SUPERIOR COURT OF NEW JERSEY
LAW DIVISION - ESSEX COUNTY
DOCKET NO. ESX-L-12345-06

ROBERTA LANGHORNE, DEPOSITION OF:

THOMAS TORRANCE, M.D

Plaintiff,

vs.

THOMAS TORRANCE, M.D., THE UNIVERSITY
HOSPITAL,
JERSEY, JOHN DOE 1-10 (fictitious
names whose present identities are
unknown), and ABC CORPORATIONS 1-10
(fictitious names whose present
identities are not known),

Defendants.

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BEFORE: ESTHER J. HODGE, a Certified Court Reporter and Notary Public of the State of New Jersey, at the offices of RUPRECHT, HART & WEEKS, ESQS., 306 Main Street, Millburn, New Jersey, on Thursday, July 26, 2007, commencing at 10:15 a.m.

-------------------------------------------------------

ESTHER J. HODGE, C.S.R

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A P P E A R A N C E S:

BENDIT, WEINSTOCK, ESQS.
BY: PETER I. BERGE, ESQ.
For the Plaintiffs

DEWEY, CHEATEM & HOWE, ESQS.
BY: KARIN J. WATTS, ESQ.
For the Defendants

ALSO PRESENT:

Annamaria L. Black,
University Hospital Claims Representative

I N D E X


| WITNESS | DIRECT | CROSS | REDIRECT | RECROSS |
| --- | --- | --- | --- | --- |
| Thomas Torrance, M.D. | | | | |
| By Mr. Berge | 4 | | | |


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1 T H O M A S T O R R A N C E, M. D.,
2 110 Remsen Street, Britton, New Jersey,
3 having been duly sworn, testifies as follows:
4
5 DIRECT EXAMINATION BY MR. BERGE:
6 Q Good morning, Dr. Torrance. I introduced
7 myself informally, but I'll do so again on the record.
8 My name is Peter Berge. I'm an attorney with the law
9 firm of Bendit, Weinstock, and we represent the
10 plaintiff, Roberta Langhorne, who has brought this
11 lawsuit.
12 Have you ever given testimony in a deposition
13 before?
14 A Yes.
15 Q How many times?
16 A I'd say four times.
17 Q What were the circumstances?
18 A Twice it was for -- well, twice it was sexual

19 assault cases where they had actually captured someone

20 and they wanted testimony as to what I had done for the

21 patient.

22 Q So these were patients that you examined

23 or participated in their care?

24 A Yes. Another was for alcohol intoxication, a

25 drunk driver, and it was an estate of one family versus



1 the driver of the car. Once when I was named in a case

2 as resident --

3 Q As a defendant?

4 A As a defendant, I was dropped from the case.

5 They said that I was not involved at that time, and

6 actually there's probably two or three other sexual

7 assault cases. It happens a lot where they actually

8 catch someone and they want you to say what you saw

9 with that patient.

10 Q So only one case where you were named as

11 a defendant in a lawsuit?

12 A Yes.

13 Q When is the last time you were in a

14 deposition?

15 A Tuesday.

16 Q Well, I'll sort of fly briefly through

17 the instructions and such since I assume you're

18 familiar with them over and over again.

19 Just a couple of preliminary questions. Are

20 you known by any other names?

21 A No.

22 Q Are you taking any medication or do you

23 have any medical conditions that would interfere with

24 your ability to either understand my questions or to

25 answer them accurately?

6

1 A No.

2 Q Have you ingested any alcohol or

3 recreational drugs today?

4 A No.

5 Q Some witnesses say "not yet." Have you

6 had sufficient time to speak to your attorney?

7 A Yes.

8 Q Do you need any more time to speak with

9 her or ask her questions?

10 A No.

11 Q You were just sworn in, and you'll

12 notice that there's a stenographer typing away here,

13 and as you know, she's going to try to take down every
14 word that's spoken here. The important implications
15 are, one, this will be made into a transcript if this
16 case should go to trial, and if you should testify at
17 trial, if your testimony were different in court from
18 your testimony here today, you could and would be
19 confronted with those discrepancies. Do you understand
20 that?
21 A Yes.
22 Q Also just for practical purposes, she
23 can't really take down two people talking at once, and
24 so try to wait until I finish asking a question before
25 you answer it. It's also important to be sure that
7

1 you're really answering a question that I'm asking as
2 opposed to the question that you think I'm asking, and
3 that's probably the hardest thing for a witness to do
4 because normally in conversation we anticipate
5 questions. If it looks like you're going to answer a
6 question before I finish asking it, I may hold my hand
7 up. It's not meant to be rude. It's to make sure the
8 record is clear. Okay?
9 A Okay.
10 Q Likewise, it's difficult for the

11 reporter to take down nonword answers like "uh-huh" or
12 "uh-uh," which again we normally use in speech, so if
13 you use one of those, chances are one of the three of
14 us will ask you, "Is that yes or is that no?" Again,
15 it's not meant to be rude, but to make sure we have a
16 clear record. Okay?
17 A Yes.
18 Q Likewise, shrugs of the shoulder,
19 movements of the head don't come out on the record, so
20 I'll ask you to always say yes or no rather than
21 gesturing. Okay?
22 A Okay.
23 Q Try to make sure that the stenographer
24 can hear you.
25 If your attorney should object to a question



1 that I ask, the chances are the objection will be
2 followed by you can answer or you may answer, which in
3 that case, go ahead. If it is not, wait until we have
4 whatever discussion we have to put our lawyer issues
on
5 the record, and someone will tell you whether or not
6 you can answer the question. All right?
7 A Yes.
8 Q If you need to refer to a document to

9 answer a question, refer to anything other than your
10 memory, please let us know what it is you're referring
11 to so we can follow along with you. In general, I
12 would just as soon you answer from your recollection
if
13 you have a recollection to answer from.
14 If you don't know the answer to a question,
15 please tell me you don't know. If you can give a
16 reasonable estimate say as to a time, a date, a
17 measurement, something like that, that's fine, but try
18 to make it clear that you're giving an estimate. It
19 was about such and such, it was between such and such.
20 That's perfectly fine. However, if it's a question of
21 guessing, don't guess. If the words "I guess" or "I
22 suppose" or "it must have been" come to mind, then
23 chances are the answer is you don't know or you don't
24 remember. In other words, if you can reasonably
25 estimate, do so and let us know you're doing so. If



1 you can't and if you don't know, please don't guess.
2 Just say you don't know or you don't remember. I may
3 in that circumstance try to give you more information
4 to help you remember or to help you put something into
5 a reasonable range, but in the end if you don't know,
6 tell me you don't know and don't guess. Okay?

7 A Okay.

8 Q If you give an answer based on what you

9 would normally do but without a recollection as to what

10 you actually did, please make that clear.

11 A Okay.

12 Q Because I really want to distinguish

13 between what you recall doing and what you are saying

14 is your normal practice and what you believe you would

15 have done in a situation but don't recall. Is that

16 clear?

17 A Yes.

18 Q Any questions about anything that I've

19 said?

20 A No.

21 Q If you need to take a break, if you need

22 some liquids or anything like that, just say so. The

23 only thing I'll ask is that if I've asked a question,

24 that you answer the question before we break so that we

25 don't have a break in between a question and an answer.

10

1 Can you just review your medical education and

2 training for me?

3 A I did my undergraduate at University of
4 Virginia. I went to New Jersey Medical School in
5 Newark from 1992 to 1996. I was an intern in internal
6 medicine at St. Luke's Roosevelt Manhattan, and then I
7 was a resident at Albert Einstein Jacobi and Montefiore
8 Medical Centers in the Bronx.
9 Q A resident in?
10 A Emergency medicine.
11 Q And I bet you saw a lot of it.
12 A You see more in Newark.
13 Q Did you take any board certifications?
14 A Yes.
15 Q What were those?
16 A I took the board exam in emergency medicine.
17 Q When was that?
18 A I was boarded in 2002.
19 Q Did you pass them on the first attempt?
20 A The written exam I passed on the first attempt.
21 The oral exam, it was the second attempt.
22 Q You said you received a board
23 certification in 2002?
24 A Yes.
25 Q What's been your work history since

1 then?

2 A I have worked as an attending at University

3 Hospital since July of 2000 until now, and I have

4 worked part-time at a couple of other institutions.

5 Q Which are those?

6 A At JFK Hospital in Edison. Do you want the

7 dates?

8 Q No.

9 A Riverview Hospital and Muhlenberg. Those are

10 connected, so that's really the same, but you go

11 between hospitals.

12 Q Between sites?

13 A Right, and then currently I do some part-time

14 at Riverview Medical Center in Red Bank.

