VIRGINIA:

IN THE CIRCUIT COURT OF CITY OF NORFOLK

MARGARET PENZOLD

Plaintiff,

vs.

At Law No.:
CL07-4822

CARL LINDEMANN, M.D.
and
TIDEWATER PHYSICIANS
MULTI-SPECIALTY GROUP, PC

Defendants.

VIDEOTAPED DEPOSITION OF JEFFREY A. BROWN, M.D.

November 9, 2009

8:58 a.m.

Taken at:

714 Libbie Avenue
Richmond, Virginia 23226

REPORTED BY: HELEN B. YARBROUGH, RPR, CCR, CLR

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ALSO PRESENT:

Ron Benton, Video Works of Virginia, Inc.

I N D E X

E X H I B I T S

THE VIDEOGRAPHER: We are on the record at 8:58. Would counsel please introduce themselves, starting with the plaintiff's counsel; indicate who you represent. And then the court reporter will swear in the witness.

MR. LEWIS: My name is Jim Lewis. I represent Margaret Penzold.

MR. REDMOND: My name's John Redmond. I represent Carl Lindemann and Tidewater Physicians Multi-Specialty Group.

JEFFREY A. BROWN, M.D., a Witness, called by the Plaintiff, first being duly sworn, testified as follows:

EXAMINATION BY MR. LEWIS:

Q Good morning, Doctor. For the record, would you tell us your full name?

A Jeffrey Allen Brown.

Q Doctor, we've been introduced earlier today. My name's Jim Lewis. I represent Ms. Penzold in this case, and you've been identified as an expert witness on behalf of the defendant, and I'm here to ask you some questions about your opinions.

Have you been deposed before?

A Yes.

Q Then I will assume you understand the rules of the road unless you tell me otherwise.

A Correct.

Q How many times have you been deposed?

A Twice.

(Dr. Brown Deposition Exhibit No. 2 is marked.)

Q Doctor, some formalities: I show you an exhibit that our court reporter has marked as Dr. Brown Number 2, ask you if you can identify that for me.

A This is my CV.

Q And is that CV as -- in its form as Exhibit 2 current, accurate, and up-to-date?

A I believe so.

Q Any changes, additions, or corrections?

A No.

(Dr. Brown Deposition Exhibit No. 1 is marked.)

Q I ask you to take a look at Dr. Brown Deposition Exhibit Number 1, which is a pleading entitled "Defendant Carl Lindemann, M.D. and Tidewater Physicians Multi-Specialty Group, P.C.'s Expert Witness Designation," and the portion of it I'm showing to you purports to summarize the opinions that you hold in this case.

First question: Have you seen that document in some form before today?

A Yes.

Q Did you draft that portion of the document that purports to summarize your opinions?

A I didn't dictate or transcribe it. This document was put together -- Dr. [sic] Redmond's office after our discussion of the case. So it reflects my thoughts, but I didn't dictate it or transcribe it.

Q Have you reviewed it in its present form?

A Yes.

Q And does it accurately summarize the opinions that you hold in this case?

A Yes.

Q Are there any incorrect opinions set forth in Exhibit Number 1?

A No.

Q Can you itemize for me, Dr. Brown, all of the medical records that you have reviewed in this case prior to formulating the opinions that you hold?

A I reviewed the medical records --

I presume -- I presume that they're all the medical records that exist.

-- that were sent, as well as the depositions to date.

Q We'll get to the deposition. But can you itemize for me the medical records that you reviewed?

A There is Dr. Lindemann's office notes.

Q Could you read them? Could you tell what they said when you looked at them?

A Some were more legible than others.

Q Were there entries that you couldn't read?

A I -- it's been a little while since I've read them, but I presume that there are probably some that I can't fully read.

Q And on these entries that you couldn't fully read, did you do anything like find out what they said like, call Mr. Redmond, call Dr. Lindemann, or did you just kind of breeze on by it?

A I have not spoken with Dr. Lindemann and I don't believe I had any discussions with Mr. Redmond about penmanship.

Q Okay. And in addition to Dr. Lindemann's office chart, can you tell me what other medical records you have reviewed?

MR. REDMOND: You can look at the stuff in the box. He's brought all the stuff, so it's --

Q Great. Feel free to look at it if that will help you answer my questions.

A I have records from Ms. Penzold's hospitalization.

Q Which one?

A I believe I have them all, but I can run them down for you.

Q The primary one that seems to exist in this case is an August 12th, 2005, Sentara Hampton CarePlex admission.

A I have -- I have that. I have -- I have that one. I had a -- an urgent center, which is called --

MR. REDMOND: Port Warwick.

THE WITNESS: Correct. The Port Warwick, that's sort of a Patient First type care center. Sentara CarePlex, 8/12/05, that was her operative date, and then a host of office evaluations and other -- and other things.

Q Can you tell me what, among those records

that you reviewed, are of primary importance to you in formulating the opinions that you hold in this case?

