the differential diagnosis of why she was hypertensive
Q In your practice, doctor, do you work with family physicians?
A, Yes.
Q~ Is there any difference in the standards of care relative to dealing with symptoms that Peggy presented with between emergency room physicians and family physicians?
A No.
Q. Are you familiar with the standards of care applicable to family physicians in dealing with patients complaining of head and/or neck pain brought on by a coughing spell?
A Yes. they're universal
Q. And when you say universal how did you become aware of those standards?
A They're taught In medical school to all physicians. They're on the licensing exams. It's something every physician has to know.
Q. Dr. Meggs, I also asked you to examine the records relative to the primary care physician's treatment?
A. Yes,
Q. And did you examine them?
A. Yes
Q. And if you could look at Exhibit [4) in the book In front or you, did you examine the records in Exhibit 14]1
A. Yes.
Q. Do you have an opinion to a reasonable degree of medical certainty as to whether his met the standard of care?
A. Yes,
Q. Would you please tell the Jury what your opinion is?
A. My opinion is it didn't meet the standard of care?
Q. Do you have an opinion to a reasonable degree of medical certainty as to whether his failure to meet the standard of care was a cause of Peggy's death?
A. Yes.
Q. What is your opinion?
A. That if an adequate history, review of systems, differential diagnosis and evaluation of her complaints had been undertaken, the tests would have been ordered which would have led to a proper diagnosis and a referral for treatment that would have greatly reduced the risk of her fatal subarachnoid hemorrhage.

Q. Doctor, let's discuss the basis of your opinions. Would you please explain to the Jury how in your opinion [the PCP] failed to meet the standard of care?
A. Well, In the history of the present illness, he is following up a visit from the chief complaint In the emergency department, and, you know, it just doesn't address all the issues; the fact that this headache came on suddenly; It was associated with coughing; that there was a headache as well as neck pain, it's just not an adequate history. The review of systems isn't there, you know. Things weren't addressed that should have been addressed. The circumstances of the onset of the illness. It's just not an adequate evaluation of this complaint.
Q. Well, if we could perhaps take all those issues individually, is it fair to say that on September 15th, when Peggy presented to the PCP, that her BP her blood pressure, was normal for a 15-year-old girl?
A. Yes.
Q. So there's no red flags you -by the way, you mentioned red flags during your direct examination. What did you mean by "red flags"?
A. It's like a slang expression that doctors use that's an element of the person's history or physical exam or test results that tell you something bad is going on.
Q. Now when you -the blood pressure at this point is not a red flag in your opinion correct?
A. Yes.
Q. Now you mentioned that there's no mention of the head or neck pain correct?
A .Yes.
Q. Now, in your opinion, would there need to be some mention of Peggy's head pain that she experienced on September 11th on September 15th?
A. Well, it's just not addressed at all. Did she have head pain that went away. Does she still have a headache? We don't know anything about the head pain from this record. It's not in the review of systems. Anybody with neck pain, of course, if you have head pain with it, it's an important component of forming a differential diagnosis.
Q. Now how would you chart for a review of systems as a family physician as opposed to as an emergency room physician?
A There's no difference.
Q. You would go through the same seven steps that you described earlier?
A. Yes.
Q. And you would chart-
A. Well, that's for the present illness, the seven steps. The review of systems is -doesn't have seven steps.
Q. Now there is a statement in [the PCP] chart indicating or recognizing that Peggy had gone to the emergency room four days earlier. Do you see that?
A. Yes.
Q. Do you have any opinions concerning the charting of Peggy's presentation to the ER?
A. It's not addressed. I mean, why did she go to the ER? I mean, this was a very unusual event for this patient to go to the ER. In reviewing her medical records, there are no other emergency visits for headache or neck pain.
Q. Now the fact that Peggy went to the emergency room four days prior by an ambulance, was that significant enough to be charted in your opinion?
A. Yes.
Q. Why is that?
A. Well, there's actually good data to show that people who, for a given complaint, go to an emergency department, that people who call an ambulance are much more likely to have something serious. So it really tilts you to think that this could be more serious than, you know, a headache that somebody calls and makes an appointment to see a doctor in a week.
Q. What should have asked her about her presentation to the emergency room four days prior?
A. Well, ideally he would want to know the whole story, "What happened at home?" 'Why did you call an ambulance?' or 'Why did your grandmother call an ambulance?' 'What were your symptoms at that time? Ideally, he would have the record from the emergency department. It's customary for hospitals who give a referral to a physician to send or fax of the record of the patient. It's a shame he didn't.
Q. If he didn't have those records available to him on September 15th, does thqt loer or maintain his standard of care?
A. I would have to say no. I mean, records get lost, the hospital doesn't send it. You know. I would say if you don't have the record, you know, you do the best you can. If there are red flags, you would need to call the hospital and get the record. But he didn't ask enough questions to know if there were red flags.
Q. Is it fair to say that If the PCP had asked about the head pain, he would have charted it - is that a fair statement?
A. No. I mean, I don' know the circumstances you know, did he chart it at the end of the day and forget something? I just don't know~