15 Q What do you do at those jobs?

16 A Attending of emergency medicine. I only work

17 at Riverview now. JFK and Muhlenberg were in the past.

18 I've not been there in four or five years.

19 Q When did you complete your emergency

20 medicine residency?

21 A 2000.

22 Q So at that point you were

23 residency-trained and board-eligible?

24 A Yes.

25 Q Do you have privileges at all of those



1 hospitals that you mentioned?

2 A Just University Hospital and Riverview

3 Hospital.

4 Q What happened --

5 A I no longer work for the facility, so I gave up

6 privileges.

7 Q And how did you come to not work there

8 anymore?

9 A I had moved from Yonkers, New York to Holmdel,

10 New Jersey and the commute was too far. Riverview

11 Hospital is only five miles from my house.

12 Q Have you ever had an application for

13 privileges at a hospital denied?

14 A No.

15 Q Have you ever had any privileges at a

16 hospital suspended, revoked or withdrawn without your

17 consent?

18 A No.

19 Q Have you ever had any disciplinary

20 action taken against you by any hospital?

21 A No.

22 Q How about by any state licensing or

23 regulating board?

24 A No.

25 Q In what states if any are you licensed



1 to practice medicine?

2 A Currently in New Jersey and Virginia.

3 Q Have you been licensed in any other

4 states?

5 A New York.

6 Q When were you first licensed in New

7 York?

8 A As a resident, between 1997 and 1998.

9 Q And when were you no longer licensed in

10 New York?

11 A I gave up my license in New York when I moved

12 to New Jersey in 2002.

13 Q Did you give that up voluntarily?

14 A Yes.

15 Q Was there any disciplinary action

16 associated with that?

17 A No, I just was not practicing in New York

18 State, and they want $800 a year to keep your license

19  in New York.

20          Q      This may seem obvious, but how would you

21  describe the nature of your practice?

22  A       I'm an emergency medicine attending.  The

23  nature of my practice is to see acute and emergently

24  ill patient in an emergency department.  I no longer

25  work in the main area, the adult section.  I see adult



1  patients as well as crisis patients as well as trauma

2  patients of all ages, including children.

3          Q      Do you supervise any health care

4  providers?

5  A       There are currently -- there are emergency

6  medicine residents that came in -- in 2005, the

7  emergency medicine residency began.  Previously to that

8  there were internal medicine residents that rotated

9  through the emergency department but no longer, and

10  then there also are surgical interns that are

11  supervised that are in the emergency department.

12          Q      When you say "supervised," by you when

13  you're working?

14  A       Yes.  Not necessarily with every patient, but

15  if they see a patient, then I supervise them, but there

16 are patients that you see primarily.

17 Q Could you explain that?

18 A Meaning that let's say there's four patients to

19 be seen. The intern does not have much experience.

20 You'll pick out a case that seems educational but not

21 difficult, and you'll give him that chart while you go

22 see the other three, and they would have no interaction

23 with those other three patients, and then you would

24 discuss the case and the management of the patient that

25 they had seen. Then you would go and examine the

15

1 patient yourself to confirm their findings.

2 Q Any other health care providers who are

3 seeing patients in your area while you're working

4 typically?

5 A In my area, no. There are nurse practitioners

6 who do work in the Fast Track area of the emergency

7 department.

8 Q Do you ever work in Fast Track?

9 A I haven't worked in Fast Track in three or four

10 years secondary to decreases in staffing, but I am the

11 collaborative physician for all of those nurse

12 practitioners.

13 Q For those who aren't familiar with the

14 system, what does that mean?

15 A The collaborative physician is the physician's

16 name basically that is on every prescription of those

17 nurse practitioners, so any prescription for the
20,000

18 patients that pass through Fast Track, my name would
be

19 on those prescriptions, as well as you're the one that

20 does basically a peer review or chart review for the

21 nurse practitioners.

22 Q Do they see the patients on their own,

23 or does a physician also see them?

24 A In the Fast Track in the State of New Jersey

25 nurse practitioners based on acuity of the patient are



1 able to work independently in the State of New Jersey.

2 Q So an N.P., a nurse practitioner, could

3 see a patient, make an assessment, develop the

4 diagnosis and treat the patient and discharge the

5 patient without them having seen a physician?

6 A Yes.

7 Q Does that happen in the main area?

8 A No, because they don't work in the main area.

9 They only work in Fast Track, and they work in an area
10 called medical screening, which is out by triage.
11 Q So for a patient that would normally be
12 seen by an N.P., would you write a note on the chart?
13 A If a patient was seen in Fast Track, primarily
14 no. No physician has a note on the chart.
15 Q If you write a note on the chart, that
16 means you see the patient?
17 A Yes.
18 Q You mentioned surgical residents
19 formerly -- surgical interns I think you said or
20 first-year residents. Right?
21 A Yes.
22 Q Formerly internal medicine residents
and
23 now --
24 A Actually, I mean medical students too also
25 rotate. Fourth-year medical students rotate through
17

1 the emergency department.
2 Q And emergency medicine residents go
3 through your area. Are any patients seen or
discharged
4 in your area who you don't either see or are discussed
5 with the resident or intern?

6 A No.

7 Q Getting a little more specific about the

8 case at hand, do you have any recollection of Roberta

9 Langhorne?

10 A I do.

11 Q We're basically talking now about April

12 17, 2006. How did you come to be involved in Roberta

13 Langhorne's care?

14 A Roberta Langhorne had been triaged to go to the

15 Fast Track area. I remember the day being very busy

16 and Fast Track being behind, so at that time I was

17 working as Associate Director of Clinical Operations of

18 the emergency department, so I asked that some of those

19 backlogged patients who had been waiting over four

20 hours at that point be brought into the main room, so

21 that's why she was actually seen in the main room

22 instead of in Fast Track.

23 Q Was she seen by an N.P. prior to you

24 seeing her?

25 A She did have a medical screening exam.

18

1 Q And what is that?

2 A My emergency department is rather small for our

3 volume, and the national standard is to see patients

4 within four hours of their arrival to the emergency

5 department, so because we do not have room to actually

6 bring them in, we have placed a nurse practitioner

7 similar to other facilities -- St. Barnabas, Robert

8 Wood Johnson do the same thing -- in a second triage

9 room to actually kind of see these patients and maybe

10 get them started with some labs or an x-ray so they

11 have at least seen a provider in that time frame.

12 Q And then you mentioned labs and x-rays,

13 so the assessment process is started by the time the

14 physician sees the patient. Is that correct?

15 A Yes.

16 Q Is that what happened in Roberta's case?

17 A Yes.

18 Q What do you remember about Roberta's case,

19 about what happened?

20 A I remember Ms. Langhorne because she had

21 waited, I mean, a long time. It had probably been six

22 hours that she had been there, and I remember her

23 having on a white jumpsuit and asking her what

24 happened, and she told me she had been jogging and

25 stepped on a nail approximately two days prior to


1 coming to the emergency department. I basically

2 remember, saying, "Well, why did you wait two days

3 before you sought medical attention, and did you see

4 your private physician," and she told me that she was

5 afraid. I told her that we basically needed to check

6 some blood work looking for infection and x-ray, and we

7 needed to make sure she did not have a fever, and then

8 I kind of stressed to her that diabetic foot infections

9 can be severe, and that we needed to check these things

10 before we made a decision on her disposition.

11 Q By the way, have you reviewed any

12 documents or records in preparation for this

13 deposition?

14 A My chart.

15 Q And what is that made up of?

16 A I guess her emergency department chart record

17 when she was here on the 17th.

18 Q Anything else?

19 A A copy I guess of her deposition was mailed to

20 me, but I did not review it fully.

21 Q And when did you last look at the

22 deposition?

23 A Yesterday.

24 Q When did you last look at the emergency

25 department chart?



1 A Before you came in.

2 Q So just to be clear, this isn't somebody

3 who, say, a nurse practitioner saw and then kind of

4 consulted with you as the attending. This is somebody

5 who you were seeing primarily as your patient. Is that

6 right?

7 A Yes. Well, she was -- she had a medical

8 screening exam. I mean, labs were drawn before she had

9 come in. I don't know what time. I would have to look

10 at the record, and then she was brought into the

11 emergency department. She was seen by either a student

12 or resident because they did not sign the chart, and I

13 do not recall who saw her, but I went to see her and do

14 my physical exam and talk to the patient.

15 Q Could you do me a favor? I have a copy

16 that we were sent of that record. Could you just

17 compare that with your copy and just let me know if

18 there are any discrepancies, if there are any pages

19 missing, anything that seems to indicate or that would

20 indicate that they're not the same?