A Primarily things -- records beginning on when she presents to Dr. Lindemann's office through when she ends up in the operating room with her general surgeon.

Q With Dr. Newman?

A Correct.

Q Okay. Can you itemize for me, Dr. Brown, what pleadings you have reviewed in this case other than Exhibit 1?

A Define "pleadings" for me.

Q The complaint, the answer filed by Dr. Lindemann's attorneys, interrogatory answers filed by the plaintiff, interrogatory answers filed by the defendant, expert witness designations.

A I have read -- I've read the entire complaint originally. I have read, I believe the expert witness designations.

Q For the plaintiff?

MR. REDMOND: Dr. Lisner, that was what it would be --

THE WITNESS: Yes. And I've read deposition from Lisner; deposition from Newman, who was the treating general surgeon; from Lisner, who's a

designated expert.

Q Yes, sir.

A I read a deposition from the patient.

Q Ms. Penzold?

A Ms. Penzold. I have depositions from her daughters, although I have not read those. And -- and those are the depositions that were --

MR. REDMOND: You read Dr. Lindemann's deposition, too, right?

THE WITNESS: Yeah, did I -- did I --

MR. REDMOND: You left him out.

BY MR. LEWIS

Q You left him out?

A I have read Dr. Lindemann's deposition.

Q When did you read Dr. Lindemann's deposition?

A I read it -- I reread it yesterday, but read it whenever it was originally provided to me, which was -- which was obviously prior to yesterday.

Q Obviously. Was it before or after Deposition Exhibit Number 1 was filed?

A Oh, before.

Q You read Dr. Lindemann's deposition before Exhibit Number 1 was filed?

A Well, I don't --

Q Let me -- let me ask it a different way rather than quibble about it.

A If you have dates --

Q Rather than quibble about dates --

A Okay.

Q -- you formulated opinions in this case --

A Correct.

Q -- prior to reviewing Dr. Lindemann's deposition, correct?

A I don't know when his deposition was done and when I received it.

Q Recently.

A Okay. Well, I get -- periodically I get mailings in this case. I put them in a box with the case. I don't always read them that day, and I read them either when I get a chance or when I'm asked to.

My original review of the case included whatever the hospital records and Lindemann's records. I don't know when -- I mean, I can sit here and go through it, but I don't know when his deposition occurred and when I read it. I formulated this opinion after my initial review of the case as it was presented to me --

Q Okay.

A -- hospital records, and presumably -- I

don't know when he was deposed and when the case was filed, but I may not have had his deposition when I -- when I did this.

Q The question I was driving at, and I'm not at all sure you can answer it, is whether or not reading Dr. Lindemann's deposition changed your opinions about this case in any way.

A The only thing I noticed from reading Dr. Lindemann's deposition is he's -- he's a painfully honest guy because he volunteered, if I'm --

MR. REDMOND: Thanks for that.

A -- he volunteered that -- he volunteered that he had a lost piece of documentation that was his homemade review of systems, which introduced a particular -- which introduced the element of chills that I don't think ever -- that anyone would have ever known about if he hadn't volunteered it. That's one thing that struck me about his deposition, frankly.

Q Right. He -- he added some things to the history that the patient had given him that he didn't chart in his primary chart.

A Correct.

Q Okay. Would the addition of that history change the opinions that you hold in this case?

A I don't think so.

Q Doctor, just for a moment, if you would, tell me what your prior experience has been as an expert witness in a medical negligence case prior to this one. How many of them have you done, have you reviewed?

A I've reviewed about a half a dozen.

Q Over what period of time?

A I came into practice in August of '96.

Q So a half a dozen since August of '96?

A Correct.

Q How is it that you first got involved in reviewing medical-legal files for insurance companies or lawyers?

A The first case I looked at, an attorney contacted me and said, "This is in your area of expertise. Are you willing to look at it?"

Q Of the half a dozen --

MR. REDMOND: Just to make record here, I want to make sure -- you made reference to insurance companies in the question, so I want to preserve an objection to that under the rule.

MR. LEWIS: Sure.

MR. REDMOND: It's not admissible as evidence.

Q Of the half a dozen or so medical-legal

files you have reviewed, how many of them have been on behalf of a representative of a physician who was being complained about, and how many of them were on behalf of a patient who was complaining about a physician?

A I have accepted one plaintiff's case, which is presumably what you're asking.

Q Yes, sir.

A I've accepted one plaintiff's case; one case in which the defendant was a nursing home, so not a physician, but for the parties defending the nursing home; and the rest that I reviewed have been for the defense.

Q Okay. And how many of the half a dozen or so cases have you given deposition testimony?

A Two.

Q Is today number three?

A Today is number three, right.

Q Can you remember for me whether -- which one each one was? Were they defense, the plaintiff, or one of each?

A One defense and then the nursing home case.

