# EXHIBIT G

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOHNNY JONES, )
Plaintiff, )
)
-vs- ) No. 17 CV-08218
)
WEXFORD HEALTH SOURCES, )
INC., and DR. MARSHALL )
JAMES, )
Defendants. )

Deposition of DR. VINCENT CANNESTRA, taken before NANCY J. BLACKBURN CSR, and Notary Public, pursuant to the provisions of the Code of Civil Procedure of the State of Illinois and the Rules of the Supreme Court thereof, pertaining to the taking of depositions at 2350 Royal Boulevard, Elgin, Illinois, commencing at 2:10 p.m. on August 9th, 2019.

REPORTED BY: NANCY J. BLACKBURN, CSR
LICENSE NO. 084-001555



APPEARANCES:

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on behalf of the Defendants.

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I N D E X


| WITNESS | EXAMINATION |
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| EXAMINATION | |
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DR. VINCENT CANNESTRA,
called as a witness herein, having been first duly sworn, was examined upon oral interrogatories and testified as follows:

EXAMINATION

BY MS. BYRD:

Q This is the case of Johnny Jones versus Wexford Health Sources, Inc. and Dr. Marshall James. It's Case No. 17 CV 8218. It's pending in the United States District Court for the Northern District of Illinois.

This is the deposition of plaintiff's retained expert, Dr. Vincent P. Cannestra. It's taken pursuant to notice and pursuant to the Applicable Federal Rules.

Dr. Cannestra, you have been sworn in, correct?

A I have.

Q And I know we met briefly off the record but my name is Sandy Byrd. I'm an attorney from the law firm of Cassiday Schade and I represent both Wexford and Dr. James in this matter.

I'm assuming you have given depositions before?

A I have.

Q And you understand the basic rules of depositions? I'm going to ask you questions. You are going to answer those questions. Your answers need to be verbal so that the court reporter can take them down, and I'm going to do my best not to talk over you and ask that you do your best not to talk over me; and I'm sure we'll both fail at that but those are the rules. Understood?
A Understood.
Q Anything about that that you can't comply with?
A Nope.
Q Doctor, I am going to show you a copy of your CV that was provided to me. Can you just take a look through that and let me know if that is current and correct?
A It is.
Q I think I will mark it as Exhibit 1.
(Exhibit No. 1 marked)
BY MS. BYRD:
Q Doctor, have you ever had any disciplinary action against you involving your license to practice medicine?
A No.
Q What percentage of the work that you do is



expert work?
A It varies from year to year. I would say presently it can be anywhere from 30 to 40 percent.
Q And the rest of your work then is in your private practice?
A Right.
Q And what exactly is that private practice?
A Orthopedic surgery.
Q When you do work as an expert, how do you get retained? How do the cases come to you is probably a better way of asking that question?
A Either I'm contacted directly by the attorneys or I have another firm that I work with called INSPE Associates where I am an independent contractor and they refer me cases.
Q Do you advertise for your expert work?
A I do not.
Q How often have you worked with the plaintiff's law firm in this matter?
A How long have I worked?
Q How many times?
A This is the only time.
Q And in your expert work, what percentage of that work is representing plaintiffs?



A Anywhere from 10 to 15 percent.
Q And the rest is representing or working on behalf of doctors?
A Defendants.
Q When you say defendants, other than doctors, who do you work on behalf of?
A So, a fair portion of my consulting work has to do with personal injury. So, it may be for the insurance companies or a business but mostly for insurance companies for personal injuries.
Q How do you get retained by insurance companies? What are your contacts with them?
A Well, either they would contact me directly via the attorney or get me through INSPE.
Q And how many open expert cases do you have currently pending?
A Define open.
Q Anything that is -- that you have been contacted to provide an opinion that you are presently working on preparing an opinion, that you are presently preparing to do a deposition, that you are presently preparing to do a trial? Anything that you have not been contacted and say this case is resolved, you can close your file?



A Oh, I don't know. I mean, I have got some cases that have been going on for two or three years that I have had no recent work on just because it's going -- it's going through the legal process or they're still taking depositions or they're still trying to track down medical records.
So, as far as open cases presently across the board, I couldn't tell you. I could guess. Recently that come to mind, maybe ten.
Q And you're not sure that that encompasses all of your open cases? That's an accurate statement?
A Again, I don't know which ones are still open, because if they settle --
Q If your file --
A -- they may not necessarily let me know that they have settled.
Q So if your file is open, how many cases do you currently have open files on?
A Well, again, define open, okay?
Q If you have not closed your file?
A Okay. I close my file when my bills have been paid. That's when I close the file. Now, if they decide to send me more records to review or they ask me to write a report or they want me to do a deposition,

then I will submit another bill; but until that time, I don't know if the file is open or closed.

**Q So this is not meant to be a difficult question. I am trying to determine how many cases you have that are currently open? Meaning, that the legal procedures to the best of your knowledge are not terminated?**

A I don't know.

**Q What percentage of your income is from expert work?**

A I'm sorry, say that again please?

**Q What percentage of your income is from expert work?**

A 30 to 40 percent. Probably closer to 30 percent.

**Q And what rates do you charge for your expert work?**

A Typically for reviewing medical records and preparation of a report is $350 per hour. For depositions, roughly $900 an hour. Rates may be different for INSPE. INSPE may be $450 per hour.

**Q What about trial work?**

A Trial work, typically it will be $2,000 an hour portal to portal.



**Q And what rates are you charging in this case?**

A For what work?

**Q For your work?**

A Are you talking deposition or are you talking --

**Q I'm talking for all of your work?**

A Just as I stated, $350 for the review of materials and the preparation of report and $900 an hour for the deposition with a two-hour minimum.

**Q What was the date that you were retained in this case?**

A I would have to look at my bill to see when I first had contact. I don't know off the top of my head.

**Q Is that something that you can determine easily?**

A If I had my bill, yep.

**Q I don't have your bills, so I can't provide you with that.**

MR. FLAXMAN: I don't have your bill either.

BY MS. BYRD:

**Q We're in your office, so I'm assuming that you have access to that?**

A I don't because I have my bills at my house.



**Q So, that is a date that I'm going to ask be provided to me after the deposition?**

**How did you get this case?**

A I was contacted by Mr. Joel Flaxman, I believe, via email.

**Q And how much time have you have spent so far on this case?**

A I would have to look at my bill but I may have stated it in my report. It looks like 21 hours for the preparation of the report.

**Q And you have done nothing since you prepared the report?**

A Other than review it for this deposition, that is correct.

**Q And how much time did you spend reviewing your report for this deposition?**

A Roughly a half hour.

**Q So, what have you been paid so far for this case?**

A I would have to look at my bill. It's been, I believe, a few thousand dollars.

**Q And again, I'll ask for that information?**

MR. FLAXMAN: I'll give it to you right now. First contact was on March 14th and we have been billed -- we



paid $5,800.

MS. BYRD: And when you say March 14th, 2019 --

MR. FLAXMAN: That's correct.

MS. BYRD: Okay. Thank you.

BY MS. BYRD:

**Q What all did you review in preparing your report?**

A It's listed in the first paragraph of my report. You want me to --

**Q So --**

A -- read it all?

**Q -- there is nothing other than what is listed in the first paragraph of your report that you reviewed?**

A That is correct.

**Q Can you tell me who Dr. Joseph Maides is, M-A-I-D-E-S?**

A I believe he was one of the physicians employed by Wexford Health Services or Sources.

**Q And who is Dr. Amy McCauley?**

A I would have to go back and look at the medical records to see who she worked with.

**Q How about Daniel Ozinga?**

A I believe he was the physician's assistant at

Lawndale Christian Health Center.

**Q Is there anything that you were not able to review for your report that you would have liked to have been able to review for your report?**

A I think the only records that I did not have were the radiographs that were obtained on November 16th of 2015.

**Q How many drafts of your report did you prepare?**

A I believe there were three.

**Q Do you still have all of those drafts?**

A I would have to look at my records to see if I do.

**Q To the extent that you have those, I would ask that those be produced?**

MR. FLAXMAN: And to the extent that you want them produced, I refer you to Rule 26 which makes drafts of reports privileged.

BY MS. BYRD:

**Q Who all had input into your report?**

A Input meaning what?