21 A Maybe this page is in a different order. This

22 page is present on both. This page is present on both.

23 I guess the order is different so far. That page was

24 there. I haven't seen this page on here yet.

25 MS. WATTS: I believe that's the last



1 page on this chart.

2 THE WITNESS: I've seen this and seen

3 this page, and I've seen this, so just the outpatient

4 billing form.

5 MS. WATTS: Do you want a copy or have a

6 look at it?

7 MR. BERGE: *If you wouldn't mind, if I

8 could have a copy at the end.

9 Q Other than this page that's labeled

10 "Outpatient Billing Form," everything which is in your

11 copy is in mine? Everything is the same?

12 A Yes.

13 Q Do you make complete and accurate notes?

14 MS. WATTS: Objection to form.

15 MR. BERGE: What's your objection?

16 MS. WATTS: Are you saying on this

17 patient, in general or are you talking about just the

18 pages he writes on or does he ensure that the entire

19 record is complete?

20 Q I'm asking in general in terms of your

21 notes.

22 A I always attempt to.

23 Q In your review of Roberta Langhorne's

24 chart, did you find any inaccuracies, and by that I

25 mean anything that to your knowledge either isn't there

22

1 and should be or is there and is incorrect?

2 A No.

3 MR. BERGE: I'm going to go ahead and

4 mark this record then as Torrance-1.

5 (Emergency Department chart, marked as

6 Exhibit Torrance-1 for Identification.)

7 Q What do you recall about Roberta

8 Langhorne's medical history?

9 A I remember her telling me that she was a

10 diabetic, that she was currently on medication, and

11 that she had a private physician that she followed up

12 with.

13 Q Anything else you recall?

14 A In terms of past medical history?

15 Q Yes.

16 A No.

17 Q And you can refer to the chart if you

18 would like. Is there anything else on the chart that

19 indicates anything about past medical history?

20 A It's just documented that she had a history of

21 diabetes and that she takes the medication Metformin.

22 Q From your perspective as an emergency

23 physician in assessing this particular patient, what
if

24 anything is the significance to that?

25 A The significance to that is that she has a
foot

23

1 injury, and diabetic foot injuries can often lead to,

2 despite treatment, infections.

3 Q And what if anything does that mean in

4 terms of the impact on the patient or the implications

5 for the patient?

6 A Well, this patient when I examined her -- and
I

7 state in the chart that she had a nonfluctuant area in
8 her foot, so you have to press on the foot to see if
9 it's fluctuant or not because fluctuance would mean
10 there was an abscess, so when I examined her it was not
11 fluctuant, so it did not appear to be an abscess, and I
12 talked to her basically about her glucose, and I asked
13 her why her glucose was 300, and she told me she had
14 not taken her medicine that morning because she had
15 just come here, and by the time I had seen her she had
16 been there over six hours, and then we had a discussion
17 before she left, and she said she would either -- well,
18 she would see her doctor, and I told her she needed to
19 return if it was worse, and she said she would take her
20 medicine when she got home because she had not taken it
21 that day.
22 Q Had she eaten that day?
23 A That I do not know.
24 Q Had she eaten while she was in the E.R.
25 for that six hours?

24

1 A That I do not know.

2 Q Normally are patients fed in the E.R.?

3 A Only if there's an order to feed them.

4 Q Would that be in the chart?

5 A That would be in the chart.

6 Q Is there any indication of that?

7 A No.

8 Q Why don't we go through the chart? I'm

9 going to start with the page that says, Emergency

10 Physician Record, Foot or Ankle Injury.

11 (Emergency Physician Record, Foot or

12 Ankle Injury, marked as Exhibit Torrance-1A
for

13 Identification.)

14 Q Did you make any of the notations on

15 that page?

16 A No.

17 Q Did you read those at any point during

18 Roberta's visit?

19 A It's my common practice to read the chart,
yes.

20 Q Do you recall reading these?

21 A Specifically, no.

22 Q But you're saying in normal practice
you

23 would have?

24 A Yes.

25 Q Normally, if there were an entry --


1 first of all, do you have any idea who did fill this
2 out?
3 A No.
4 Q If there were an entry on this page
5 completed by someone else, which I guess from what
6 you're saying was the case in this circumstance, if
7 there were an entry on this page which conflicted with
8 something that you either elicited in speaking to the
9 patient in terms of history or observed on physical
10 examination, would you note that in your notations?
11 A Normally, yes.
12 Q So on the left there's a box entitled
13 "HPI" and "chief complaint." Just for the record
14 what's HPI?
15 A History of present illness.
16 Q Down under "context," where it says I
17 believe, "pain radiates to calf and thigh" -- does
that
18 look to you like what it says?
19 A Yes.
20 Q Do you recall whether or not you were
21 told that or if that differed at all from the history
22 that you took?

23  A        I do not recall.

24           Q       What, if anything, would that have

25  signified to you in terms of someone with a puncture in

26

1  their foot?

2  A        If there were other findings such as a fever or

3  a foreign body in their foot or a cellulitis that

4  extended to the calf or to the thigh, then it would

5  have had significance to me.

6           Q       What's cellulitis?

7  A        Cellulitis is a local skin infection.

8           Q       Moving down to where it says "VS" --

9  that's vital signs.  Correct?

10  A        Yes.

11           Q       Is there any significance to the heart

12  rate of 100?

13  A        A heart rate of 100 could mean several things.

14  The normal heart rate can go from 60 to 80, so a heart

15  rate of 100 could mean the patient is in pain.

16           Q       To the right of that it says "last

17  tetanus immunization"?  What does that say underneath

18  that?

19  A        I believe it says, "greater than five years."

20 Q What's the significance of that if any?
21 A Well, tetanus is a common immunization. It's
22 necessary usually every ten years, but sometimes with
23 an injury you would give it if there's an injury that
24 occurred greater than five years, so I mean, if nothing
25 has happened to you you should get it every ten, and if



1 something has happened to you, you should probably get
2 it every five.
3 Q Would that indicate that she should get
4 a tetanus immunization if that notation is accurate?
5 A Yes.
6 Q Let's go to the next page which looks to
7 me like a continuation on the top. It says
8 "leg/knee/thigh."
9 I didn't mention if you have any emergencies,
10 of course, you can break for those.
11 A Okay.
12 Q Do you have that next page where it says
13 "leg/knee/thigh" on the upper left?
14 A Yes.
15 Q Is that a continuation of the same form?

16 A Yes.

17 Q So I'm not going to mark that

18 separately.

19 A On the bottom there it says page two of two.

20 Q It does indeed. Did you make any

21 notations on this sheet?

22 A Yes.

23 Q Which notations did you make?

24 A Under "faculty."

25 Q What does it say?

28

1 A "Patient presents with two-day history of left

2 foot pain radiating into her calf. Patient describes

3 stepping on a nail," and then it says, "Left foot

4 one-by-one centimeter area, nonfluctuant, possible

5 abscess."

6 Q Below that?

7 A "Foot wound," and then there's my signature,

8 and I printed my name, and then put my physician ID

9 number.

10 Q On the upper right-hand corner there's

11 some notations?

12 A Yes.

13 Q Could you explain those please?

14 A The left notation is the lab work from what we
15 call the CBC.
16 Q Just for the record, that's complete
17 blood count?
18 A Complete blood count.
19 Q Go ahead.
20 A To the right is a notation of a chemistry
21 panel.
22 Q What do these reflect?
23 A Well, the white count --
24 Q Let me back up a little. Are these her
25 results?

29

1 A These are her results in terms of the CBC.
2 MS. WATTS: Just to clarify, is that
your
3 handwriting?
4 THE WITNESS: No.
5 Q Do you know who wrote that there?
6 A No.
7 Q Did you observe it?
8 A I recall observing them and reviewing them on
9 the computer. I'm most likely the person who circled
10 those, the 11.1 as well as the 316.
11 Q What are they and why did you circle

12 them? Start with, what are they?

13 A The 11.1 is the white blood cell count which is

14 a sign of infection, which you would suspect would be

15 very elevated if a diabetic had a foot infection

16 presenting 48 hours after their injury. Normally you

17 would see a white count of 15,000 to 25,000 at that

18 point because the infection had time to fester. I

19 circled it because it was basically within the normal

20 range, but at the top of normal depending on what lab

21 you use.

22 Q What's the top of normal for your hospital? Do

23 you know off the top of your head?

24 A I don't know specifically. Most labs tend to

25 be between 4,000 and 10.4 or 4,000 and 11.8 depending

30

1 on the lab.