Q Okay. So you did not give deposition testimony in the plaintiff's case that you accepted?

A Never got that far.

Q Okay. Do you remember who the attorneys were defending the nursing home?

A The firm was LeClairRyan. It was a young associate who's no longer there, and I would have his name on file, but I can't remember it.

Q Do you remember who the plaintiff's lawyer was?

A Robert Carter from Appomattox.

Q Did that case go to trial?

A That case was settled.

Q And in the second case, which was a defense case, as I understand it, who represented the doctor?

A Kelvin Newsome --

Q What firm?

A -- from LeClairRyan. He's in their Washington office now, was in Richmond at the time.

Q And who represented the plaintiff, if you recall?

A Mick McConnell. That case is from '98 or '99, maybe.

Q Old?

A Yes.

MR. REDMOND: I think Kelvin's in Virginia Beach now --

THE WITNESS: Okay.

MR. REDMOND: -- near me.

Q Have you ever looked at a case for Mr. Redmond or any member of his firm prior to the Penzold case?

A Yes.

Q How many?

A One.

Q And did you agree to testify on behalf of their client in that case?

A I did.

Q Have you testified in that case?

A I did.

Q Was it --

A But I was not deposed. That's why -- that's the gap here. The plaintiff's counsel chose not to depose me.

Q But the case went to trial?

A Correct.

Q And I appreciate you've pointed out a gap in the way my question was worded.

Now, let's talk about trial appearances. How many times have you testified in court in a medical malpractice case?

A Once.

Q And that was on behalf of a doctor?

A Correct.

Q And it was defended by Mr. Redmond's firm?

A Correct.

Q Was it defended by Mr. Redmond?

A No.

Q Who was the lawyer?

A What's the lady --

MR. REDMOND: Joan Mielke.

THE WITNESS: Correct.

Q What was the claimed malpractice in that case?

A Failure to diagnose and adequately treat a traumatic ankle wound that resulted in amputation.

Q Have you ever been sued before, Doctor, for malpractice?

A Yes.

Q How many times?

A Twice -- twice, technically. I -- I had a case in the late nineties that lasted several years that was -- that required depositions and expert witnesses. Several years ago, I had a case filed by a fellow here in town related to a broken central line, which was nonsuited -- nonsuited the next day and then dismissed with prejudice three days later. So -- but you have to list that one. You have to count it,

so --

Q The ankle amputation case, what happened to that?

A Defense verdict.

Q So it went to trial?

A Correct; in Fredericksburg.

Q You told me earlier you have never spoken to Dr. Lindemann?

A Correct.

Q So I take it you don't know him?

A Correct.

Q You know anybody in his group?

A I do not.

Q As I recall this record, Dr. Brown, Ms. Lindemann was 89 years old when she presented to Dr. Lindemann with complaints of right hip pain. Is that your understanding?

MR. REDMOND: Ms. Penzold.

MR. LEWIS: That's what I meant. What did I say? Ms. Lindemann?

MR. REDMOND: Yeah, you did.

MR. LEWIS: You got another lawsuit you're trying to file here that I don't know about?

MR. REDMOND: I might.

Q In your career, Dr. Brown -- I'm just trying

to get a feel for the way your surgical practice works. When patients are referred to you for evaluation of abdominal pain, do they usually come to you with a confirmed diagnosis of appendicitis, or do they usually come to you looking for you to make the diagnosis or rule it out?

A Both.

Q Can you give me some kind of breakdown? Usually they -- or is it kind of like 50-50?

A With regards to abdominal pain, it's probably 50-50. We see patients in the office electively or semi-electively where the referring physician's not sure what's the matter with them. We get called to see patients in the emergency room that have more of a diagnosis because they have been evaluated there, or they have had some imaging studies.

Specifically regarding appendicitis, probably more cases than not of appendicitis have a diagnosis when we're called because of the widespread use of imaging technology and the fact that those folks often end up in the emergency room before we see them.

Q Right. If you are asked to see a patient with abdominal pain where the referring physician

isn't real sure what's going on, if appendicitis is on your differential, what do you do to confirm it or rule it out?

A It depends a little bit on the patient, their age, and their body habitus.

Q I don't want to waste your time here, Doctor, any more than I already have. So let's just say, how about an 89-year-old lady with similar physical characteristics to Ms. Penzold?

MR. REDMOND: Let me make it clear for the record that he's not going to testify as a standard-of-care expert, so --

MR. LEWIS: Okay. Well, that'll -- that'll streamline today.

MR. REDMOND: You can -- you can do this if you want, but he's a surgical expert.

Q That's fine. Answer my question, and we'll move on.

A History, physical examination at first.

Q Tell me about the physical exam. What would you do?

A Well, they need -- they need an abdominal examination, obviously. Physical exams are tailored to what the issue is. Frankly, they are tailored to -- they are tailored to the patient, their

complaints, and what your suspicions are if you have any suspicions. Sometimes you don't; sometimes you do. Clearly, if you are worried that someone has appendicitis, the abdominal exam is part of it. Occasionally examination of their leg and hip flexion is part of it too.