**Q Meaning any input whatsoever into the content of your report?**

A I sent my initial report to Joel Flaxman and we discussed it. I know that subsequent x-rays were



provided that I requested. So, as part of one of my -- excuse me -- one of my revisions of my report was the inclusion of my findings of the x-rays.

**Q Anybody else have input?**

A No.

**Q Who all helped write your report?**

A I was the sole writer of the report.

**Q No one other than you had input into your report or helped write your report?**

A I reviewed it with Mr. Flaxman, Joel Flaxman. He at times wanted some clarification on wording in the report. Some of it I agreed with. Some of it I did not agree with.

**Q Do you recall what writing you agreed with and what writing you didn't agree with?**

MR. FLAXMAN: I'll object to that and instruct the witness not to answer because you are inquiring about drafts of reports.

BY MS. BYRD:

**Q How many drafts did you exchange with Mr. Flaxman?**

A Again, only three drafts.

**Q So, your final report is essentially the fourth version of the report?**



A I believe it's the third.

**Q So, there were two drafts prior to the final version?**

A Correct.

**Q How do you communicate with Mr. Flaxman? Do you email?**

A Email and phone.

**Q While preparing your report or preparing for this deposition, did you take any notes?**

A No. Well, I took notes for my report and then once I completed my report, those notes were destroyed because everything in my notes is in my report. As you can see, the report is very thorough and detailed.

**Q Did you prepare an outline of your report?**

A I did not.

**Q Do you have a file for this case?**

A Just my bill and the report.

**Q So you didn't keep any of the records that you were provided?**

A I have a record and CD.

**Q And you don't consider that to be part of the file that you have for this case?**

A It's not my own personal file but it's a CD of the medical records that I reviewed.



**Q So, the entirety of the information that you have about this case is your bill, your report and then the documents that you reviewed that are listed in paragraph one of your report?**

A That is correct. I would have to go back and look to see if there were any additional medical records that were sent to me via email. I don't recall.

**Q Would you not have included those in paragraph one of your report if they were sent to you via email?**

A I would have.

**Q So, regardless of the form that they are kept in, the only records you have pertaining to this case are the records listed in paragraph one of your report and your bill?**

A That is true.

**Q How many times have you testified at a deposition as an expert?**

A Too many to count.

**Q Does that mean more than a hundred?**

A Possibly. I have been doing expert work for, I think, since 2006.

**Q So, it could be more than a hundred? Is it more than two hundred?**

A I don't know. I mean you are talking about a 13-year period. Some years are busier than others. As far as how many depositions I have given, I couldn't tell you over that 13-year period. I think I provided a list of what I have done in the last five years.

**Q I'm just trying to narrow it down as to how many times you have testified in depositions?**

A I couldn't tell you whether it was 100 or more or less.

**Q In your 13 years, there are 156 months. So, how many times a month roughly do you testify?**

A Less than once a month.

**Q So, it would be less than two hundred times?**

A Yes.

**Q So, somewhere between a hundred and a hundred and fifty depositions, is that a fair number?**

A It could be less.

**Q I'm not -- I don't know the answer.**

A Neither do I.

**Q I'm trying to narrow it down?**

A Neither do I. That's why I said, I don't know.

**Q It's certainly less than 156, is that fair? Since there are 156 months in 13 years?**

A Again, I said less than once a month.



**Q So, how many times have you testified at trial?**

A Are you including arbitration with that or not?

**Q Let's start with trial?**

A Once.

**Q How about arbitrations?**

A Once.

**Q Have you ever been barred from testifying as an expert?**

A I have not.

**Q Have you ever had your report barred?**

A Not to my knowledge.

**Q How many correctional health care cases have you been involved in?**

A Probably ten or less.

**Q I'm sorry, ten or less?**

A Yes.

**Q What kind of cases are those?**

A One was a police shooting. One is -- several typically are due to inadequate medical treatment are the claims for various orthopedic conditions. Whether it's the low back pain or knee pain or shoulder pain. Slip and falls at the correctional facility. One is an opinion as to whether an inmate's previous orthopedic injuries caused sufficient disability that he could not



have perpetrated the crime, and that's all that I can recall off the top of my head.

**Q In the inadequate medical treatment cases, are those all on behalf of inmates?**

A Correct.

**Q Have you ever testified on the behalf of a doctor in a correctional health care case?**

A I have not. Let me think, I have not.

**Q Have you ever practiced medicine inside a correctional facility?**

A I have not.

**Q What kind of prison policies have you reviewed in this case?**

A None.

**Q Any other case you reviewed prison policies?**

A None.

**Q What about correctional health care standards? Have you reviewed any of those?**

A I have not.

**Q Do you consider yourself to be an expert in correctional health care?**

A Define correctional health care.

**Q Health care that is provided within a correctional facility to inmates within that facility?**



A Since I have never practiced such a position, I would say no.

**Q What is a patellar tendon rupture?**

A The rupture of the patella tendon which is a tendon that originates from the inferior or bottom portion of the kneecap and attaches to the shin bone.

**Q How does one rupture their patellar tendon?**

A Most commonly occurs with a high load impact activity on the legs such as running, coming down the stairs, a stumble but there is typically a high load delivered to the knee.

**Q And what are the typical symptoms of a patellar tendon rupture?**

A You could have pain, swelling, tenderness, inability to extend the knee, difficulty flexing the knee. You could have a palpable gap in the tendon. You can have a collection of fluid in the knee, what we call a hemarthrosis or a fusion. You can have a hypermobile patella. You can have a superiorly migrated patella or high-riding patella. You can have over the long term or longer term, you could have quadriceps tendon atrophy, pain or tenderness. You can have night pain. You can have inability to walk or inability to bear weight on the leg. You can have bruising or

ecchymosis. You could have redness and those are the majority of the symptoms or findings.

**Q Is there a typical presentation of someone who has a ruptured patellar tendon?**

A Typically, severe pain, inability to bear weight on the leg, an inability to extend the knee, a hypermobile patella, palpable gap, tenderness at the patellar tendon, difficulty flexing the knee. Potentially a high riding patella. Certainly, swelling and an effusion or a hemarthrosis in the knee.

**Q And you said hypermobile?**

A Hypermobile patella.

**Q What is that?**

A So, because the tendon attaches the kneecap to the shin bone, it essentially anchors the kneecap. When you rupture that tendon, that kneecap loses one of its points of fixation and as a result, that kneecap can be pushed or subluxed either medially or laterally or up and down, meaning inferior/superiorly.

So, a patellar tendon rupture allows that patella to shift or move much more easily.

**Q How many of these injuries do you see in your practice? Is it a common injury?**

A It is not a common injury.



**Q On a typical month, how many would you see?**

A Not even one a month.

**Q How many in an average year?**

A It can be anywhere from, in this practice, two to six maybe a year. Six probably would be on the high side in this area.

**Q And when you say in this area, you mean in orthopedics?**

A In this suburb.

**Q In Elgin?**

A In Elgin.

**Q But your specialty is orthopedics, is that correct?**

A That is correct.

**Q And so is it fair to say that someone with this injury eventually makes it to an orthopedist in the typical case?**

A Yes.

**Q It's not something that a general practitioner would tend to treat, correct?**

A It is not an injury that a general practitioner should treat.

**Q So, a general practitioner should refer a patient to an orthopedic specialist if they suspect this type of injury?**



A Yes.

**Q And when a general practitioner refers a patient to a specialist for this type of injury, what is the typical amount of time that you see between the person seeing their general practitioner and coming to you?**

A A week or less.

**Q And as a general practitioner, what should a general practitioner be looking for to determine if a referral is necessary to an orthopedist?**

A Well, certainly the number of symptoms and exam findings that I stated previously; but obviously if the patient can't extend their knee and they can't walk on their leg, if there is severe pain and a palpable gap in the tendon, these are clearly signs that a referral is absolutely necessary.

**Q And how would a general practitioner determine if there is a palpable gap in the tendon?**

A Examining the patient's knee.

**Q And what is it that they should do to that knee to determine that?**

A If there is a palpable gap?

**Q Correct.**



A Palpate the tendon.

**Q What are the available treatment options for a patellar tendon rupture?**

A I think the main treatment option is surgical repair.