2 Q I'm going to give you a result from

3 later in Ms. Langhorne's care just for reference, and

4 actually I think I'll that mark as Torrance-2.

5 (Blood test results, marked as Exhibit

6 Torrance-2 for Identification.)

7 Q Do you see a reference range for the

8 white blood cells?

9 A On this it says 4.5 to 11.0.

10 Q So she was -- her result was slightly

11 above that. Correct?

12 A .1 above the range for University Hospital.

13 Q And below that somebody wrote "seg 75."

14 What does that mean?

15 A Seg is a type of white blood cell count.

16 Q What's their significance?

17 A Their significance if they are usually above 90

18 percent, it could mean that an infection is present.

19 Q Were you going to say something else?

20 A They can be elevated just from stress, pain.

21 Q Do you know off the top of your head

22 what the upper limit is for the percentage at

23 University Hospital?

24 A Usually seg should probably be about two-thirds

25 of the white blood cell count.

31

1 Q So these are a little above that.

2 Correct?

3 A Yes.

4 Q The other circled result is 316. What's

5 that result?

6 A That's the glucose.

7 Q What's the significance of that?

8 A The significance is if a patient had taken the

9 medicine, it would be that it's elevated despite

10 therapy, but the patient had told me she did not take

11 her medicine that day, so I did not find it that

12 significant.

13 Q Would it be significant if she had not

14 eaten?

15 A If she had not -- let me think about that

16 question for a moment. I guess that would depend on

17 what time she took the medicine.

18 Q Hypothetically if she had taken her

19 medicine and eaten normally the day before but had

20 neither taken medicine nor eaten that day, would --

21 first of all, that's an elevated blood sugar. Correct?

22 A Yes.

23 Q Would an elevated blood sugar be

24 significant?

25 A If you were normally untreated, it would be

32

1 significant, but if you explained why it's elevated,

2 then I would not take it as significant.

3 Q Just to have everything clearly on the

4 record, what is an abscess? You said "possible

5 abscess"?

6 A An abscess is a contained space of infection.

7 Q Let's move to the next page.

8 A The MSE form.

9 MR. BERGE: We will mark that whatever

10 the next letter is.

11 (Medical screening exam, marked as

12 Exhibit Torrance-1B for Identification.)

13 Q I think you might have mentioned that

14 before, but what's the MSE?

15 A Medical screening exam.

16 Q And who was that done by?

17 A I cannot make out the signature.

18 Q Can you make out or do you know the
type

19 of practitioner it was?

20 A That's a nurse practitioner.

21 Q And that's an I.D. number by the name?

22 A Yes.

23 Q Did you look at this either before or

24 during your evaluation of Roberta Langhorne, the
medical

25 screening exam?

1 A I don't recall directly, but my normal practice

2 would be to review it.

3 Q Can you read what it says under "chief

4 complaint"?

5 A "Jogging and stepped on nail two days ago."

6 The next word I cannot read, and then the word after

7 that says "painful."

8 Q That wouldn't be "now red, painful"?

9 A I guess it could be.

10 Q But you're not sure?

11 A I'm not sure.

12 Q Down at the bottom of that same left

13 column where it says "vector exam" -- what does that

14 mean?

15 A The medical screening exam is just -- vector

16 exam means an exam of just where the complaint is,

17 meaning that if it's a foot complaint they wouldn't

18 examine the heart or the lungs or the abdomen.

19 Q What does that say?

20 A It says, "Positive swollen, tender." I think it

21 says -- "site of wound" is crossed out and "nail

22 entry."

23 Q Actually there's a notation on the right

24 at the top where there's some labs that were also noted

25 there, ESR and CRP. What are those?



1 A An ESR is a sed rate. It's a nonspecific test

2 often used in rheumatology, lupus, things along those

3 lines.

4 Q And what's the significance in this

5 situation?

6 A I'm not sure what their thought process was for

7 their significance because it's normally not my

8 practice to send sed rates on infections.

9 Q Why is that?

10 A It's not really in the standard literature all

11 the time to send a sed rate.

12 Q Do you know if a result ever came back

13 for that?

14 A That I do not know.

15 Q Did you see it noted anywhere?

16 A No.

17 Q And CRP?

18 A CRP is a relatively new study. It's called a

19 C-reactive protein. It's not really in emergency

20 medicine literature. It actually wasn't present when I

21 trained. It's something orthopedic people would often

22 send.

23 Q It's not something that you would have

24 normally looked at in a patient such as Roberta for an

25 emergency visit?



1 A No.

2 Q Below that under "progress," what does

3 that say?

4 A It says, "DT greater than five years."

5 Q What does that mean?

6 A I think they're noting the presence of tetanus

7 or not.

8 Q And then below under "plan"?

9 A It says, "labs." I'm not sure what the next

10 word says.

11 Q And then the signature of the nurse

12 practitioner?

13 A Yes.

14 Q The next page with pictures of body

15 parts, I don't see any notations on that. Do you?

16 A No, there's only a notation of the body part

on

17 the previous sheet, page one of the two sheets.

18 Q Where the puncture was. That's

19 Torrance-1A. So it looks like the bottom of the right

20 foot. Is that right?

21 A Yes.

22 Q There's a dot, and then what does it say

23 underneath that?

24 A It looks like "TSE," but I do not know what

25 that stands for.



1 MS. WATTS: For the record, I think it's

2 the left foot, isn't it? I believe you said right.

3 THE WITNESS: Left foot.

4 MS. WATTS: We're looking at it from the

5 mirror image.

6 Q Which foot is that? Are you saying it's

7 the right or the left?

8 A It was her left foot.

9 Q But I mean this picture, isn't that a

10 picture of the right foot?

11 A I think if you would be standing looking down

12 at your feet --

13 Q Well, you have on the left there, you

14 have the dorsum of the feet. Correct?

15 A Yes, you do.

16 Q And on the right you have the bottom, so

17 we're looking at the bottom on those?

18 A Yes, because it looks like it goes right, left,

19 right, left.

20 Q If you were looking at the bottom of the

21 feet --

22 MS. WATTS: It's the patient's left foot.

23 Right?

24 THE WITNESS: Okay.

25 Q I don't know. If I'm lying flat down --

37

1 anyway, whatever. In any case, it was however in

2 actuality the left. Is that correct?

3 A Yes.

4 Q Is that, assuming it was on the correct

5 foot, approximately where the puncture was?

6 A It was in the metatarsal area of the foot.

7 Q What is that for the lay readers?

8 A You have the bones in the midfoot, and then the

9 bones of the metatarsals which are actually in the

10 foot, and then you have the bones of the toes, of the

11 phalanxes of the toes.

12 Q Skipping ahead to the Nurse Triage

13 Assessment Notes, other than really a name and number

14 at the top and a date, I just see a big sort of

15 scribble in the middle of the page. Do you have any

16 idea what that says?

17 A Epic.

18 Q Epic?

19 A Yes, it's the computer system at the hospital.

20 Q What's the significance of that being

21 written there?

22 A Normally when I see that, that means the
triage

23 is in the computer. It's no longer handwritten. It's

24 done in the computer.

25 Q Again, for the lay reader what is the
38

1 triage?

2 A The triage is the initial evaluation on

3 presentation from a nurse.

4 Q On the next form I have, the next page
I

5 have is nursing intervention?

6 A Yes.

7 (Nursing intervention form, marked as

8 Exhibit Torrance-1C for Identification.)

9 Q Is that something you looked at during

10 your evaluation and care of Ms. Langhorne?

11 A This, no.

12 Q Do you ever look at it?

13 A I would, but these were the orders -- I guess

14 what I'm trying to say is I wrote orders for

15 antibiotics and pain medicine on the order sheet, and

16 it was documented that it was done, so it's just the

17 same thing written in two different places, so I had

18 observed it on my order sheet, and the labs you could

19 see were sent when I reviewed the medical screening

20 exam because the nurse just writes MSE because it's
not

21 this nurse that sent the labs.

22 Q But you are accustomed to looking at

23 these at one time or another?

24 A Yes. I know what information is there. It
was

25 just on another spot on the chart.

39

1 Q I understand. Looking at this now,

2 could you tell me what this says?