Q Why?

A Because if -- if you adduct or move the hip a certain way and they've got a retrocecal appendix or appendix with a certain amount of inflammation, you can elicit -- you can elicit symptoms or signs that way.

Q Okay.

A And then following the history and physical comes whatever further evaluation, whether laboratory or imaging studies you think are appropriate, if you think you need them or not.

Q If you think you need some lab work, what are you looking for? What specific tests do you want to see the results of?

A You're more interested in the hematology than the chemistry, specifically white blood cell count, blood counts, those kinds of things.

Q Okay. What imaging studies would you order if you decided, "Gee, I'd like to get a" -- what would

it be, for an 89-year-old like this lady, if you're trying to rule out appendicitis?

A Right. It depends a little bit on the patient's body habitus, thin versus heavy.

Q Which one is Ms. Penzold?

A She's described in some of Dr. Lindemann's office notes as being overnourished, but I don't know her BMI --

Q Okay.

A -- or her height and weight, frankly, off the top of my head. So I don't know.

Q Okay.

A If -- for a very thin person, an ultrasound is an appropriate zest. For a heavy person, a CT scan is appropriate. But it also depends on whether they have renal dysfunction and can get the dye, whether they can swallow enough to drink the oral contrast. So you have to tailor your imaging a little bit to what the patient can do and what's appropriate for them.

Q Do you know whether or not Dr. Lindemann had ultrasound capability in his office when this lady presented in August of '05?

A I do not.

Q Do you know whether or not he had any

imaging equipment available in his office to him on that day?

A I do not.

Q As I understand it, Doctor, Mr. Redmond has represented to me that you don't intend to comment on the standard of care and whether or not Dr. Lindemann complied with it in his care and treatment of this patient. Is that correct?

A That's correct.

Q Okay. If you want to refer to Exhibit Number 1, feel free. I'm looking at the bottom of page 2, the last sentence, "Dr. Brown will testify as to the extreme rareness of an acute appendix in a hernia sac and inguinal hernia and in general Ms. Penzold's surgical presentation."

Can you elaborate on that comment for me?

A Yes. And may I -- may I also comment in this -- I don't know if this copy's the same as the copy I have or if I missed this when I read it. But her hernia is a femoral hernia.

Q Not inguinal?

A It's not -- her hernia's --

MR. REDMOND: That's a mistake.

MR. LEWIS: I knew that when I read it, but thank you for pointing that out.

MR. REDMOND: That's a mistake on my part; that should be "femoral."

THE WITNESS: I'm surprised I let that --

MR. REDMOND: Do you want to correct that --

THE WITNESS: I'm surprised --

MR. REDMOND: -- or leave it the way it is?

MR. LEWIS: I don't care. I knew what you meant.

MR. REDMOND: Yeah.

THE WITNESS: But there's a difference.

Q Let me get, Dr. Brown -- at the risk of wasting your time, let me get your definition of a femoral hernia as it applies to the Penzold case.

A Femoral hernias are hernias that exit the abdominal cavity or present beneath the inguinal ligament rather than above.

Q Okay. And how is it -- how is it different than an inguinal hernia?

A They are much less common and much more rare and a lot harder to diagnose.

Q How do you diagnose it in a lady like Ms. Penzold if it was on your differential?

A The same way we just talked about with appendicitis, the history and physical. I think that femoral hernias are less often diagnosed -- let me

rephrase that. I know that femoral hernias are much less often diagnosed on physical exam and more often picked up on imaging studies. They're just harder to find on physical.

Q Can you also elicit discomfort by manipulating the hip or femur in a patient, as you described for me, with appendicitis?

A You might, depending on -- depending on whether it was incarcerated or not incarcerated --

Q During --

A -- at the time of your exam.

Q At the time of your exam. Doctor, is -- when -- as I understand it from Dr. Newman, what happened to this lady is that the appendix dropped down into the hernia at some point during the development of the hernia; and as luck would have it, the appendix decided to go acute at or about the same time, sort of like the perfect storm?

A That, or the appendix may have entered the hernia sac and had its blood supply compromised, which is what strangulation means.

Q And --

A And the blood incarcerates a strangulation, and then the appendix died or became acute, whatever term you care to use, as a result of being

incarcerated. And I -- I don't think there's ever any way to know which of those two things it was, whether there was an acute appendicitis that, because she's a multiparous, elderly person with patulous tissues and she had a redundant mesentery that would drop down into -- into the hernia and the acutely inflamed appendix got into this generous hernia sac, or whether her normal appendix got in the hernia sac, which was tighter and got compromised and then died. I don't think -- I don't think Newman will ever know. I certainly won't ever know. No none will ever know that, but it's one of those two things.

Q Do you know Dr. Newman?

A No.