**Q Is that the only option?**

A For your debilitated person or someone who is a non-ambulator, someone who is severely demented or elderly, potentially you could cast that person to treat the tendon rupture; but in all likelihood, they will not do well as far as being ever able to walk again or extend the knee.

**Q How often do you perform this surgery?**

A Not often.

**Q You said you see somewhere between on average two to six cases a year. So, would it be fair to say that you do the surgery roughly two to six times a year?**

A Typically, if I find a patient with this patellar tendon rupture, I will send them to my partner who does more of have them than I.

**Q So, how many of these surgeries have you ever performed?**

A Probably less than ten.

**Q And when is the last time that you performed one?**
A It's been years.
**Q How many years?**
A Probably over ten years.
**Q How does a patellar tendon rupture differ from a patellar tendon tear?**
A Well, you could have a partial tear of the patellar tendon. I have seen that recently, and depending upon the severity of the tear, they may be treated non-operatively without surgery. When you have a rupture, you have a 100 percent tear of the tendon. Most people when they talk about patellar tendon tears, they talk about a complete rupture. I would say a patellar tendon rupture is much more common than a partial tear of the patellar tendon. Those typically are much more rare than a complete rupture.
**Q So, if I am understanding you correctly, both a patellar tendon rupture and a patellar tendon tear are the tendon tearing. The rupture is just a complete tear. Where if someone is referring to a patellar tendon tear, they are referring to an incomplete tear? Like there are portions of the tendon that are still intact?**



MR. FLAXMAN: Let me object to the form of the question which was compound.
THE WITNESS: When typically people talk about a patellar tendon tear, they are talking about a complete rupture. Just because a partial tear is so rare.
BY MS. BYRD:
**Q Would the symptoms of a tear versus a rupture be the same?**
A Are you talking about a partial tear or what the lay person says is a patellar tendon tear?
**Q I am talking about your definition that a rupture is a complete tear but that you can have an injury that is not a complete tear which is what you call a tear which is -- I should say, you could have an injury that is not a complete rupture which is what you are referring to as a tear?**
A That's not what I am referring to as a tear. You asked me what the difference is between what people call a patellar tendon tear and a rupture.
**Q No. I asked you what the difference between a tear and a rupture is and you told me what people call it. So I am asking you, are the symptoms of a tear the same as the symptoms as a rupture?**
MR. FLAXMAN: Object to the form of the question.



He's really explained between a tear and a partial tear and it's confusing. Could you rephrase it?
BY MS. BYRD:
**Q A rupture is a complete tear, is that an accurate statement?**
A Yes.
**Q And if someone does not completely tear their patellar tendon, there can be a partial tear, is that correct?**
A Correct.
**Q And that is not a rupture, correct?**
A Correct.
**Q So, can we agree to call that a tear?**
MR. FLAXMAN: No, we can't agree. It's a partial tear.
THE WITNESS: You can have different severity of partial tears, okay?
BY MS. BYRD:
**Q Okay.**
A The greatest severity is a complete rupture, a complete tear.
**Q How is that a partial tear then? Let's stop there?**
A I didn't say partial tear, I said tear.



**Q Okay. So, on the extreme of a fully intact patellar tendon to a complete rupture, let's say halfway in between those two on a continuum, what would you call that?**
A That would be a 50 percent partial tear.
**Q So, can we -- Are the symptoms of a partial tear the same as the symptoms of a complete rupture?**
A It depends on the severity of the partial tear.
**Q Okay.**
A So, you can have a 10 percent portion of the tendon rupture and 90 percent intact. That is going to be much different than if you had 90 percent completely torn and only 10 percent intact.
**Q So, let's say we have a 50 percent, in between those two. Are those symptoms going to be the same as the symptoms of a complete rupture?**
A Some will be, yes.
**Q You said that a partial tear is much more rare than a full rupture?**
A In my experience, that is correct.
**Q How often do you see partial tears in your practice?**
A I think I have seen one in ten years.
**Q And is surgery the only treatment for a partial**

tear?
A Again, it depends on what portion of the tendon is completely torn.
**Q Is it fair to say that someone who presents with a 10 percent partial tear is going to have symptoms that are less severe than someone who presents with a full rupture?**
A Yes.
**Q When you initially see a patient in your private practice, do you take a medical history from that person?**
A I do.
**Q And what does that history typically entail?**
A Are we talking about specifically tendon injuries or are we talking about any injury?
**Q Any orthopedic injury?**
A Well, typically it's going to occur when the symptoms first began, what their symptoms are presently, what their symptoms have been in the past, how long has the condition been present, what things aggravate it, what things make it better, what treatment have they had for it, what evaluations have they had, whether their symptoms are improving with time or treatment, what impact does it have on their



ability to function, the location of their pain. Any other associated symptoms such as swelling or instability, loss of range of motion, areas of tenderness or the location of their pain, whether there is any crepitation. If they noted any bruising, any redness, any deformities. That's the basics.
**Q And are you the person that takes that history or is that done by a nurse or a physician's assistant or --**
A It's done by me.
**Q How important in making your diagnosis is it that the patient be honest with you about the history of that injury?**
A It's important.
**Q It's something that you rely on in making your diagnosis?**
A That is one portion, yes.
**Q And I know you said it's been over ten years since you have done a patellar tendon rupture surgery but do you currently do other types of orthopedic surgeries?**
A I do.
**Q Is that a major part of your practice is doing surgery?**



A Yes.
**Q When you do surgery on patients, do you give them discharge instructions?**
A Yes.
**Q And what is the purpose of discharge instructions?**
A Primarily educate the patient about what to expect and what things are recommended as far as postoperative care.
**Q And the recommendations that you make regarding post-operative care, how important is it that the patients follow through on that?**
A Well, it depends upon the surgery but obviously since we are giving them instructions, it's our suggestions.
**Q And you wouldn't be suggesting things that aren't necessary, is that fair?**
A They're recommendations, yes.
**Q And it's your recommendation that they follow through on what you provide in your discharge instructions, correct?**
A Correct.
**Q And you recommend those things because it will make their recovery better, the outcome of their**



**surgery better, is that fair?**
A Yes.
**Q When you have a patient come into your private practice and your recommendation is that that patient has surgery, what is the process that the patient has to go through with his or her insurance company to get that surgery approved?**
A It usually needs to be authorized by the insurance company.
**Q Is that something that you're involved in?**
A No. My office staff does that. Obviously if it's an emergency surgery, that doesn't require authorization and it's just that, it's an emergency.
**Q But in non-emergent situations, you don't perform surgery until it's been approved by the insurance company, is that fair?**
A Correct.
**Q Do you know how long that process typically takes from the time you recommend surgery until an insurance company approves it?**
A It all depends upon the insurance company.
**Q And do you have -- Is there an average amount of time?**
A Usually, we like to get the pre-authorization

in a weak or less. Obviously for the more urgent cases, we will get it within one or two days.

**Q And when you say pre-authorization, how is that different than an authorization?**

A I would say they're synonymous.

**Q Have you ever done surgery on a patient for a ruptured patellar tendon without obtaining an MRI first?**

A I don't believe so.

**Q How about without obtaining an x-ray?**

A No.

**Q And is it fair to say that before you can obtain an MRI or -- certainly before you can obtain an MRI, that that also needs approval of an insurance company?**

A Yes.

**Q How about x-rays? Does that typically need approval of an insurance company?**

A No.

**Q And you said before, it depends on the insurance company how long it takes to get the authorization, correct?**

A Correct.

**Q Some are faster than others, correct?**



A Correct.

**Q How familiar are you with Sheridan Correctional Center?**

A I only know it by name and the records that I reviewed.

**Q How do inmates at Sheridan obtain their health care? What is the process they have to go through?**

A I don't know.

**Q What are the processes at Sheridan Correctional Center for an inmate to schedule surgical procedures?**

A I assume you are talking about non-emergent surgeries?

**Q Correct.**

A So, on the few cases that I have done regarding correctional facilities, my understanding is that the health care is provided by a third party health system; and therefore, for patients or inmates who need surgical intervention or referrals or advanced imaging, that there has to be an authorization from the third party that manages the health care system.