3 A It says, "Levaquin, 500 milligrams PO," which

4 is orally, and then it says, "Percocet, one tab PO,"
5 which also means orally.
6 Q Are there times on those?
7 A There are no times here. Here, yes, 1755.
8 Q Which is what in normal people time?
9 A 5:55.
10 Q Do you know if that reflects the time
11 ordered or the time given?
12 A I would have to look at what time I wrote the
13 order. I wrote the order at 5:50.
14 Q Would that likely be the time given or
15 do you know?
16 A I would have to go with the documentation.
The
17 nurse documented that they gave it at 5:55.
18 Q What's Levaquin?
19 A Levaquin is a fluoroquinolone antibiotic.
20 Q What's Percocet?
21 A Percocet is a pain medicine. It is five
22 milligrams of Codeine with 325 milligrams of Tylenol.
23 Q Codeine?
24 A Yes.
25 Q It's not hydrocodone?
40

1 A No.

2 Q But it's a narcotic?

3 A Yes.

4 Q On the next page, nursing assessment, I

5 just want to go down that.

6 (Nursing assessment, marked as Exhibit

7 Torrance-1D for Identification.)

8 Q Do you recall looking at this?

9 A I do not recall looking at this.

10 Q Would it be your normal practice to look

11 at it?

12 A The nurse's assessment, it would be my normal

13 practice to look at it.

14 Q I just draw your attention to the middle

15 column, maybe a third of the way down where it says

16 "neuro." They've circled alert and oriented times

17 three. What's oriented times three?

18 A She knows person, place and time.

19 Q Is that normal?

20 A Yes.

21 Q Below that where it says "psych," it has

22 circled, "cooperative, affect normal"?

23 A Yes.

24 Q And eye contact?

25 A Yes.



1 Q Is that consistent with your

2 observations?

3 A Yes.

4 Q The next page, Nursing Assessment and

5 Progress Notes, did you look at that time at the time

6 that you were taking care of Roberta?

7 A I normally would. I don't recall if I looked

8 at it that day.

9 (Nursing Assessment and Progress Notes,

10 marked as Exhibit Torrance-1E for

11 Identification.)

12 Q Now, can you read for me what the first

13 line says again acknowledging -- these are nursing

14 notes. These were made by a nurse and not by you?

15 A Yes.

16 Q Are you able to read that first note

17 that starts at 1715?

18 A Yes, it says, 5:15, "Received patient AAO times

19 three. No distress. Positive mild edema to left

20 foot." There's a question mark, and then it says,

21 "Foreign body. Pedal pulses palpable. Await M.D.

22 eval."

23 Q Is anything there inconsistent with your

24 assessment?

25 A No.



1 Q What is edema?

2 A Edema is swelling.

3 Q Then down at the bottom where it says

4 1900, what does that say?

5 A "D/C home, AAO times three. Prescription

6 given. RX given. D/C'd with family via wheelchair."

7 Q Does that sound about right in terms of

8 when she would have been discharged from your

9 involvement?

10 A I'm looking at the record. I wrote a discharge

11 at 6:55.

12 Q And 1900 is 7:00?

13 A The 1900 is 7:00, and it appears on the

14 computerized record that she was -- that this was

15 printed at 7:13 p.m., the discharge record.

16 Q When you're saying "this," just to be

17 sure we're on the same page this says, "University

18 Hospital Emergency Department" at the top. "Patient,

19 Roberta Langhorne," and then the mailing address which
20 is blank, and then it says "dispo summary printed." Is
21 that the same page we're talking about?
22 A Yes.
23 Q What is that page?
24 A This page is the first page of a computerized
25 system called Wellsoft. This is the form that goes
43
1 into the chart, and then there's a second form with
2 instructions that goes to the patient.
3 Q So this would have been printed out
4 before she left?
5 A Yes, she would have had to sign and then been
6 given these instructions.
7 Q Where would she sign?
8 A Looking at the record going back to the first
9 page that I have, it's here. It says, "I've received
10 my discharge instructions and they have been explained
11 to me."
12 Q That's the first page that's marked on
13 here?
14 A Yes.
15 Q Let me go back just so we're staying in
16 order. This is a physician order sheet.

17 MR. BERGE: Why don't we go ahead and

18 mark this one?

19 (Physician order sheet, marked as

20 Exhibit Torrance-1F for Identification.)

21 Q Now, did you make notations on this

22 page?

23 A Yes.

24 Q There are notations that you did not

25 make. Correct?

44

1 A Yes.

2 Q Which are those?

3 A The top four lines where the nurse practitioner

4 wrote at 3 p.m.

5 Q And can you just read me the notations

6 that you did make? First of all, these are notations

7 that you wrote for the nurses to carry out. Is that

8 correct?

9 A Yes.

10 Q Can you read to me what it says?

11 A The first notation is 4/17, April 17th, 5:50.

12 "Percocet, one tab by mouth. Levaquin, 500 milligrams.

13 Left foot x-ray."

14 Q That's your signature?

15 A Yes.

16 Q The next one?

17 A 4/17 at 6:55. "D/C home. Foot wound.

18 Prescription for Levaquin and Percocet."

19 Q And then your signature?

20 A Yes.

21 Q Go to the next page which in mine is a

22 radiology report.

23 (Radiology report, marked as Exhibit

24 Torrance-1G for Identification.)

25 Q That's been marked Torrance-1G for

45

1 Identification. What is that sheet?

2 A This is a document showing the x-ray report.

3 Q Of the left foot?

4 A Yes.

5 Q And that's the x-ray that you ordered?

6 A Yes.

7 Q What was the purpose of that x-ray?

8 A To rule out a foreign body because she had

9 stepped on a nail. To rule out there was no piece of

10 the nail in her foot.

11 Q Could that give you clinically any

12 information in her case?

13 A Yes, it could show if there were evidence of

14 what we call osteomyelitis which is an infection of the

15 bone.

16 Q Did you look at that x-ray?

17 A My normal practice is to look at the x-ray but

18 review it with the radiology resident.

19 Q Do you recall doing that in this case?

20 A I do not recall, but my general practice is to

21 always go to the radiology resident.

22 Q What is the actual reading there?

23 A The reading here is the attending's. It's not

24 the resident's. It says, "Three views of the left

25 foot. Soft tissue swelling is demonstrated in the

46

1 plantar region near the heads of the metatarsals,"

2 which is that part of the midfoot. "There is no

3 evidence of fracture or radiopaque foreign body. There

4 is a calcaneal" -- your guess is as good as mine how to

5 pronounce that. They're saying it's an osteophyte in

6 the calcaneus, which is the rear part of the foot.

7 Q What if anything is the significance of

8 that report?

9 A The significance was that they did not find any
10 foreign body because a nail would be radiopaque, and
11 then they did not discuss anything about signs of
12 infection in the bone.
13 Q What about the soft tissue swelling?
14 First of all, when they say soft tissue swelling of the
15 plantar region near the heads of the metatarsals, what
16 does that mean exactly?
17 A Basically it's the ball of the foot.
18 Q On the skin or is it inside? Where is
19 it in terms of depth?
20 A They don't actually talk about depth. They're
21 just talking about the region of the foot. The
22 metatarsals are the bones proximal to the toes where
23 she actually had the puncture wound.
24 Q It would be in lay terms back from the
25 toes or toward the heel from the toes?

47

1 A Toward the heel from the toes.
2 Q Soft tissue is what?
3 A Edema, which was noted.
4 Q Soft tissue as opposed to bone?
5 A Yes.

6 Q So there was swelling near the heads of
7 the metatarsals. What's the head of the metatarsals?
8 A You have the metatarsals. The head of the
9 metatarsals is the part closer to the toes, and then
10 you have the bones to the toes.
11 Q That would be in the area of the
12 puncture wound?
13 A Yes. She had a puncture basically at the base
14 of the metatarsus.
15 Q The puncture wound was at the
16 metatarsus?
17 A If you're talking about the metatarsus, I'm
18 using my hand as a demonstration because it's basically
19 the same, but they're called the metacarpal bones. She
20 had a puncture wound here, basically at the head of the
21 metatarsus.
22 Q At the head?
23 A Right.
24 Q Which is where they're talking about in
25 the radiology report?

48

1 A They are talking about similar, yes, that
2 region.

3 Q So they were saying the soft tissue had

4 swelling?

5 A Some soft tissue swelling.

6 Q On the next page that I have which says,

7 "Admission Medication Reconciliation," do you have

8 that?

9 A Yes.

10 (Admission Medication Reconciliation,

11 marked as Exhibit Torrance-1H for

12 Identification.)

13 Q That's marked Torrance-1H for

14 Identification. Is that something that you looked at?

15 A I don't recall if I looked at it.

16 Q You didn't write that, did you?

17 A No.

18 Q Would you normally look at it?

19 A If the medications were not documented

20 somewhere else in the chart, then yes, I would look at

21 it or if they were on several medications.

22 Q What does it indicate on this page?

23 A It indicates the patient has no allergies, that

24 the patient took Metformin which is a diabetic

25 medication which is twice a day, and that it was signed

1 by a Nurse Janet Clausson.