Q. Is it fair to say that if a patient had gone to the emergency room in an ambulance, that during her follow up visit should would likely tell the doctor her chief complaint for her ambulance trip?
A. I would think so,
Q. I have no further questions.

CROSS BY WILLIAM BONEZZI, DEFENSE ATTORNEY:
Q. Doctor, I represent Dr. Hanninger and her professional organization. I have some questions for you this afternoon, but before I get into that, I want to preface my remarks by telling you that if something I ask you does not make sense, would you be kind enough to let me know, kind enough to let me know and I'll do my best to rephrase it.
A Yes.
Q. Okay, Before I started. I made a note in regards to a comment tha1 you made about Primatene Mist. Now, Peggy Rainey was a diagnosed asthmatic, was she not?
A. Yes.
Q. And now she had been taking a medication for her asthma, wasn't she?
A. Yes.
Q. And as a matter affect, I believe that at the time of her death there was an inhaler that was in her purse, and that was the Primatene Mist that was found on or about October 8th of 2001, correct?
A. I'll look. Yes.
Q. Okay. Now are you aware of whether or not she took the Primatene Mist on 9/11/01, prior to the time that she went to the emergency room?
A. No.
Q. Okay. I would presume, and correct me if I'm wrong, that the facts that you obtained in this case would have been from going through the records and reading testimony that had been provided by other individuals such as Peggy's grandmother, you read that?
A. Yes.
Q. And you read the deposition testimony, presumably, of her mother, her father, her sisters, etc.?
A. No. I didn't.
Q. You did not?
A. ~ read those depositions.
Q. Okay; fair enough. Did you read the deposition of a Dr. P____
A. I don't remember if I did or not.
Q. Okay. Dr. P____, I'm not sure if he's going to be called in this case, but he is an emergency room physician out California. He is also Board-certified in emergency medicine. Board-certified in internal medicine and also in critical care. Does that ring a bell as it relates to whether or not you may have read his deposition?
A. I don't believe I did. I don't recall reading his deposition~
Q. Fair enough. Did you read the discovery deposition of the neurologist who has been retained on behalf of the plaintiffs, now living in Arizona.
A. No.
Q. Old you reed Dr. O-----'s deposition? He is also a board certified emergency physician and internal medicine. Did you read his deposition?
A. No.

Q. Did you review the testimony -- strike that. Did you review the Rural Metro record of 10/8/01?

A. I have that. It's -- and I have seen that, yes.

Q. Okay. And it would appear from that record that there was a conversation that had taken place with the grandmother as it relates to what was found at the scene and what information was available.

A. What tab is that?

Q. It's No. 2, sir. I'll show it to you. When we looked at Tab No. 2, we only looked at the first page, which would have been the Rural Metro ambulance run sheet of 9/11, and it's right here.

A. Yes, I have seen this record, yes.

Q. And did you take the information that is contained in this record into account when you formed your opinion?

A. Yes.

Q. Okay. And, presumably, when you read Exhibit [2], which is the Rural Metro ambulance run sheet of 9/11/01, you also took the information contained therein into account when you formed your opinions, correct?

A. Yes.

Q. Have you treated patients in the emergency room

that have been brought in by ambulance and have had benefit of a review of the ambulance run sheet prior to the time that you have treated the patient?