**Q And do you know if that is the case at Sheridan Correctional Center?**

A It is based on the records that I reviewed.

**Q And what do you -- Tell me everything that you**



**know about that process?**

A So, the physician who is recommending surgery will submit a form for the surgery to be authorized.

**Q To whom?**

A To the third party administrator.

**Q And then what is the process after that?**

A And then the physician who ordered the procedure waits for the response.

**Q How long does that process take?**

A I guess it depends upon the third party administrator.

**Q In your experience, how long does that process take?**

A Typically, two weeks or less.

**Q And once that process is complete or before, based on your experience, who schedules the appointment for the inmate to either have the consultation or the surgery?**

A I'm sorry, the question again.

**Q Who schedules the appointment for the inmate to have the consultation or the surgery? Does the inmate pick up the phone in the prison and call someone or does someone else take care of it?**

A I believe it would be the managing physician



taking care of that inmate.

**Q So, it's your belief that the managing physician picks up the phone and calls and schedules the appointment for the inmate to have whatever out -- whatever care outside the prison facility the inmate needs?**

A My understanding is that there is a referral to a specialist or a request for surgery. That the ordering physician submits the request. If the request is granted, then the physician follows up with either arranging the specialist's consultation or making arrangements for the eventual surgical procedure; but typically if it's a specialist doing the procedure, it's going to be the orthopedic surgeon who will have to wait for the authorization from the third party administrator.

**Q Do you believe that that prison physician has control over the, using your example, the orthopedic surgeon's schedule?**

A I'm not sure what you are asking?

**Q Is it the prison physician who is able to call the outside specialist and make an appointment when the prison doctor thinks that it should be made? Or is that prison doctor dependent upon the scheduling of the**

outside consultant?
A I guess I'm still not sure what you are asking?
Q If the prison doctor called your office and said that he wanted one of his inmates to come see you today, August 9th, at 2:00 p.m. at the exact time that we had our deposition scheduled, would that prison doctor be able to put that patient on your schedule or would you say I'm sorry, I'm not available then?
A Well, I would say that we can see that person at the next available appointment.
Q So, the scheduling is dependent upon your availability, correct?
A Obviously.
Q Okay. So, even if the prison doctor wanted that patient to get in and see you at a time that you were not available, you would not be able to see that person then, correct?
A Yes and no. I mean, we have had physicians call us directly saying this is an urgent case. Can you get this person in? Can you squeeze him in today, and, you know, when we have that physician-to-physician communication and the urgency is communicated, yes, we get them in whether there is a conflict or not.
Q But just to get someone on your day-to-day



schedule, that doesn't happen, correct?
MR. FLAXMAN: Object to the form of the question.
THE WITNESS: Again, if we are contacted with an urgent matter, regardless of what day it is and regardless of how busy I am, I will see that person.
BY MS. BYRD:
Q What do you know about the security issues involved in taking prisoners out of the controlled prison setting for medical appointments?
A I do know they need to be accompanied by the prison staff.
Q What else do you know about that, about the security issues?
A They do need to be transported in a secure environment.
Q Anything else?
A No.
Q There is nothing else that you know? Or there is nothing else that you believe is an issue? It was probably a bad question on my part.
A That would be the extent of my knowledge of the security issues as far as transferring inmates.
Q In your report you use the word infirmary repeatedly. What is your definition of the prison



infirmary?
A Just that, an infirmary where patients can be seen and evaluated by the medical staff.
Q So, I'm just trying to get your understanding of the term. Would it be kind of the prison equivalent of your medical office?
A Well, I don't know. I haven't seen their infirmary, so --
Q You used the term. So that's why I'm just trying to clarify in your mind what you meant by that term?
A I used that term because that is the term in the medical records.
Q So, it was -- it's your belief that when Mr. Jones, the plaintiff in this case, saw Dr. James, that each time he saw Dr. James, he, Mr. Jones, and Dr. James were located within the prison infirmary?
A I do not know if Mr. Jones was seen by Dr. James in the infirmary on every occasion. Now, if there is a particular date that you have a question about, we can certainly go to the medical records and see if it records where Dr. James did his evaluation.
Q So, it's your testimony that if you used the word infirmary in your report, it's because you got



that word from the records?
A As best as I can recall, correct.
Q Tell me what you know about the prison grievance process?
A So, the inmate needs to fill out a form stating their grievance and it's returned to the appropriate personnel.
Q And who are the appropriate personnel?
A It depends on, my understanding, what the grievance is.
Q So, if an inmate had a grievance about their medical care, what would they do with that form?
A Again, they would hand it to the appropriate personnel.
Q And who are the appropriate personnel?
MR. FLAXMAN: Objection. It's beyond his personal knowledge.
MS. BYRD: That's kind of my question.
MR. FLAXMAN: Well, I mean you are asking him questions about things that he knows nothing about.
MS. BYRD: I said what is your knowledge? If he doesn't have any knowledge, then he should say I don't know. Not an objection.
MR. FLAXMAN: It is an objection when you ask

somebody to state something for which they have no personal knowledge about it, it's not going to be admissible. It's not competent testimony.
MS. BYRD: I'm allowed to figure out what he knows and doesn't know and my question is what does he know; and if he doesn't know, then his answer should be I don't know.
MR. FLAXMAN: He told you that he knows this stuff from reading it but it's not admissible evidence.
MS. BYRD: He didn't say that in response to this question. I said what do you know about the prison grievance process and he said that the inmate fills out a form and hands it to the appropriate personnel. So, I'm asking who the appropriate personnel is. I'm trying to determine the extent of his knowledge. That is the point of deposition.
MR. FLAXMAN: Not in an expert deposition. He doesn't have to have personal knowledge about anything other than the things about which he is providing opinions.
MS. BYRD: And it appears in his report, so I can ask questions about it.
MR. FLAXMAN: Well, I'm not interfering with asking questions but this is really not very productive.



BY MS. BYRD:
**Q So who is the appropriate personnel?**
A It looks like the grievance that he filed was received by Wexford Health Sources.
**Q And on what do you base that statement?**
A Based on the medical records.
**Q So, it's your testimony that Mr. Jones filled out a grievance and it was received by Wexford and you deduced that from reviewing the medical records?**
A Correct.
**Q What do you know about the collegial review process?**
A So, when the prison physician needs to discuss or obtain authorization for further medical care of an inmate, he has a review with a supervising physician.
**Q And what about the utilization management process? What do you know about that?**
A Nothing.
**Q Do you have knowledge about any Illinois Department of Corrections directives or policies?**
A No.
**Q When Mr. Jones first presented to Dr. James in this matter, he presented and indicated that his left knee pain was a 4 of 10, correct?**



A That is correct.
**Q Dr. James noted that there was no swelling on Mr. Jones' knee, correct?**
A Let me correct my previous answer. It wasn't Dr. James who documented that his knee pain was 4 out of 10. It was the nurse.
**Q Thank you. You are correct on that. That nurse also noted that there was not any swelling, correct?**
A Correct.
**Q No tenderness?**
A Correct.
**Q And no bruising, correct?**
A Correct.
**Q She didn't observe any kinds of cut or open area on Mr. Jones' head, correct?**
A No.
**Q That was on, I think, the 14th -- November 14th of 2015, correct?**
A That is correct.
**Q And Dr. James then first saw Mr. Jones on November 16th, correct?**
A Correct.
**Q And is that an appropriate time frame within**



**which to see a patient who presented with left knee pain a 4 of 10, no swelling, no tenderness and no bruising?**
A If in fact that was true, yes.
**Q Do you have any reason to believe that that wasn't true?**
A I do.
**Q Why do you believe that that nurse's notes from November 14th, 2015 are untrue?**
A Because he had a complete rupture of his patellar tendon which causes swelling and tenderness.
**Q And what motivation would the nurse have to report inaccurate notes?**
A I don't think she had any motivation to record inaccurate notes. I just don't think she closely examined Mr. Jones' left knee.
**Q So, when Dr. James saw Mr. Jones on November 16th, 2015, Dr. James noted that -- I wish that they both didn't have J names -- Mr. Jones' left lower extremity had increased knee swelling and pain, correct?**
A Yes.
**Q What about -- Is there anything about that that tells you that the nurse incorrectly recorded her notes**

on November 14th of 2015?
A Well again, with a known acute patellar tendon rupture, you would have immediate pain and tenderness.
**Q And isn't it fair to say that the nurse on November 14th relied on what Mr. Jones told her in terms of recording his level of pain and his level of tenderness or any other injury that is not observable?**
MR. FLAXMAN: Object. The witness doesn't know what the nurse relied upon back in November of 2014 -- 2015. Only the nurse knows what she relied on.
BY MS. BYRD:
**Q You can answer.**
A The question again please?
**Q I said, isn't it fair to say that the nurse would have relied upon Mr. Jones' representations to her as to his level of pain and his level of tenderness?**
A Well, those are symptoms. What she inaccurately recorded was his physical exam findings.
**Q So, it's your testimony that she determined that his pain level was a 4 of 10?**
A That's not a physical exam finding.
**Q How would she have come up with that number of 4 of 10?**