2 Q Does it say how often it was taken, that

3 it's taken twice a day on this sheet, or are you saying

4 that from your knowledge?

5 A From my knowledge.

6 Q But it doesn't say anything about the

7 route or the frequency in this case, does it?

8 A No.

9 Q Or the last dose?

10 A No.

11 Q As a matter of fact, anywhere in the

12 chart is there anything to indicate when she took her

13 last dosage of Metformin?

14 A Not in the chart.

15 Q There's nothing to indicate her last

16 meal?

17 A Not that I've seen in the chart.

18 Q In your experience, is it common to have

19 to order narcotic medication for a puncture wound two

20 days after it happened?

21 A Yes. I mean, everyone's pain scale is

22 different. You can't say that one person feels pain as

23 opposed to another person that feels pain.

24 Q Now, the Percocet was given at 5:55 and

25 the discharge instructions were printed at 7:13?

50

1 A Yes.

2 Q Would you expect that narcotic to have

3 taken effect by the time she was being discharged?

4 A Within an hour you would have seen some effect.

5 Q So that's a little over an hour and a

6 quarter. Correct?

7 A Yes.

8 Q She was given Percocet and Levaquin in

9 the E.R. and also discharged with those?

10 A Yes.

11 Q With prescriptions for those I should

12 say?

13 A Yes.

14 Q The Percocet was for pain. Right?

15 A Yes.

16 Q What was the purpose of the Levaquin?

17 A The Levaquin is an antibiotic. She did have

18 some edema at the site, and she is diabetic, so

19 standard would be to cover the patient with antibiotics

20 because there's no way of telling if any bacteria is in

21 the wound, so I discussed with her that antibiotic,

22 Levaquin, and I gave her a prescription for Levaquin

23 and then asked her to follow up.

24 Q What kind of footwear was she wearing

25 that the nail went through when she had the puncture?

51

1 A I don't recall. I think if we look at the

2 chart, she was wearing a sneaker.

3 Q Does that have any medical significance?

4 A Sometimes sneakers can carry a bacteria called

5 pseudomonas.

6 Q What's the drug of choice for

7 pseudomonas?

8 A Orally Levaquin would cover pseudomonas.

9 Q Is that the most effective oral drug for

10 pseudomonas?

11 MS. WATTS: Objection to form, "most

12 effective."

13 A That I would not know because you would have to

14 culture any bacteria and do a sensitivity and

15 specificity test on it.

16 Q Is Levaquin the preferred drug for

17 treatment or prevention of pseudomonas infection if you

18 don't have a culture?

19 A I couldn't tell you from the literature. My

20 practice and that of my colleagues is to use Levaquin,

21 especially if the patient has insurance because it's a

22 very expensive medication.

23 Q Now, you said to cover the patient, to

24 cover the patient with an antibiotic. At different

25 places in the chart it says she had swelling. She had

52

1 edema, redness. You said there was a one-by-one

2 centimeter area that was not fluctuant, but she had a

3 possible abscess. Was that antibiotic being given to

4 prevent an infection or to treat an infection?

5 A To prevent an infection. I mean, she had a

6 local injury. She did have a break to the skin. The

7 most common bacteria would be strep and staph that are

8 on the skin, so it's safe to assume that either strep

9 or staphylococcus could be in that wound, and being a

10 diabetic who is immunocompromised you would always give

11 antibiotics.

12 Q So in this patient -- let's see. She
13 had a puncture wound that was two days old, pain
14 radiating to her calf and thigh, redness, soft tissue
15 swelling, rapid pulse, slightly elevated WBC, slightly
16 elevated segs, elevated blood sugar. First of all, did
17 you feel that she did not have any signs of infection?
18 A Well, her pulse could definitely be secondary
19 to pain. She said she was in severe pain. Pain
20 radiating to the calf and the thigh does not seem to go
21 along with the injury in the foot unless she had a more
22 significant injury, unless you were thinking of some
23 other type of injury, as though maybe she fell after
24 she stepped on the nail. I don't know that. Her white
25 count was 11.1 which in my experience if a diabetic is

53

1 two days after an injury, that is within a normal
2 range. I think if I could look at this -- the other
3 thing that you would look for is what we call bands,
4 which is another type of neutrophil, and those are
5 young neutrophils that are acutely fighting infection,
6 and if that is elevated, then you would suspect that as

7 a current infection now, but she had no bandemia on the

8 lab work that was sent, looking at it now, and she did

9 not have a fever.

10 The other thing was that I talked to her about

11 this. I said to her, "You are diabetic." She gave me

12 an explanation for her elevated glucose saying she had

13 not taken her medicine, saying that she did want to go

14 home because she had been there about seven-and-a-half

15 hours at that point, and that she would take her

16 medicine and she would follow up with her physician.

17 On the discharge which we cannot see here, the

18 second page of Wellsoft for foot injury it basically

19 says that this visit is for emergency care only. I'm

20 paraphrasing that, and you should follow-up with your

21 physician or with the medical clinic. Now, that is not

22 in this chart, but if you would have someone go to

23 University Hospital and pull the program, the program

24 of Wellsoft, the sheet that she was given says that in

25 bold print.

54

1 (Computer printout, marked as Exhibit

2 Torrance-1I for Identification.)

3 Q Would that, at least the content of that

4 be reflected here on the first page, under disposition
5 --
6 A With our program here it's not reflected, but
7 with the actual program the patient is given the sheet
8 that they sign for. It says that they should follow
up
9 with their physician or with the medical clinic, and
10 then I discussed with her returning if it got worse,
11 and I actually saw her when she did return.
12 Q Is there anywhere that you noted that
13 discussion with her in the chart?
14 A No, I did not note that, but I did remember
15 that because when I saw her when she returned -- I'm
16 not sure if it was the 24th or 25th. I saw her -- my
17 shift was over. She was in the emergency department
18 waiting room. I saw her. I asked to look at her foot
19 because I remembered her, and it was much more
20 edematous than it was when we saw her on the 17th, and
21 I basically said, "You need to come in. You've
22 basically had antibiotics and you still have an
23 infection," and I actually went and got her chart and
24 brought her to the front of the line, which caused me
a
25 lot of grief because there were about 50 patients
ahead

1 of her, and they all cursed and yelled at me, and I
2 brought her immediately to a bed and gave her to Dr.
3 Shahiti, who is the Chief of the Emergency Division,
4 and he saw her on the second visit, and I don't have
5 that chart here, but that's what it shows.
6 Q Where it says on the page that we
7 have -- I'll refer back to the marking. It's
8 Torrance-1I. What are we calling this page?
9 A This is a sheet from a program called
Wellsoft.
10 It's a computerized program that University Hospital
11 uses to print out discharge instruction. These are
one
12 out of two pages, possibly three pages that were
13 printed out, but this is the page that goes into the
14 record. The other two pages are given to the patient.
15 Q Where it says "disposition," that says
16 the medical clinic. Where it says follow-up one and
17 the time, the patient calls for an appointment?
18 A The time?
19 Q In terms of follow-up date. It says --
20 A It says call for an appointment, but at that
21 time she said that she had a regular physician. Now,
22 most people who have a regular physician will go to
23 their regular physician, but you have to provide some

24 other means of follow-up in case they cannot get to
25 their physician.



1 Q If a patient has an infection, you've
2 mentioned a white blood cell count of 15,000 or higher.
3 You mentioned the presence of bands. Is there a point
4 in the evolution of the infection before that when the
5 white count has not yet risen that high?
6 A There can be.
7 Q Is there a point at which the body isn't
8 producing bands yet and you won't see those?
9 A There would be. It's never safe to assume, but
10 you would think that 48 hours later since those are the
11 youngest cells and the first ones made, that they would
12 be present at that time.
13 Q Wouldn't that be in conjunction with a
14 higher white blood cell count?
15 A No, you can have bands with any white blood
16 cell count. You can have a white blood cell count of
17 two and have 30 bands say in an HIV immunocompromised
18 patient or a breast cancer patient who is on
19 chemotherapy. They can have a white count of 0.5 and

20 50 bands.

21 Q You mentioned immunocompromised

22 patients, and diabetics are immunocompromised. Is the

23 response that an immunocompromised patient mounts

24 against infection less than in people who are found not

25 to be immunocompromised?

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1 A They're able to mount a response, but their

2 response may not be the same.

3 Q So it could be atypical?

4 A Yes.

5 Q Was she given a tetanus shot?

6 A It's not documented here.

7 Q Did you order one?

8 A I did not order a tetanus shot, though -- which

9 is the case not necessarily that's a problem unique to

10 University Hospital. It's a problem in emergency

11 medicine that for the past three years there's

12 approximately two to three months a year where we don't

13 have a tetanus shot to give.

