

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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10

11

12 ALSO PRESENT:

13 Ron Benton, Video Works of Virginia, Inc.

14

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I N D E X

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PAGE

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BROWN, JEFFREY A., M.D.

18

By Mr. Lewis

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E X H I B I T S

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DR. BROWN EXHIBITS

PAGE

23

No. 1 Defendants' Expert Designation

24

4

No. 2 Curriculum Vitae

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4

1 THE VIDEOGRAPHER: We are on the record at
2 8:58. Would counsel please introduce themselves,
3 starting with the plaintiff's counsel; indicate who
4 you represent. And then the court reporter will swear
5 in the witness.

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

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

11

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

15

16 EXAMINATION BY MR. LEWIS:

17

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

20 A **Jeffrey Allen Brown.**

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

1 Have you been deposed before?

2 **A Yes.**

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

5 **A Correct.**

6 Q How many times have you been deposed?

7 **A Twice.**

8

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

11

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

16 **A This is my CV.**

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

19 **A I believe so.**

20 Q Any changes, additions, or corrections?

21 **A No.**

22

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

25

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

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

10 A **Yes.**

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

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

18 Q Have you reviewed it in its present form?

19 A **Yes.**

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

22 A **Yes.**

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

25 A **No.**

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

4 A I reviewed the medical records --

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

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

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

11 A There is Dr. Lindemann's office notes.

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

14 A Some were more legible than others.

15 Q Were there entries that you couldn't read?

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

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

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

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

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

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

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

10 Q Which one?

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

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

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

19 MR. REDMOND: Port Warwick.

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

25 Q Can you tell me what, among those records

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

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

7 Q With Dr. Newman?

8 **A** **Correct.**

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

12 **A** **Define "pleadings" for me.**

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

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

20 Q For the plaintiff?

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

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

1 designated expert.

2 Q Yes, sir.

3 A I read a deposition from the patient.

4 Q Ms. Penzold?

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

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

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

11 MR. REDMOND: You left him out.

12 BY MR. LEWIS

13 Q You left him out?

14 A I have read Dr. Lindemann's deposition.

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

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

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

22 A Oh, before.

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

25 A Well, I don't --

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

3 A If you have dates --

4 Q Rather than quibble about dates --

5 A Okay.

6 Q -- you formulated opinions in this case --

7 A Correct.

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

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

12 Q Recently.

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

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

24 Q Okay.

25 A -- hospital records, and presumably -- I

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

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

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

11 MR. REDMOND: Thanks for that.

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

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

22 A Correct.

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

25 A I don't think so.

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

6 **A I've reviewed about a half a dozen.**

7 Q Over what period of time?

8 **A I came into practice in August of '96.**

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

10 **A Correct.**

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

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

17 Q Of the half a dozen --

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

22 MR. LEWIS: Sure.

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

25 Q Of the half a dozen or so medical-legal

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

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

8 Q Yes, sir.

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

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

16 **A Two.**

17 Q Is today number three?

18 **A Today is number three, right.**

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

22 **A One defense and then the nursing home case.**

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

25 **A Never got that far.**

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

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

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

8 A **Robert Carter from Appomattox.**

9 Q Did that case go to trial?

10 A **That case was settled.**

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

13 A **Kelvin Newsome --**

14 Q What firm?

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

17 Q And who represented the plaintiff, if you
18 recall?

19 A **Mick McConnell. That case is from '98 or**
20 **'99, maybe.**

21 Q Old?

22 A **Yes.**

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

25 THE WITNESS: Okay.

1 MR. REDMOND: -- near me.

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

5 A Yes.

6 Q How many?

7 A One.

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

10 A I did.

11 Q Have you testified in that case?

12 A I did.

13 Q Was it --

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

17 Q But the case went to trial?

18 A Correct.

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

21 Now, let's talk about trial appearances.

22 How many times have you testified in court in a
23 medical malpractice case?

24 A Once.

25 Q And that was on behalf of a doctor?

1 **A Correct.**

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

3 **A Correct.**

4 Q Was it defended by Mr. Redmond?

5 **A No.**

6 Q Who was the lawyer?

7 **A What's the lady --**

8 MR. REDMOND: Joan Mielke.

9 THE WITNESS: Correct.

10 Q What was the claimed malpractice in that
11 case?

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

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

16 **A Yes.**

17 Q How many times?

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

1 **so --**

2 Q The ankle amputation case, what happened to
3 that?

4 A **Defense verdict.**

5 Q So it went to trial?

6 A **Correct; in Fredericksburg.**

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

9 A **Correct.**

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

11 A **Correct.**

12 Q You know anybody in his group?

13 A **I do not.**

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

18 MR. REDMOND: Ms. Penzold.

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

21 MR. REDMOND: Yeah, you did.

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

24 MR. REDMOND: I might.

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

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

7 **A Both.**

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

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

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

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

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

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

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

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

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

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

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

19 **A History, physical examination at first.**

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

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

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

7 Q Why?

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

13 Q Okay.

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

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

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

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

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

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

5 Q Which one is Ms. Penzold?

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

9 Q Okay.

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

12 Q Okay.

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

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

24 **A I do not.**

25 Q Do you know whether or not he had any

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

3 **A I do not.**

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

9 **A That's correct.**

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

16 Can you elaborate on that comment for me?

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

21 Q Not inguinal?

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

23 MR. REDMOND: That's a mistake.

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

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

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

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

5 THE WITNESS: I'm surprised --

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

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

9 MR. REDMOND: Yeah.

10 THE WITNESS: But there's a difference.

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

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

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

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

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

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

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

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

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

10 Q During --

11 A -- at the time of your exam.

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

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

22 Q And --

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

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

13 Q Do you know Dr. Newman?

14 A No.

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

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

1 **occurrence.**

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

4 A **Both.**

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

7 A **No.**

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

13 A **That's what you just asked.**

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

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

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

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

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

1 **that.**

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

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

9 Q Okay. Then it's --

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

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

21 A **Correct.**

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

24 A **Yes.**

25 Q "In general, appendicitis would not give a

1 patient hip pain."