A That's a history. That's a symptom.
**Q And the history is obtained from the patient, correct?**
A That is correct.
**Q So, if she wrote down that the level of pain was 4 of 10, it's because she obtained that during a history?**
A That is correct.
**Q And the history is given to her by the patient?**
A I'm not disputing her history taking. I'm disputing her physical exam capabilities.
**Q And when you say her physical exam, what are you referring to?**
A Examination of his left knee.
**Q When she recorded that there was no swelling, no tenderness and no bruising, is that physical exam or is that his --**
A That's physical exam.
**Q So you weren't present, correct, on November 14, 2015?**
A That is correct.
**Q So, you did not observe Mr. Jones on that date, correct?**
A That is correct.



**Q And you have never met the nurse that took that physical exam, correct?**
A That is correct.
**Q So, you don't have any way of noting or knowing for a fact if what she wrote down was exactly what she observed, correct?**
A What I know is with an acute patellar tendon rupture, you will have tenderness and you will have swelling.
**Q Absolutely every single time?**
A Yes.
**Q So, if she wrote down that there was no swelling, no tenderness and no bruising, is it unreasonable that Dr. James did not see Mr. Jones for two days? That's the information that he was presented with? Regardless of whether it's correct or incorrect, that's the information that he had?**
A Well, I don't know what information he had on the night of November 14th of 2015.
**Q I'm not asking you about the night of November 14th of 2015. I'm asking you about the date that Dr. James first saw Mr. Jones which was November 16th, 2015, correct?**
A Well, I don't know what you are asking me? You



are asking about the information that Dr. James had from the nurse.
**Q So, is it correct that the first time Dr. James saw Mr. Jones was on November 16th of 2015?**
A That is correct.
**Q And is it correct that the medical records reflect that the only thing that Dr. James knew at that time is that Mr. Jones' pain level was a 4 of 10, that he did not have any swelling, tenderness or bruising to his knee, is that correct?**
MR. FLAXMAN: Let me object to the question because medical records don't show what somebody knew. They show what is written in the medical records, not what somebody knew.
MS. BYRD: And that's why my question is, do the medical records reflect it?
MR. FLAXMAN: Why don't you reask the question?
BY MS. BYRD:
**Q Isn't it true that on November 16th of 2015, the first date that Dr. James saw Mr. Jones, that the medical records reflected that Mr. Jones' level of pain was a 4 of 10? That he did not have any swelling, tenderness or bruising to his knee, is that correct?**
A Are you asking me if Dr. James reviewed the

medical records of November 14th?
**Q I'm not asking you that, because you would have no way of knowing that. I'm asking you if that is what the medical records reflected?**
A Well, the medical records of November 14th show that the nurse documented that he did not have any left knee swelling or tenderness.
**Q Or bruising, correct?**
A Correct.
**Q And that his pain level was 4 of 10, correct?**
A That is correct.
**Q So as you sit here today, you don't have any knowledge that Dr. James had any information other than that when he saw Mr. Jones on November 16th of 2015, correct?**
A That is correct.
**Q Okay. So with that information, is it unreasonable that Dr. James did not see Mr. Jones immediately after his injury on November 14th, during the day on November 15th, and that he only saw him on November 16th? Is that unreasonable with that information?**
A No.
**Q When Dr. James examined Mr. Jones, he noted**



**that there was increased knee swelling and pain, correct?**
A Correct.
**Q And he ordered an x-ray of Mr. Jones' knee, correct?**
A Correct.
**Q And you previously testified that you have never done this surgery on a ruptured patellar tendon without first obtaining an x-ray, correct?**
A Correct.
**Q So, an x-ray is an important diagnostic tool for this injury, correct?**
A Correct.
**Q And it was not unreasonable for Dr. James to order an x-ray upon his initial examination of Mr. Jones, correct?**
A Well, his initial examination of Mr. Jones lead him to believe that there was a possible patellar tendon rupture; and therefore, in addition to an x-ray, he should have ordered an MRI scan.
**Q So, that was not my question. My question is, it was not unreasonable for Dr. James to order an x-ray of Mr. Jones' knee on November 16th of 2015, correct?**
A Correct.



**Q You have indicated in your report that Dr. James' examination was, I think it says, limited at best?**
A Third paragraph.
**Q His examination of the left knee was limited at best. Tell me what you mean by that?**
A So, the only physical exam findings that he documented was swelling and pain. Now, if you are worried about a patellar tendon rupture, there is something more that would have led you to believe that there is a patellar tendon rupture, and he doesn't document that. He doesn't document any of the findings other than swelling and pain that I had previously outlined earlier in this deposition.
He either didn't examine Mr. Jones' left knee or he failed to document it; but certainly if he had a concern about a patellar tendon rupture and if he examined Mr. Jones' left knee in a detailed fashion and accurately, it would have been clear that there was a complete rupture of the patellar tendon.
**Q So, what should he have done differently?**
A I can list again all the clinical findings on exam of a patellar tendon rupture.



**Q I didn't ask what the findings would be. I asked what should he have done differently?**
A So, he should have documented that there was a palpable gap in the tendon. He should have documented that Mr. Jones had no ability to extend the knee. He should have documented that Mr. Jones could not walk normally on the leg. He should have documented that there was tenderness over the patellar tendon. He should have documented that there was an effusion or hemarthrosis in the knee. He should have documented that there was painful range of motion of the knee. He should have documented that the patella was hypermobile. He should have documented that there was possibly a high riding patella. I'm done.
**Q And again, you weren't there for the examination, correct?**
A I wasn't.
**Q So, how do you know that each of those things that you just said he should have recorded were present? How do you know they were present on that date?**
A Because they're present in every patient with an acute patellar tendon rupture.
**Q Without fail?**

A The only one that may not have been easily identifiable would be the high riding patella, but all the other ones most certainly were there.

**Q After Dr. James -- during, before, Dr. James ordered that Mr. Jones not go to work, school, the yard, the gym, day room activities and group therapy, correct?**

A Correct.

**Q He ordered that Mr. Jones have meals in his room for four weeks, correct?**

A Correct.

**Q He ordered that Mr. Jones have a low bunk and a low gallery permit, correct?**

A Correct.

**Q Do you know what a low bunk and a low gallery permit is?**

A I assume it means that you are the lower of the two bunks in the cell and that he's on the first floor.

**Q And Dr. Jones ordered -- I'm sorry -- Dr. James ordered that Mr. Jones be able to have crutches, correct?**

A Correct.

**Q Do you have any issue with any of these orders?**

A No.



**Q When Dr. -- When the x-ray results were returned, they indicated that Mr. Jones had a slightly high riding patella, correct?**

A Correct.

**Q What is a slightly high riding patella?**

A Well, it's a patella that is no longer in its normal position in the knee. Now again, these x-rays I don't have for review. I only have the radiologist's report, but even the radiologist saw that there was a abnormality of the patella consistent with the patellar tendon rupture.

**Q The x-ray, the radiologist report says that it's slightly high riding. What does that mean?**

A Well, without looking at the x-rays, I can't tell you how high riding the patella was. Slightly is a subjective term. One person may say 2 millimeters is slightly. Another person may say 6 millimeters is slightly. I can't tell you without looking at the x-rays myself whether I agree with that interpretation.

**Q So, that was not my question. My question is what does it mean if someone writes slightly high riding?**

A It means there is a high suspicion for a patellar tendon rupture.