Q We digressed a bit, Doctor. Back to the last sentence of page 2, with your correction, what I'd like you to do is explain to me what you mean by that sentence, and I know you didn't write it, but it's being attributed to you.

A You mean, (Transcribed as read) "In general, Dr. Brown will testify as to the extreme rareness of an acute appendicitis in a hernia sac and femoral hernia, and, in general, her surgical presentation" -- I didn't type it, but that's my -- those -- that's my opinion. It is -- it is an incredibly rare clinical

occurrence.

Q Do you hold that opinion based upon your personal experience, the literature, or both?

A Both.

Q Okay. Have you ever seen a presentation like the one Ms. Penzold presented with?

A No.

Q Do I understand correctly -- I think I do, but you're not going to testify as to whether or not Dr. Lindemann's conduct in this case complied with the appropriate standard of care in failing to diagnose whatever it is I think he should have diagnosed?

A That's what you just asked.

MR. REDMOND: He's not going to say that he violated or complied with the standard of care.

MR. LEWIS: Basically, he's just going to say this is an incredibly rare occurrence?

MR. REDMOND: A clinical occurrence. I mean, to be fair, that's part of the -- part of the mix, but there will be no standard-of-care testimony.

Q Let's just talk about general surgeons, then, Doctor. Is it your opinion that a general surgeon would never make this diagnosis in the absence of operative intervention?

A No. That's -- that's -- I'm not suggesting

that.

Q Okay. How would you go about ruling this out if it was on your list of differentials, its rareness notwithstanding?

A I'll answer the -- it's inconceivable that -- to me, as a practicing general surgeon, that acute appendicitis in a femoral hernia sac would ever be on my list of differentials.

Q Okay. Then it's --

A It's more likely -- it is much more likely that I would be trying to sort out a problem and I didn't know what it was, and I would stumble on this. And if I -- if the patient was exceedingly thin, I might be able to pick it up on physical exam. It's much more likely that I would find it on an image, or someone else would find it on an imaging study.

Q You would go about the clinical examination in much the same way you described for me earlier when evaluating a potential appendicitis or femoral hernia patient?

A Correct.

Q I'm on page 3 of Exhibit 1 now, Dr. Brown, second paragraph. You with me?

A Yes.

Q "In general, appendicitis would not give a

patient hip pain."

I think you told me earlier that in certain circumstances manipulating the hip might elicit pain in an appendicitis patient with a --

I can't remember the phrase.

-- retrocecal, maybe, appendix?

A But that's -- that's -- this sentence says that appendicitis doesn't give you hip pain, which is a true statement. If you have a certain type of pelvic abscess or retrocecal appendix, you may be able to elicit pain with manipulating the hip. But it's not hip pain, per se. It's pain in the abdomen, with a retroperitoneum -- which is the space behind. You elicit that by maneuvering -- by flexing the leg, by abducting or adducting it. But that's not hip joint pain. That's pain in the pelvis or the retroperitoneum. So there's a little bit of a distinction.

Q Is it pain that a patient like Ms. Penzold might describe, for lack of better words, as "hip pain"?

A Conceivably.

Q Next sentence: "It would be an extreme stretch to expect a family physician to diagnose appendicitis from hip pain."

You're not going to talk about that in the courtroom, are you?

MR. REDMOND: To be fair, he's going to say clinically -- and you've asked him a bunch of clinical questions as a surgeon, that it's extremely rare to diagnose this.

MR. LEWIS: Right. I'm just -- I'm just -- this is -- this is a standard-of-care comment here, in my view, and I just want to make sure that I can kind of scratch the family physician part of it out.

MR. REDMOND: You can do that.

MR. LEWIS: Okay.

Q Down -- a little bit farther down, the third paragraph, Dr. Brown, "Dr. Brown, who has communication with family practitioners virtually every day, would not have expected a family practitioner to diagnose a hernia or acute appendix under these circumstances."

A Same comment.

MR. LEWIS: Well, I don't want to beat this to death, but you've really -- you've put a bunch of standard-of-care stuff in here.

MR. REDMOND: I'm not sure that's a standard-of-care statement. I can tell you he's not going to give standard-of-care testimony. Now, you

know, if he's asked if this is rare, rare is rare, and rarer is rarer, he's going to say yes.

Q If a family doctor that you deal with -- you have a group of family practitioners who have a referral relationship with you, I presume.

A Correct.

Q And when they have a patient that has presented with a constellation of symptoms that they're not sure what's going on, do you expect them to consult you?

A Yes.

Q Let's go to page 4. "Finally, Dr. Brown will opine regarding the infectious and necrotizing fascitis."

What does that mean? What is it that you're going to talk about when it comes to infectious material or necrotizing fascitis, or should I just keep reading along, and we'll get to it?

A Well, that's -- I mean, that's how she became so critically ill, is that she had something in a closed space. She had a necrotic appendix or an acute appendicitis in a closed space, which ultimately gave her gas, gave her gas in her thigh, and that's ultimately how the diagnosis was made.