A. Is the question "Do I review ambulance run sheets?"

Q. No. When you've had a patient -- and maybe this was poorly phrased. But where you had patients who have come into your ER and they have been brought to your ER by ambulance, such as what happened in this particular case, and there has been a run sheet prepared, do you take into account the information that's contained in the run sheet when you're treating your patient?

A. Yes.

Q. And, again, presuming that the run sheet was available at the time?

A. Yes.

Q. Okay. Now the information that is provided in the run sheet is information that is provided by either the patient or a member of the patient's immediate family or the individuals that are there at the time the patient is picked up by ambulance, correct?

A. Yes.

Q. Now, pertinent findings are that when Rural Metro arrived on the scene, they found Peggy Rainey sitting on the couch, is that correct?

A. You're talking about --

Q. 9/11, sir.

A. 9/11. I was still on --

Q. My apologies. We'll get to the 10/8 in a moment.

A. Yes, they found her sitting on the couch.

Q. And it says "ABC intact," which means airway, breathing and circulation?

A. Yes.

Q. All right. And, so, "Patient had a sudden onset of neck and head pain this a.m. after coughing." You saw that?

A. Yes.

Q. However, it would appear as though questions were also directed to Cheryl Houser and/or her grandmother, and those questions elicited the following, and that is that Cheryl denied being dizzy at that time, correct?

A. Yes.

Q. She denied being nauseous?

A. Yes.

Q. She denied vomiting?

A. Yes.

Q. She denied numbness and tingling in her extremities?

A. That's correct.

Q. And she was able to move her neck. Did you see that?

A. Yes.

Q. Okay. Now when she got to the hospital, she was ultimately triaged by the triage nurse.

A. Yes.

Q. And you've already discussed some of the findings relative to triage findings, correct?

A. That's correct.

Q. And someone told the triage nurse Peggy had neck pain?

A. Yes.

Q. And also that she had a headache?

A. That's correct.

Q. Okay. Then there is another record -- by the way, this record is the typed record that you have also referenced. That would be 1-5. Do you have that, sir?

A. Yes.

Q. Okay. Now you were aware that this is information obtained by Kelly McKinney, the physician assistant?

A. That's correct

Q. Did you read her deposition testimony

A. No.

Q. Did you read Dr. Hanninger's deposition?

A. No.

Q. OK. So as you sit here today, you are unaware of their findings and the significance of their findings, what they did with their findings?

Q. OK. Ms. McKinney took a history that Peggy had a frontal headache which lasted a few hours. See that?

A. Yes.

Q. Going back to the triage data, it would appear that either Peggy and/or her grandmother told the triage nurse that she had a stiff neck and that she was nauseous and had some vomit of liquid material that morning. Ado you see that?

A. Correct.

Q. OK. Now the information given to the triage nurse is at odds with shat was provided to the EMS and the PA, correct.

A. Correct.

Q. All right. Now with Ms. McKinney's note, it appears there was no vomiting or blurred vision. And that's important, that there was no blurred vision?

A. It could be, yes.

Q. Okay. And there has been no photophobia, and that would be basically pain on light, or direct sunlight or light coming from a ceiling light. That could also be important, correct?

A. Bothered by light.

Q. Yes. And that's important, isn't it?

A. Yes.

Q. Okay. "Patient denies it is the worst headache ever." That is important, isn't it?

A. Yes.

Q. All right. Because when you're trying to determine whether or not a patient is in one of those two categories that you testified to, that is a life-threatening situation versus a non-life threatening situation, you want to ask questions in regards to the headache, the severity of the headache, and just factors involving that headache, correct?

A. Yes.

Q. And when you're told as a physician that "This is not the worst headache that I have ever had," that is taken into account when attempting to arrive at a diagnosis or what the underlying problem may be, correct?

A. That's one factor, yes. But it's not the only factor.

Q. Okay. But it's one factor.

A. It's one factor. One has to integrate all the data.

Q. Absolutely. So you don't rely upon one thing. You rely upon a number of things.

A. Yes.

Q. Okay. And as a physician or a physician's assistant, one of your priorities is to elicit information from the patient or from whoever brought the patient in?

A. That's correct.

Q. Because you order a test as a physician, you have to have a medical indication for that test, correct?

A. Yes.