**Q And that's what that would mean to everyone who sees that term?**

MR. FLAXMAN: Everyone who is a physician?

BY MS. BYRD:

**Q Everyone that is a physician, sure?**

A With a traumatic injury? Yes.

**Q Define traumatic injury?**

A An injury to the knee.

**Q So, every injury to the knee is a traumatic injury?**

A Yes.

**Q So, if I bump into your table on my way out of door and get a bruise to my patella, that is a traumatic injury?**

A Correct.

**Q And if I fall down a flight of stairs and injure my knee that way, that's also a traumatic injury?**

A Correct.

**Q So, every single injury to the knee is a traumatic injury?**

A Yes.

**Q And that's your opinion? Or that is the generally accepted medical definition of traumatic**



**injury to the knee?**

A Well, that's the whole definition of injury. You have a trauma to a certain body part. It's almost repetitious. You can't have an injury without trauma and you can't have trauma without an injury if it's truly traumatic.

**Q What effect would the fact that there was an intermedullary rod in Mr. Jones' distal femur have on this particular injury?**

A None.

**Q Why?**

A Because the intermedullary nail was used to fix a femur fracture from a gun shot wound to the thigh which is a fair distance away from where Mr. Jones ruptured his patellar tendon.

**Q When Mr. Jones returned to the infirmary on December 3rd of 2015, you noted or the nurse noted that he complained of pain that was 5 of 10, correct?**

A Correct.

**Q Do you also believe that that is inaccurate?**

MR. FLAXMAN: I object to the form of the question, also.

THE WITNESS: I never stated that the previous rating was inaccurate.

BY MS. BYRD:
**Q Do you believe that this is an accurate recording, 5 of 10 pain?**
A Yes.
**Q And that, again, is something that would have come from Mr. Jones, correct?**
A Correct.
**Q It indicates that the nurse discovered that Mr. Jones' range of motion was limited, correct?**
A Correct.
**Q It doesn't say that he was unable to use his leg, correct?**
A He was unable to use it normally.
**Q How? Tell me what a range of motion being limited is?**
A It means --
**Q In this context means?**
A It means that he doesn't have normal motion of his knee.
**Q But it doesn't mean that he has no motion of his knee, correct?**
A That is correct.
**Q Then Dr. James saw Mr. Jones on December 8th of 2015, correct?**



A Yes.
**Q In that time frame, between November 16th of 2015 when Dr. James first saw Mr. Jones and December 8th of 2015, what information do you have about Mr. Jones' requests for medical treatment in those intervening days?**
A I'm sorry, the question again?
**Q What information do you have regarding Mr. Jones' requests for medical treatment between November 16th of 2015 and December 8th of 2015?**
A Well, he returned back to the infirmary on December 3rd for persistent symptoms.
**Q Do you have any knowledge that he attempted to obtain medical treatment between November 16th and December 3rd?**
A I have no medical records to say one way or the other.
**Q Do you have any knowledge that Mr. Jones sought and was denied treatment in those -- between November 16th and December 3rd?**
A I have no documentation to support that.
**Q Do you have any knowledge that between December 3rd and December 8th that Mr. Jones sought treatment and was denied treatment?**



A I'm sorry, between which two dates?
**Q December 3rd and December 8th?**
A No.
**Q What do you know about the process for an inmate inside Sheridan Correctional Center to obtain health care when they need or want health care?**
A My understanding is there is an infirmary that they have access to for health care.
**Q And that's an infirmary that they can present themselves to at any time? Or is there a process that they need to go through?**
A I believe -- My understanding is they have to make a request.
**Q And how does that request get processed?**
A I believe the inmate has to fill out a form for the request.
**Q Do you have any knowledge or information that Mr. Jones did that between November 16th and December 3rd?**
A I don't have any knowledge of that.
**Q Do you have any knowledge or information that Mr. Jones did that between December 3rd and December 8th?**
A Well, he must have to get into the infirmary on



December 3rd and then he was scheduled to follow up five days later with Dr. James.
**Q So my question was, between December 3rd and December 8th, do you have any knowledge that he filled out a form and asked to be seen sooner than December 8th?**
A I don't have any information about that.
**Q And on December 8th when Dr. James saw Mr. Jones, Dr. James noted that Mr. Jones' swelling had increased, correct?**
A Dr. James documented that Mr. Jones had persistent left knee swelling. I don't know if it was documented that it was increased.
**Q He also noted that there was persistent pain, correct?**
A Correct.
**Q Did not note that that pain had increased, correct?**
A He made no mention of whether it was increased or decreased.
**Q And he noted that the patella was notably displaced, correct?**
A Correct.
**Q And at that time, Dr. James then referred**

Mr. Jones for an orthopedic intervention, correct?
A No. I believe he ordered the MRI scan.
Q I don't believe he ordered the orthopedic evaluation at that time.
Q In paragraph two of page three of your report, does it not state his plan was to refer Mr. Jones for orthopedic intervention?
A Sure, but that doesn't mean that he did order on that date an orthopedic evaluation.
Q You don't consider -- Well, would you require that a patient have -- You said you require a patient have an MRI before you would do a surgery on a ruptured patellar tendon, is that correct?
A That is correct.
Q So, is it fair to say that ordering an MRI is a precursor to seeing an orthopedist?
MR. FLAXMAN: I object to the use of the word precursor which I think it doesn't mean what you think it means.
THE WITNESS: I would disagree.
BY MS. BYRD:
Q Okay. So, if a patient came to see you and it was suspected that that patient had a ruptured patellar tendon, would you refer that patient get an MRI?



A Yes.
Q So that you could confirm what your suspicions were, correct?
A Yes.
Q So, it is medically sound to get that MRI prior to the patient seeing a doctor, correct? Seeing an orthopedist?
A No, it's not.
Q Why is it not?
A Because if your index of suspicion for a patellar tendon rupture is that high that you are going to get an MRI scan on the knee three weeks after the injury and rupture, you better send him to the orthopedic surgeon right away.
Q And why is that?
A Because now it's been a three-week delay since the injury and as a result, the results of any surgical intervention have been diminished; and the longer you wait, the greater likelihood that she's not going to have a successful result of the surgery to repair or reconstruct that tendon, if there is a delay in treatment.
The longer you wait to get him in to see the orthopedic specialist, the less



likely he's going to have a successful result of treatment by the orthopedic surgeon.
Q Would your answer to that question change at all if the referring physician is aware that the orthopedic surgeon requires an MRI when the patient is presented for an exam?
A No.
Q So, even if the referring physician knew that the orthopedic surgeon would require an MRI, the referring physician should not order one?
A I didn't say that.
Q So, how would your answer change if the orthopedic -- or if the general practitioner referring physician knew that information in advance?
A I still would have the person see an orthopedic surgeon; and if there is going to be a delay in seeing the orthopedic surgeon because that orthopedic surgeon wants an MRI first, knowing that it has already been a three-week delay in the process of ordering an MRI scan, then I would have him see someone else, from the orthopedic surgery standpoint. Time is of the essence at three weeks after an acute patellar tendon rupture.
Q On December 29th, you indicate in your report that Mr. Jones wrote a grievance, correct?



A I did.
Q And is it fair to say that Mr. Jones' concern in his grievance is that he makes sure that he has time to recover from his surgery before he gets released?
A Correct.
Q In fact, he knows the exact number of days until his release, correct?
A Correct.
Q And he indicates that he needs to be able to recover so he can work, correct?
A Correct.
Q Tell me what Mr. Jones' job is when he's out of prison?
A I don't know if he had any specific job that he was going to return to after his release. I know according to his grievance, that he was interested in returning back to some form of work.
Q And prior to his incarceration, when was the last time that Mr. Jones worked?
A That, I don't know.
Q And in Mr. Jones' grievance, he doesn't complain of any pain, correct?
A He does not mention it.
Q He doesn't complain of swelling, correct?