14 Q Do you document that when that's the

15 case?

16 A In my practice I have not documented it.

17 Q You have not?

18 A No.

19 Q Is the patient counseled to obtain one

20 from somewhere or --

21 A They're counseled -- in my practice if we don't

22 have it, I tell them to get it from their private

23 physician.

24 Q What's the period of time that you can

25 safely wait to get a tetanus shot if you have an injury

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1 that would normally require one?

2 A The exact amount of days I'm not sure.

3 Q Is there any cure for tetanus?

4 A There's a treatment for tetanus. I would have

5 to have a text -- actually, I've never treated a

6 patient with tetanus.

7 Q It's very serious, isn't it?

8 A It is.

9 Q Is there anything in the chart to

10 indicate that she was advised to get a tetanus shot?

11 A No, that is just per my conversation with her

12 about diabetes, about her elevated glucose, about why

13 she didn't take her medicine that morning and how she

14 said she would take the medicine when she went home.

15 She was actually pretty eager to go because she had

16 been there for eight hours, which is about the standard

17 in our emergency department on a busy day.

18 Q If a diabetic patient, and not

19 necessarily Roberta Langhorne, comes into the E.R.

20 having just sustained a puncture wound, when should

21 they be rechecked? After what period of time if any?

22 A You would tell them -- which I had told her

23 verbally -- to be rechecked with any signs of worsening

24 symptoms, and you would probably want the patient to be

25 checked within two or three days by their private

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1 physician.

2 Q Did you give Ms. Langhorne any

3 information or instructions about the antibiotics she

4 was taking?

5 A I remember telling her once daily.

6 Q Did you tell her what it was for?

7 A I told her that she is a diabetic, and she runs

8 a high risk of infection in her foot, and she should

9 come back if it gets worse. She should follow up with

10 her physician.

11 Actually when I saw her when she returned I

12 said, "Why didn't you return sooner or go to your

13 doctor?" She said she did not go to her doctor and she

14 said she was going to continue -- she knew it was

15 worse, but she was going to continue the antibiotic

16 hoping it would get better.

17 Q Did you tell her the purpose of the

18 antibiotic, in other words, why you were prescribing it

19 for her?

20 A To try to prevent infection because she having

21 some edema. She did not have a foreign body, and there

22 was no signs of infection in the bone on the x-rays,

23 and that we were going to start her on oral

24 antibiotics.

25 Q To prevent infection?

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1 A To prevent infection.

2 Q Did you tell her anything about how long

3 antibiotics take to work or to have an effect?

4 A That I can't recall.

5 Q Do you usually?

6 A No. Like how long -- I'm sorry.

7 Q When you prescribe an antibiotic, do you

8 tell the patient this should kick in or this should

9 work in X period of time?

10 MS. WATTS: Objection. It depends on the

11 antibiotic and the case. Do you want to give a

12 specific example or this case?

13 MR. BERGE: No, because he doesn't

14 remember but in general.

15 A In general I tell them what the antibiotic is

16 for and on what schedule they should take the

17 antibiotic and what side effects they may have from the

18 antibiotic. In her case I just told her, "You're on

19 this antibiotic, but if you do have signs of infection,

20 you need to return."

21 Q And again, that's not noted anywhere?

22 A No.

23 Q No, it's not or yes, it's correct? That

24 was a bad question.

25 A It's not on this chart. It is noted on the

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1 second page of Wellsoft that she needs to follow with

2 her doctor or return to the medical clinic, and we also

3 noted that we told her to call for an appointment in

4 the medical clinic so she would have follow-up.

5 Q That appointment -- do you happen to

6 know if someone calls today for an appointment when

7 they'll get into the medical clinic?

8 A Right now, no. Oftentimes it can be an

9 extended period of time if they do not preface it with,

10 "I was seen in the emergency department." If the

11 person does not say the emergency department, it could

12 be a month or more, but again, she told me that she had

13 a private physician, so you wouldn't think that she

14 would follow up in your clinic if she says she's going

15 to her doctor.

16 Q If she were to act consistently with

17 this, she could have called her doctor and made an

18 appointment?

19 A Yes.

20 Q Theoretically that could be in a week?

21 A I don't know her doctor. Theoretically it

22 could be in a week, but we also told her to return if

23 it was worse, and then when she returned I asked her,

24 "If this is worse why didn't you return sooner," and

25 she said she was going to continue the antibiotics,
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1 that she knew it was worse and that we had told her to
2 return but she wanted to wait.
3 Q When she left and you had this
4 conversation with her, that was at her discharge?
5 A That was at her discharge.
6 Q And she had already taken the narcotics?
7 A Yes, she had taken one Percocet about an hour
8 and a quarter before.
9 Q And you said she had been there for
10 about eight hours now, something like that looking at
11 the chart?
12 A This chart was made at 11:45, and I saw her
13 sometime after 5:00.
14 Q Initially?
15 A Yes.
16 Q Do you refer to any emergency medicine
17 texts in your practice?
18 A Yes.
19 Q Which ones?
20 A Usually Tintinalli's.
21 Q Have you used or referred to Rosen's
22 Emergency Medicine text?

23 A Yes.

24 Q Since you saw Ms. Langhorne come in

25 when she returned with a worsening infection subsequent

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1 to that, did you have any discussions with any other

2 providers regarding her case, any other physicians?

3 A No. Between her first visit and her second

4 visit?

5 Q After, when you saw her come back. You

6 said you actually saw her come in and you took her

7 ahead of the line.

8 A I actually saw her sitting in the room waiting

9 to be registered to be seen, so she was the newest

10 person when I saw her. I took her chart, and I took

11 her inside despite other patients.

12 Q And you caught flack for it, but my

13 question is since you were aware that she had come back

14 with this additional edema and you made sure she was

15 seen right away subsequent to that, after that did you

16 discuss her case with any other physicians informally

17 to start with?

18 A Informally, my boss had said that he had

19 admitted her to podiatry, that they had started her on

20 some other antibiotics. I don't recall what antibiotic

21 it was, and she was admitted to podiatry.

22 Q Did you have any other further

23 discussions either with your boss or with anyone else?

24 A The patient advocate came to me and said that

25 the patient was upstairs and she was upset about her

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1 infection in her foot, and then I told the patient

2 advocate I would like to see the patient, but she said

3 she did not want to see me.

4 Q Were you involved in any meetings or

5 reviews or formal discussions of that case?

6 A No.

7 Q Are you aware of any meetings, reviews

8 or formal discussions of that case?

9 A No.

10 Q Or grand rounds, anything like that?

11 A No.

12 Q Would you agree that given her white

13 count, the swelling, the pain, the redness, et cetera,

14 that she might have had signs of an early infection

15 when you saw her?

16 MS. WATTS: Objection. Now or then?

17 MR. BERGE: I don't understand your

18 objection.

19 MS. WATTS: Are you talking about did
he

20 think infection now or did he think she had infection

21 looking back on it now?

22 Q Do you think that now given those

23 things?

24 A Even then she does have some local edema, so

25 she has sustained an injury. It doesn't appear that



1 she has a systemic or a widespread cellulitis

2 infection. Does she have a local infection right at

3 the puncture wound? I would say yes, and that's why
we

4 covered her with antibiotics.

5 If I attempted to admit this patient to the

6 hospital, it would not have happened. They would have

7 discharged her.

8 Q Why is that?

9 A Basically the medical attending or consult in

10 my experience admitting patients from an emergency

11 department would come and say that the patient does
not

12 have bands, does not have signs of bony infection,
does

13 not have fever, and it's covered by antibiotics, has

14 explained why her glucose is elevated, and has said

15 that she would take steps to correct it herself, and

16 she has a private physician with which she could follow

17 up.

18 Q And you said medical. You didn't obtain

19 a surgical or podiatric consult. Correct?

20 A No, because she had a private physician. If I

21 thought she had needed admission, I would have

22 consulted them. What most likely would have happened

23 if they consulted is they would have discharged her.

24 Q The second page which we have marked as

25 Torrance-1A which is the Emergency Physician Record,

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1 Foot or Ankle Injury, in your faculty note you say a

2 one-by-one centimeter area nonfluctuant. Area of what?

3 Do you know what you meant by that?

4 A Edema.

5 Q So swelling?

6 A Yes.

7 Q And possible abscess, in other words,

8 there could be an abscess?