And again, whether -- whether she had acute

appendicitis and it ruptured there, whether it was a non-ruptured acute appendicitis, whether a torted, necrotic normal appendix, it's impossible to say. But it's -- but that's ultimately how they made the diagnosis, is they had some imaging which showed them gas in the thigh. And she bounced around from the family doctor's office to Port Warwick, then to the ER at her ultimate hospital before anybody could figure it out -- until she got far enough along the infectious process that she had gas.

Q You understand, Dr. Brown, that it is -- I hate to use the word "my." It is the plaintiff's contention in this case that the diagnosis should have been made before Friday?

A I understand.

Q That we should have gone down a path starting with Monday?

MR. REDMOND: Before or after the beauty shop visit?

MR. LEWIS: Both.

MR. REDMOND: I just want to clarify.

MR. LEWIS: You are so rude.

MR. REDMOND: I just wanted to clarify.

Q And the way this is worded, if you keep on reading the rest of this paragraph, "In other words

the outcome would still have been the same."

Are you prepared to testify that had this diagnosis been -- and by "this diagnosis," I mean something that needed to be surgically addressed, whether they had figured out it was a femoral hernia, whether they had figured out it was an acute appendix, either or both, on Monday or Tuesday, this lady's outcome would have been the same?

A My -- what I'm -- what I'm suggesting is that given the extreme rarity of this clinical entity, I think it is virtually impossible that any primary care physician in his office -- his or her office -- would have ever been able to make this diagnosis on August 8th based on his clinical exam, simply because osteoarthritis and degenerative joint processes and aches and pains in 89-year-olds are infinitely more common than either femoral hernias or acute appendicitis by themselves; and you put the two together, and it's a vanishing number.

So I think -- so my contention is that there's virtually no way that he was going to make this diagnosis based on physical exam. Whether you could read his handwriting or not, regardless of whatever he put on the sheet, he wasn't going to make this diagnosis based on clinical exam in his office.

Now -- and my contention is, based on this, is that it was going to take the appearance of gas in -- it was going to be something as dramatic as her getting deathly ill, which she really wasn't, because as Mr. Redmond points out, she was conducting some normal activities even the day of her surgery. So she didn't -- it wasn't acute cardiopulmonary decompensation that got her to medical -- the ultimate operation, which could have easily happened, but it was the progression to gas in her thigh. And I think -- my contention is that's what was -- that was what was going to have to happen before this -- before we could have made a diagnosis. And I think that would have been extraordinarily difficult for a general surgeon, in his office, to do.

That's my -- that's my take on this -- on this paragraph.

Q Okay. Let's go back to Monday. Let me start it this way, Doc: What was going on with this lady on Monday? Three days of constant hip pain, chills, and --

MR. REDMOND: She didn't have chills on Monday.

MR. LEWIS: I know that. I'm --

MR. REDMOND: You don't want to live with

that fact.

MR. LEWIS: Chills. And what was the other thing that was on the missing sheet? Nausea?

MR. REDMOND: It was abdominal pain, the week before.

MR. LEWIS: That's right.

Q -- chills and abdominal pain a week earlier. And Dr. Lindemann doesn't remember whether they had resolved or not, but she wasn't complaining about them on Monday. She was just complaining of three days of constant hip pain, and you know what his physical exam elicited. What do you think was going on with this patient on Monday?

A That's virtually impossible for me to say without examining her; but again, 89-year-old ladies with hip pain are pretty common. A week history of some chills a week ago but no chills today --

Q Abdominal pain a week ago.

A -- abdominal pain a week ago but no abdominal pain today, coupled with a benign abdominal exam, I might have been comfortable not pursuing her abdomen further.

You also have to remember that it's very possible at this point that if she did have an inflamed appendix, that appendix wasn't in her abdomen

anymore. It might have well been in her femoral canal. You'll never know. There's no way to know.

Q There's no way to know because no imaging studies were done, correct?

A She was not imaged on the 8th.

Q Can you tell me what a CT scan would have shown, had she been?

A Of course I can't.

Q Right. How about blood work? Was any blood work done by Dr. Lindemann?

A I don't believe so.

Q Do you have --

A I have records.

Q -- any way of knowing what the blood work would have shown us --

A Of course not.

Q -- had he done it?

How about, was she running a fever on Monday?

A There's no documented fever.

Q There's no documented temperature, is there?

A That's correct.

Q All right. Back to my earlier question: I understand your opinions about the unlikeliness of anyone achieving a diagnosis on Monday or Tuesday, but

I want you to assume that they did for the purpose of this question. Is it still your testimony that the outcome for this lady would have been the same if this diagnosis -- something going on with her appendix, a femoral hernia, had been made earlier?

A Well, it depends -- obviously what you're suggesting is hypothetical.