A He does not mention it.
**Q He doesn't complain of limited range of motion correct,**
A He does not mention it.
**Q He doesn't complain of tenderness, correct?**
A That is correct.
**Q He doesn't complain of bruising, correct?**
A That is correct.
**Q He doesn't complain of any of the symptoms that you indicated would be present for a patellar tendon rupture, correct?**
A Well, I don't think that was the point of his grievance, what his residual symptoms are. I think his grievance was that he wanted to get this ball rolling.
**Q But my question was, he didn't complain of any of those symptoms, correct?**
A That is correct.
**Q And you testified earlier that this grievance was received by Wexford on December 29th, correct -- I'm sorry, on January 6th. Correct?**
A 2016, correct.
**Q And how do you know that it was received by Wexford on that day?**
A Based on the medical records that I reviewed.



**Q And if you learned that the grievance was not received by Wexford, would that change any of your opinions as it relates to Wexford in this case?**
A No.
**Q Why not?**
A Because now it's six weeks after his acute patellar tendon rupture and he still hasn't gotten an MRI scan and he still hasn't seen the orthopedic surgeon. He still is struggling with extending his knee. He is still dysfunctional and again, there is further delay.
**Q When Mr. James -- I'm sorry Mr. Jones had his MRI, it showed a clinical impression of a patellar tendon rupture, correct?**
A Correct.
**Q What does that mean? What does clinical impression mean?**
A That's the diagnosis.
**Q And it also said that there is a small tear in the posterior horn of the medial meniscus, correct?**
A Correct.
**Q And what does that mean?**
A He had a small tear in his meniscus.
**Q Is that something that requires surgery?**



A If the patient is symptomatic and fails conservative measures, often people are treated for it, yes.
**Q But it's not something that requires surgery?**
A Not absolutely, no.
**Q And is there any way to know if that tear happened at the same time as the rupture?**
A There is not.
**Q They can happen independently, correct?**
A Yes.
**Q What does it mean that there is no chondromalacia?**
A No softening of the cartilage or arthritic changes. Although, the radiologist noted some low grade chondromalacia of the kneecap.
**Q Can you explain? Because I noticed that. What are the -- How can there be none and low grade?**
A I think the radiologist was talking about the medial compartment where the meniscal tear was, that there was no chondromalacia.
**Q And then the low grade is?**
A Underneath the knee.
**Q Under the kneecap itself?**
A Correct.



**Q What is a 1.6 centimeter defect consistent with superiorly retracted patella? What does that mean?**
A So, as a result of his complete patellar tendon tear or rupture, the quadriceps muscle, which no longer is being opposed, contracts; and as it contracts over the course of time, it pulls the kneecap towards the hip joint. So, that creates a wider and wider gap at the side of the patellar tendon rupture. So, that is what the radiologist saw.
Now at nearly three and a half months -- no, excuse me, do my math right -- seven weeks roughly since the tear, that there is a gap or defect where the patellar tendon originally lied. As a result of the contracture of the quadriceps muscle, the kneecap then becomes retracted superiorly or migrates superiorly towards the hip joint.
**Q Is there a normal gap like someone whose patellar tendon is fully intact?**
A Normal is no gap.
**Q So, 1.6 is from 0 to 1.6 centimeters abnormal?**
A Anything is abnormal.
**Q Okay. So, there should be no gap at all?**
A That is correct.
**Q And what does it mean that the patella was high**

**riding and subluxed 4 millimeters laterally?**

A So, as a result of the patellar tendon rupture, again, the patella has retracted superiorly or up the thigh and therefore, it was high riding. Meaning, it was riding high in the knee joint which is consistent with a complete tendon rupture; and as a result of the pull of the quadriceps muscle, it started to sublux or partially dislocate 4 millimeters to the outside of the knee joint.

**Q So again, is that a 0 to 4 -- 0 would be normal?**

A Correct.

**Q Okay, and is there a way to know if this high riding patella is now higher -- closer to the thigh than the slightly high riding that showed up in the x-ray?**

A I would have to look at those original films to tell you.

**Q What does it mean when the radiologist says there is minimal edema in the inferior aspect of the patella?**

A It means that the -- that because of the length of time since the original injury, that most of the swelling and edema, synonymous with swelling, was



really minimal at the area of the tendon rupture.

**Q And then the radiologist uses the word torn patellar tendon. Is that kind of what we already discussed about tear versus rupture and some people using them interchangeably?**

A Yes.

**Q And it says, it appeared thickened which is compatible with retraction, mild changes and consistent with a contusion or chronic tendinopathy. What does that mean?**

A So, the tendon completely ruptured and it became retracted and because -- think of the patellar tendon as a rubber band. So, normally it's pulled tight because that's the way you extend your knee and that's what holds you up on your leg when you are walking or standing or on a single leg stance on the affected leg. So when that tendon ruptures, that tension is completely released and that patellar tendon or rubber band accordions. It does this. So now because it's accordioned, it becomes thickened and now that it's been seven weeks, it becomes fibrosed and scarred.

**Q You state in your report that Dr. James was aware of the results of the MRI on January 18th of**



**2016. That's the date that the MRI was performed, is that correct?**

A That is correct.

**Q On what do you base that opinion that Dr. James knew that day what the results of the MRI were?**

A Because on January 18th, Dr. James filled out a Medical Special Services Referral and Report to the orthopedic surgeon at Midwest Orthopedic Institute and on referral he wrote a complete tear of the patellar tendon at its origin.

**Q And what is the significance of that to you?**

A He was aware of the complete tendon rupture as confirmed by the MRI scan on January 18th.

**Q And why is that significant to you that he found out the results the same day in your opinion?**

A Because he should have picked up the phone and gotten Mr. Jones in to see the orthopedic surgeon as soon as possible. He should have done that weeks prior.

**Q Do you know if Dr. James has the ability to just pick up the phone and call an orthopedic surgeon and get Mr. Jones in?**

A He should have. Whether it was to his superiors at Wexford or to his collegial physician that



he reviews things with. He should have done something much more expeditiously because it wasn't until February 8th that Mr. Jones actually got in to see the orthopedic surgeon which was almost three weeks after Dr. James knew the MRI scan findings confirmed a complete tendon rupture from two months earlier. I mean, that's just crazy.

**Q And what knowledge do you have that Mr. Jones could have gotten in to see the orthopedic surgeon sooner than February 8th, 2016?**

A This is where it becomes the responsibility of the treating physician to do everything possible to get that patient in to be seen and treated by the surgical specialist.

**Q Okay. So my question was, what information or knowledge do you have that Dr. James could have gotten Mr. Jones in to see the orthopedic surgeon sooner than February 8th of 2016?**

A He could have done a lot of things. He could have sent him to the hospital.

**Q My question to you is, what information or knowledge do you have that Dr. James had the ability to get Mr. Jones in to see the orthopedic surgeon sooner than February 8th of 2016?**

A My knowledge is he could have sent him to the hospital for immediate orthopedic consultation.
**Q And that's your opinion as to what he should have done?**
A If he could not have gotten him in to see an orthopedic specialist within five days, in my opinion, of noticing the MRI scan findings, he should have sent him to the hospital to get treated.
**Q When Mr. Jones did see the orthopedic surgeon, that was Dr. Bell, correct?**
A Correct.
**Q And that was on February 8th, 2016, correct?**
A That is correct.
**Q And after Dr. Bell examined Mr. Jones, Dr. Bell did not immediately perform surgery on Mr. Jones, correct?**
A He recommended surgery as soon as possible.
**Q But my question is, he did not immediately perform surgery on Mr. Jones, correct? He did not do emergency surgery on February 8th of 2016, correct?**
A He did not do emergency surgery because at this point it was no longer emergent. He's been almost three months now since his injury.
**Q And he did not -- He didn't recommend emergency**