9 A Yes, my differential diagnosis is possible

10 abscess, so that's to rule out osteomyelitis which is
11 the infection of the bone which the x-rays are for.
12 Q Did the x-ray -- first of all, to be
13 clear again for the record, what does "rule out" mean?
14 A To make sure that that doesn't exist.
15 Q Can an x-ray rule out that osteomyelitis
16 doesn't exist?
17 A If osteomyelitis is present on x-ray, it can be
18 detected, but that oftentimes is up to the skill level
19 of the radiologist. I mean, I've had patients who they
20 said osteo and patients that they don't say osteo, and
21 maybe it was osteo. I'm not a radiologist.
22 Q My question though is if osteomyelitis
23 is not seen on a plain x-ray, does that rule out
24 osteomyelitis? Does that mean the patient doesn't have
25 it or does that rule it out?

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1 A It's the test you use to rule it out. I'm not
2 sure of the question, does it rule it out.
3 Q Did you in your mind rule out
4 osteomyelitis when you took that x-ray and the
5 radiology resident said there were no signs of it?

6 A Yes. They had told me that there were no signs

7 of it. They reviewed the x-ray, so they told me there

8 was no foreign body, and they did not document anything

9 about osteomyelitis.

10 Q So in your mind osteomyelitis was ruled

11 out?

12 A It was highly unlikely.

13 Q Are you aware of any other studies that

14 you could do that would be more accurate or sensitive

15 to rule out osteomyelitis?

16 A There are other studies, not that are commonly

17 used in an emergency department.

18 Q When you said "possible abscess," are

19 there any diagnostic studies that could detect whether

20 or not there was an abscess?

21 A If there were fluctuance, you could have done a

22 needle aspiration.

23 Q So in an area that has a possible

24 abscess but isn't fluctuant, are you aware of any

25 radiologic study that you could do that would rule in

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1 or out an abscess?

2 A Not available in the emergency department.

3 (Whereupon, a break was taken.)

4 Q Does the University Hospital emergency

5 department have any sort of treatment guidelines for

6 specific types of injuries?

7 A Itself? I would say no. It would be standard

8 practice of emergency medicine.

9 Q Would you agree with the statement that

10 patients with puncture wounds to the foot require early

11 follow-up?

12 A Yes, that's why we told her to follow up early,

13 and I was upset with her when she came back five days

14 later and said, "Why didn't you come sooner?"

15 Q Would you agree or disagree with the

16 statement that treatment for diabetic patients with

17 infection includes rapid culture and antibiotics,

18 glycemic control and generally hospitalization?

19 A With diabetic infections?

20 Q That treatment for diabetic patients

21 with infection includes rapid culture and antibiotics,

22 glycemic control and generally hospitalization?

23 A Yes.

24 Q Was anybody else during --

25 MR. BERGE: Strike that.

1 Q During the April 17th, 2006 visit when
2 you saw Roberta Langhorne, was anyone else involved in
3 the treatment decisions regarding her care other than
4 you?
5 A No, but I did not order the lab work.
6 Q I notice on the radiology report that it
7 just said rule out foreign body. Do you think it would
8 have been helpful to the radiologist to know that this
9 was a diabetic with a puncture wound?
10 A Actually, my common practice is when I go to
11 speak to the radiologist I tell them what the patient
12 has.
13 Q And that's the resident who is there at
14 the time?
15 A Right.
16 Q Is that who dictates the final report
17 such as the one that's here in the chart?
18 A In this case -- it's never who dictates the
19 final report.
20 Q The person who dictates the final report
21 isn't the person you talked to?
22 A That's correct.

23 Q That's correct?

24 A That's correct.

25 Q So again, do you think it would have



1 been helpful for the person who dictated the final

2 report and did the final reading to know that this was

3 a diabetic patient with a puncture wound?

4 A I do not know if they did or did not know that

5 because the order form is not here, the actual

6 radiologic request form.

7 Q Where it says -- we'll go back to this.

8 It's marked Torrance-1G. Where it says, "History,

9 47-year-old female, rule out foreign body," where would

10 that have come from?

11 A Well, they would have had a request form that

12 would have had some writing on it, and then they would

13 have pulled from it in its entirety or piecemeal what

14 they needed to dictate.

15 Q So the radiologist who did the final

16 report and dictated this body of information, that was

17 written on the form to look at? Is that right on the

18 order form?

19 A I believe so, yes.

20 Q Did you write the order form or did

21 someone else?

22 A That I cannot recall. I wrote the order to

23 have it done, but I cannot recall whether I wrote the

24 actual radiologic request form.

25 Q Had it been written on the order form



1 that this was a diabetic with a puncture wound, do you

2 know whether or not that would have been placed here on

3 the history?

4 A No, I do not know.

5 Q From your knowledge of hospital workings

6 and of this hospital's workings, would that be

7 significant to a radiologist in assessing that x-ray,

8 that it was a diabetic with a puncture wound?

9 A I do not know.

10 Q Well, you mentioned that sometimes, for

11 instance, seeing osteomyelitis and sometimes they

12 don't. Do you think the radiologist might have ben

13 looking more carefully for an osteomyelitis if he or

14 she had known that this was a diabetic with a puncture

15 wound?

16 A I believe any radiologist would have been

17 looking for osteo with a puncture wound because that's

18 of absolute importance, and these two radiologists

19 looked at it and neither saw osteo.

20 Q They actually didn't say that. Correct?

21 A No, they didn't talk about it, but they have to

22 talk about their positive findings.

23 Q But they also say there's no evidence of

24 a fracture. Correct? You didn't say anything about

25 ruling out a fracture?

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1 A Right.

2 Q Do you rely on any literature to keep

3 current in developments in emergency medicine?

4 A I usually read Emergency Medicine Reports as

5 well as documents from ACEP, American College of

6 Emergency Physicians.

7 Q Are you a member of the college?

8 A Yes.

9 Q Since when?

10 A I first joined as a resident. I may have

11 lapsed later as a resident because of the cost, and

12 I've been pretty much a member consistently since I was

13 board certified.

14 Q Does ACEP publish any guidelines for
15 patient care or patient recommendations?
16 A For different patients -- I mean, they talk
17 about different diagnoses and medical entities and what
18 they believe treatment should be.
19 Q Do you follow those?
20 A Yes.
21 Q Do you believe that they set the
22 standard of care in emergency medicine?
23 Let me rephrase that. Do you agree that they
24 set a standard of care in emergency medicine?
25 A I believe they do that.

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1 Q Any organizations, are there any other
2 organizations that you believe set a standard of care
3 in emergency medicine?
4 A In emergency medicine? I mean, there's the
5 Society of Academic Emergency Medicine.
6 Q Are you familiar with any of their
7 guidelines or recommendations?
8 A I don't generally read a lot of their
9 literature.
10 Q Do you receive any medical journals?

11 A I receive ACEP's Medical Journal, and I receive

12 Emergency Medicine Reports.

13 Q That's it? Not like JAMA?

14 A No, that's $1,000 a year, just those two, and I

15 have four children.

16 Q When you're in the emergency department,

17 do you ever have occasion to consult a text on

18 infectious diseases?

19 A There are texts of emergency medicine inside

20 the department.

21 Q But none on other specialties?

22 A On orthopedics and usually surgery.

23 Q That's it?

24 A I can't say specifically every book but in

25 general -- and pediatrics.

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1 Q What surgical texts do you refer to

2 there if you have occasion to?

3 A I don't know the name of the surgical text.

4 MR. BERGE: I am done.

5 MS. WATTS: I have no questions.

6 (Witness excused.)

7 - - -

8 (Whereupon, at 12:10 p.m., the foregoing

9 Deposition Proceeding was concluded.)

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1 C E R T I F I C A T E

2

3 I, ESTHER J. HODGE, a Certified Court

4 Reporter and Notary Public of the State of New Jersey,

5 certify that the foregoing is a true and accurate

6 transcript of the testimony of the aforementioned first

7 duly sworn by me.

8 I further certify that I am neither attorney

9 nor counsel for, nor related to or employed by any of

10 the parties to the action in which the deposition is

11 taken, and further, that I am not a relative or

12 employee of any attorney or counsel employed in this

13 case, nor am I financially interested in the action.

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21 CERTIFIED COURT REPORTER

22 NOTARY PUBLIC OF NEW JERSEY

23 CERTIFICATE NO. XI01179

24

25

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1 LITIGATION SUPPORT INDEX

2

3 DIRECTION TO WITNESS NOT TO ANSWER

4

5 Page - Line

6 None

7

8

9 REQUEST FOR PRODUCTION OF DOCUMENTS

10 Page - Line

11 None

12

13

14 MOTIONS TO STRIKE

15 Page - Line

16 None

17

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