Q Yes, sir.

A If you want to take -- if you want to go down the hypothetical road, the problem is that you don't know what you would have diagnosed on Monday. Was it simply a femoral hernia that was causing her pain? Was it a femoral hernia that had a normal appendix in it? Was it a femoral hernia with nothing in it and an acute appendix in the abdomen? It depends on what you diagnose.

Now, if you take -- if you want to suppose that all she had was an uncomplicated femoral hernia, obviously that's -- that's something you can take care of fairly straightforwardly, but you don't know -- you don't know what she had on Monday.

Q Is it fair to say that she didn't have necrotizing fascitis?

A Presumably, based on the records available, she did not have necrotizing fascitis on the 8th.

Q And as I reviewed the records, Doctor, and feel free to correct me, it appears that the necrotizing fascitis was the primary cause of the extensive surgical intervention that Dr. Newman and his fellow surgeons made on Friday, which -- that ultimately resulted in skin grafts and drains and all of that other stuff this lady endured. Am I reading the record correctly?

A Go back to the first part of your -- what was the gist of your question?

Q From the family's take, the real torture -- their word, not mine -- that this lady went through was secondary to the extensive tissue disruption, skin grafting drains, et cetera, that she underwent. And my take on the record is all of that surgical intervention was primarily necessitated by the necrotizing fascitis process. Do I read this correctly?

A I think the first -- I think the first part of your statement is correct, in that I'm -- I'm sure that the patient's -- everything the patient went through and that the family had to watch her go through were as a result of that. That's correct. She got that because she had infected tissue in a closed space.

When you have appendicitis that's in the abdomen, ruptured or not ruptured, there's some space there, and generally, if it ruptures, it becomes walled off, a little bit easier to take care of through -- beneath the inguinal ligament in a femoral hernia in the anterior thigh, you've got -- you've got an infectious process in a closed space, and it starts to get into the tissue planes, and in this case the fascia -- and obviously I wasn't there at the time of her surgery, but then you have fascial planes that are infected.

So she -- she got fascitis because she had an acutely inflamed or a necrotic appendix in a closed space in her thigh.

Q Let me ask the question a little differently because, again, as lawyers, we are always looking for the bit "yes/no," and sometimes they're hard to get.

If this lady has been surgerized --

MR. REDMOND: Surgerized?

MR. LEWIS: Surgerized. I'm not sure that's a word, but I seem to think it is.

Q If this lady had been operated on before the necrotizing fascitis occurred, would she have still gone through the skin grafts and then drains and all of that?

MR. REDMOND: I'm going to object to that as being vague and incomplete. But go ahead.

Q Again, I'm looking for a "yes/no" if you can give it to me.

MR. REDMOND: I don't know how a "yes/no" --

A If -- if she's operated on before there's necrotizing fascitis, she would not need as extensive a debridement or reconstruction.

Q Fair enough. Your designation says you're going to refer to medical illustrations, diagrams, or simulations. Do you have any such --

A I don't have any --

Q -- demonstrative evidence available to you today?

A I do not.

MR. REDMOND: No. There will be -- if you want to share demonstrative evidence, we can talk about doing that.

MR. LEWIS: Yeah, I do.

MR. REDMOND: There will be medical illustrations that I use at trial. I haven't decided what I'm going to use yet.

By the way, just for the record, I don't know -- we may disagree on this, Jim, but I don't

think the pretrial order contemplates that demonstrative evidence has to be shared in the exhibit/witness list. You and I may agree that we can do that --

MR. LEWIS: Okay. That's fine. We'll talk about it.

MR. REDMOND: -- because it's demonstrative.

Q Can you remember, or can you tell from anything in front of you, Doctor, when you were first contacted in this case?

A I cannot, without going back and looking at the cover letter. I don't know if I retained that or not.

Q When you were contacted in the case, had Dr. Lindemann already been sued, or do you know?

A I believe so.

Q Doctor, how do you charge lawyers for your time?

A We bill by the hour.

Q What's your hourly rate?

A I believe it's $400 for chart review, $500 for meetings with counsel, and then we have a flat daily rate for court appearances.

Q How about depositions like this morning? What are you charging me?

A I think it's $500 an hour, but don't hold -- the bookkeeping -- the bookkeeping department has a form, which I'll provide for you before you leave.

Q Fair enough.

A But I believe that's correct.

Q Is there any way for you to estimate for me, Doctor, the total number of hours you've spent reviewing this case prior to this morning?

A I have about eight hours, total, in the case.

Q Is that eight hours of record review, or is part of that eight hours talking to counsel?

A It's both.

Q Most of it record review?

A It's two-thirds record review and a third with Mr. Redmond, probably.

Q Okay. What causes femoral hernias in patients like Ms. Penzold, Dr. Brown?

A They have a weakness. They develop a weakness along the femoral vessels that an eventration of the peritoneum develops in over time, and then either their bowels, their ovaries, something else from the intra-abdominal cavity finds its way into the -- into the hole.