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

5 I can't remember the phrase.

6 -- retrocecal, maybe, appendix?

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

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

22 **A Conceivably.**

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

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

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

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

11 MR. REDMOND: You can do that.

12 MR. LEWIS: Okay.

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

19 A **Same comment.**

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

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

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

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

6 A Correct.

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

11 A Yes.

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

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

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

25 And again, whether -- whether she had acute

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

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

15 A I understand.

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

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

20 MR. LEWIS: Both.

21 MR. REDMOND: I just want to clarify.

22 MR. LEWIS: You are so rude.

23 MR. REDMOND: I just wanted to clarify.

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

1 the outcome would still have been the same."

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

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

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

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

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

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

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

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

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

1 that fact.

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

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

6 MR. LEWIS: That's right.

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

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

18 Q Abdominal pain a week ago.

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

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

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

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

5 **A She was not imaged on the 8th.**

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

8 **A Of course I can't.**

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

11 **A I don't believe so.**

12 Q Do you have --

13 **A I have records.**

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

16 **A Of course not.**

17 Q -- had he done it?

18 How about, was she running a fever on
19 Monday?

20 **A There's no documented fever.**

21 Q There's no documented temperature, is there?

22 **A That's correct.**

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

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

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

8 Q Yes, sir.

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

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

22 Q Is it fair to say that she didn't have
23 necrotizing fasciitis?

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

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

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

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

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

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

12 So she -- she got fasciitis because she had
13 an acutely inflamed or a necrotic appendix in a closed
14 space in her thigh.

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

18 If this lady has been surgerized --

19 MR. REDMOND: Surgerized?

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

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

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

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

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

7 **A If -- if she's operated on before there's**
8 **necrotizing fasciitis, she would not need as extensive**
9 **a debridement or reconstruction.**

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

13 **A I don't have any --**

14 Q -- demonstrative evidence available to you
15 today?

16 **A I do not.**

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

20 MR. LEWIS: Yeah, I do.

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

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

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

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

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

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

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

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

16 A I believe so.

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

19 A We bill by the hour.

20 Q What's your hourly rate?

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

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

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

4 **Q** Fair enough.

5 **A** But I believe that's correct.

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

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

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

13 **A** It's both.

14 **Q** Most of it record review?

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

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

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

25 **Q** Is it generally part of the aging process?

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

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

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

14 **Q** Right.

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

17 **Q** I was -- strike that.

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

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

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

9 **A** The age. I don't think their age matters
10 much anymore. We have some very debilitated
11 50-year-olds and some highly functioning
12 octogenarians. So I think it's, again, in my clinical
13 practice, and there's entire -- as I'm sure you are
14 aware, there's a vast literature on surgery in the
15 elderly. In my experience, it's much more based on
16 the individual, their personality type, their access
17 to care, et cetera, than just their age.

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

22 **A** To the older end of the spectrum.

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

25 **A** Increasingly common.

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

3 A **And demographic shifts.**

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

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

14 Q Yes, sir.

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

18 Q That you haven't seen already?

19 A **Correct.**

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

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

1 MR. LEWIS: You understand the question.

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

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

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

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

16 MR. REDMOND: He'll read.

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

19

20 AND FURTHER THIS WITNESS SAITH NOT.

21

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

23

24

25

1 COMMONWEALTH OF VIRGINIA,
2 CITY OF RICHMOND, to wit:

3
4 I, Helen B. Yarbrough, a Notary Public for
5 the Commonwealth of Virginia at Large, do hereby
6 certify that the foregoing deposition of Jeffrey A.
7 Brown, M.D., was duly sworn to before me at the time
8 and place set out in the caption hereto.

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

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

14
15 Helen B. Yarbrough
16 Helen B. Yarbrough, RPR, CCR, C
17 Notary Public for the
18 Commonwealth of Virginia at Large
19 VCRA Certification #0313016



20 My Commission expires:
21 July 31, 2013
22 Notary Registration Number: 158897
23
24
25

1 COMMONWEALTH OF VIRGINIA,
2 _____, to wit:

3
4 I, Jeffrey A. Brown, do hereby certify
5 that I have read the foregoing pages of typewritten
6 matter numbered 1 through 45, and that the same
7 contains a true and correct transcription of the
8 deposition given by me on the 9th day of November,
9 2009, with the exception of the noted corrections,
10 to the best of my knowledge and belief.

11
12 _____
Date Jeffrey A. Brown

13
14
15
16 Subscribed and sworn to before me this
17 _____ day of _____, 200__.

18 My commission expires
19 _____.

20
21 _____
Notary Public

22
23 Notary Registration Number: _____

24
25