Q Is it generally part of the aging process?

A It can be -- it can occur -- hernias can occur -- general laxity of tissues with aging, chronic constipation, chronic cough, heavy lifting, obesity. Those are the risk factors for hernias.

Q Doctor, do elderly people who are suffering appendicitis at some stage present differently than the younger population?

A Not necessarily. I think it's more patient-specific. Some patients are quicker to complain than others. Some are more stoic. So I don't think you can generalize based on age. Excluding the -- excluding the tiny children, you know, the little ones --

Q Right.

A -- I don't think you can generalize based on age.

Q I was -- strike that.

I was perusing the medical literature on appendicitis in the elderly, and I came across a number of articles, a textbook on geriatric emergency medicine, all which seemed to stand for the proposition that the elderly don't present -- the elderly suffering with appendicitis don't present with classical clinical presentations. Has that not been your experience?

A That has not been my experience. In my experience, the number -- with as long as -- the way people are living, the fact that some people are highly functional well into their -- well into their eighties, I don't think the number matters much anymore.

Q You mean -- when you say "the number," you mean age?

A The age. I don't think their age matters much anymore. We have some very debilitated 50-year-olds and some highly functioning octogenarians. So I think it's, again, in my clinical practice, and there's entire -- as I'm sure you are aware, there's a vast literature on surgery in the elderly. In my experience, it's much more based on the individual, their personality type, their access to care, et cetera, than just their age.

Q Is -- is your patient population, let's say for the last five years, is it -- is it leaning in any particular direction age-wise, or are you pretty much across the board?

A To the older end of the spectrum.

Q And is that pretty common in a general surgical practice just because the older you get --

A Increasingly common.

Q The older you get, the more likely you are to need some type of surgery?

A And demographic shifts.

Q Right. Doctor, the reason I came here today was to find out the gist of the opinions you intend to share with the jury who tries this case. And this is somewhat of an unfair question; but in some way or the other, have you and I touched on all of the primary opinions that you hold in this case?

A I think so, although I would reserve -- there are some people that haven't been deposed yet, I presume. Other -- other information and paper may trickle into my office --

Q Yes, sir.

A -- between now and trial, so I would reserve the right to have some other opinions regarding information I see later.

Q That you haven't seen already?

A Correct.

Q But based upon what you have seen, when I get up and walk out the door, are you going to turn around to Mr. Redmond and go, "Golly, I can't believe he didn't ask me about widgets"?

MR. REDMOND: Well, I'm not going to elicit any expert opinion on widgets.

MR. LEWIS: You understand the question.

MR. REDMOND: I understand your question. I expect to be considerably more detailed in the presentation to the jury as you --

MR. LEWIS: But I want to make sure there aren't any topics that I have missed that you intend to cover with this witness. And I don't expect you to testify here this morning. That's why I'm asking him.

MR. REDMOND: No, I mean, I'll be fair with you. I -- he's going to -- I'll have him sit down and show -- I mean show the anatomy with illustrations, things like that. In terms of his -- the expertise given, I think you've covered the main points.

MR. LEWIS: I'm done. Thank you very much for your time. Again, I apologize for being late.

MR. REDMOND: He'll read.

THE VIDEOGRAPHER: And we're off the record at 9:49.

AND FURTHER THIS WITNESS SAITH NOT.

(The deposition ended at 9:49 a.m.)

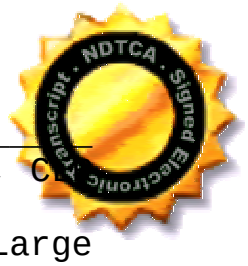
COMMONWEALTH OF VIRGINIA,

CITY OF RICHMOND, to wit:

I, Helen B. Yarbrough, a Notary Public for the Commonwealth of Virginia at Large, do hereby certify that the foregoing deposition of Jeffrey A. Brown, M.D., was duly sworn to before me at the time and place set out in the caption hereto.

Further, that the transcript of the deposition is true and correct, and that there were two exhibits filed with me during the taking hereof.

Given under my hand this 16th day of November, 2009.



Helen B. Yarbrough, RPR, CCR, CLR
Notary Public for the
Commonwealth of Virginia at Large
VCRA Certification #0313016

My Commission expires:
July 31, 2013
Notary Registration Number: 158897

COMMONWEALTH OF VIRGINIA,

_____, to wit:

I, Jeffrey A. Brown, do hereby certify that I have read the foregoing pages of typewritten matter numbered 1 through 45, and that the same contains a true and correct transcription of the deposition given by me on the 9th day of November, 2009, with the exception of the noted corrections, to the best of my knowledge and belief.

_____ _____

Date Jeffrey A. Brown

Subscribed and sworn to before me this _____ day of _____, 200__.

My commission expires _____.

_____

Notary Public

Notary Registration Number: _____