**surgery and have that denied by Dr. James, correct?**
A He recommended surgery as soon as possible.
**Q The surgery was done on February 16th, correct?**
A Another eight days later.
**Q So, when did it -- when was the time frame that it was no longer emergent to do surgery? What was the day that occurred?**
A The longer you wait, the less likely you are going to have a successful outcome. So, these tendon ruptures should be repaired as soon as possible. Optimally, in three weeks or less. Optimally, in the first ten days. Once you get beyond three weeks, your outcome starts to diminish. Certainly at three months, they are greatly diminished.
**Q The surgery that was performed by Dr. Bell, that was a successful surgery, correct?**
A In what sense?
**Q In that Dr. Bell was able to accomplish what it is he believed he could accomplish when he did the -- when he started the surgery or recommended the surgery?**
A To me a successful surgery is one where the patient fully recovers his function and has no symptoms or pain. That wasn't Mr. Jones. Mr. Jones still had problems with his knee after Dr. Bell's surgery and he



had such symptoms that he required a second surgery by another orthopedic surgeon. Do I think his surgery was successful? By my definition, no.
**Q What would you have done differently to make it a successful surgery?**
A I think at three months, I don't think anything could have been done to make it a successful surgery. The delay was too long.
**Q Would you at the time Mr. Jones had his initial surgery, would you have expected that he would need to undergo a second surgery?**
A I would say I would not be surprised that he would require another surgery, particularly for stiffness of the knee given the chronicity of his patellar tendon rupture and the difficulty in reconstructing the tendon. The delay was such that Dr. Bell could not repair the tendon. He had to reconstruct the tendon by using cadaver tendon, and Dr. Bell clearly showed in his operative report how much scarring and fibrosis there was in the knee as a result in the delay of treatment.
**Q Is there anything that would have prevented the second surgery from needing to occur?**
A Yes. Operating on the patellar tendon rupture



in a timely fashion.
**Q Which you are saying was anything short of three weeks?**
A Shorter than three weeks, best case scenario less than ten days.
**Q So, anything over three weeks would have resulted in the same scenario?**
A Again, the longer you wait, the greater the likelihood of having these complications; and for Mr. Jones, it was chronic pain and stiffness.
**Q Do you have personal knowledge on the follow through that Mr. Jones did after his first surgery in terms of following the discharge recommendations of Dr. Bell?**
A To some degree, yes.
**Q And what do you know?**
A I believe he was referred to the orthopedic team at Rush Hospital.
**Q Anything else?**
A I know that he required physical therapy eventually for the knee.
**Q And was that recommended as part of his discharge from Dr. Bell?**
A I believe Dr. Bell recommended physical therapy

during the time frame that he was treating Mr. Jones.

**Q And what do you know of Mr. Jones' follow through on that recommended physical therapy?**

A Well, I know he had physical therapy at Midwest Orthopedic Institute.

**Q Anything else?**

A I would have to go back and look at the medical records to see if Dr. Bell recommended physical therapy at the prison and after his release from the prison.

**Q Inside Sheridan Correctional Center, where do inmates go to get their meals?**

A The meal haul.

**Q And where is that located in relation to where Mr. Jones' cell was prior to his surgery?**

A I do not know.

**Q Do you know anything about the logistics inside the prison that are involved with an inmate receiving their meals in their cell as opposed to going to the meal haul?**

A I do not.

**Q Do you know how far it was that Mr. Jones had to travel to obtain his meals when he had to go to the meal hall to get his meals?**

A I do not.

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**Q Once Mr. Jones got to the meal hall, what was the process for him getting his meal? What did he physically have to do to get his meal?**

A I do not know.

**Q What injuries did Mr. Jones suffer as a result of having to leave his cell to get his meals?**

A So, it appears that Mr. Jones did have a fall and I believe he sustained an injury to his other knee.

**Q And that was during the time that he was still receiving his meals in his room, correct?**

A I don't believe so. I think Dr. James removed those allowances -- I would have to look at the date. I don't recall specifically the date. I know I have it somewhere in my report.

**Q Page 4 of your report you indicate that on January 23rd, Mr. Jones had his Ibuprofen prescribed again. He was given 50 tablets and on January 25th, the nursing staff documented that Mr. Jones was using two crutches and his left knee had restricted range of motion due to a previous injury. He had a recent fall after his right knee buckled. He fell onto his buttocks and injured his right shoulder, correct?**

A That is correct.

**Q And then on February 2nd you indicate that Dr.**

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**James denied the extension of Mr. Jones' special order to receive meals in his room, correct?**

A That is correct.

**Q So, the falling happened prior to that being denied or extended -- not extended, correct?**

A That happened before. His fall where he injured his right shoulder and buttocks occurred before Dr. James rescinded his allowance to have meals in his cell.

**Q So, what injuries did Mr. Jones suffer as a result of Dr. James not extending his permit to have his meals in his room?**

A I don't believe he sustained any injuries after that date.

**Q So, you don't believe he sustained any injuries as a result of Dr. James not extending that permit, correct?**

A It's not documented in the medical record, correct.

**Q There are none that you are aware of, correct?**

A Correct.

**Q On what do you base your opinion that Dr. James deviated from the standard of care in his evaluation and treatment of Mr. Jones' acute patellar tendon**

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**rupture?**

A Dr. James delayed treatment for Mr. Jones' acute patellar tendon rupture in regards to his untimely referral to the orthopedic specialist as well as ordering the MRI scan.

**Q Anything else?**

A He also deviated from the standard of care that he provided inadequate follow-up after his evaluation of Mr. Jones on November 16th, 2015 after he clearly had a suspicion for an acute patellar tendon rupture.

**Q What was inadequate about his follow-up?**

A He wanted to see him on an as-needed basis.

**Q And what does an as-needed basis mean within the prison correctional setting?**

MR. FLAXMAN: Object to the form of the question.

THE WITNESS: I think it's irrelevant what it means. What it means is if you have a person where you are suspicious about an acute patellar tendon rupture, you better provide some follow-up to make sure that this person doesn't have that tendon rupture because that tendon rupture requires surgery in an urgent fashion.

Clearly by November 30th, Dr. James had no inclination to see Mr. Jones in follow-up

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after his initial injury after ordering the x-rays.

**Q Anything else?**

A No.

**Q On what do you base your opinion that Dr. James performed an inadequate physical examination of the knee?**

A Again, during his initial evaluation of Mr. Jones on November 16th, 2015, he missed the clear signs of an acute patellar tendon rupture. Had he made an accurate diagnosis based on hs physical exam, or at least had follow-up of Mr. Jones in a timely fashion to reexamine his left knee, then there wouldn't have been the delay in seeking appropriate surgical intervention for his traumatic injury.

**Q And again, you weren't present for the physical exam, correct?**

A I was not.

**Q So, you don't know whether or not Dr. James actually examined for these symptoms that you said should be there, correct?**

A Well, if he did, he should have put them in his medical documentation.

**Q So, it's an issue with the documentation?**

A I think it's an issue of his lack of concern



for potential patellar tendon rupture. Because clearly, he was suspicious for it and he had his follow-up on an as-needed basis; and something that requires surgery absolutely in a young active individual.

**Q On what do you base your conclusion that Dr. James never bothered to follow up on the radiograph testing that he ordered on November 16th of 2015?**

A So, Dr. James signed the nurse's injury report of November 14th 2015 on November 30th of 2015, more than two weeks later; and on that report he signed, he wanted to see the offender on an as-needed basis only. Clearly, if he saw the x-rays or the x-ray report, his suspicion for patellar tendon rupture would have been vastly increased.

**Q And that's the only thing that you base that conclusion on, is that --**

A That he did not see the x-rays?

**Q Yes.**

A Well, if he had seen the x-rays, it certainly would have been outside the standard of care not to see Mr. Jones back in an immediate fashion because the x-rays were consistent with a complete patellar tendon rupture.

**Q And that x-ray report being the one that said**



**it was a slightly high riding patella, correct?**

A That is correct.

**Q Is that the same reason that you concluded that it's clear from the medical record that Dr. James never saw the radiologist's report of the x-rays until he saw Mr. Jones on December 8th of 2015?**

A If he saw the x-ray or the x-ray report, then it was his absolute obligation to reevaluate Mr. Jones in an immediate fashion for further evaluation for patellar tendon rupture; but clearly by November 30th, he had no interest in seeing Mr. Jones for a scheduled appointment. He wanted to see him on an as-needed basis. So, either he saw the x-rays and understood the findings and ignored them or he never looked at the x-rays. Either one is outside the standard of care.

**Q On what do you base your opinion that the shortcomings from the standard of care constituted no treatment at all?**

A Because the treatment for an acute patellar tendon rupture in a young, active individual is surgical and surgical optimally within ten days.

**Q And when you use the term young, tell me what that means to you? Because that clearly has different meanings to all of us.**



A True. Certainly it becomes urgent when you have someone, depending upon their comorbidities and their health, to have this fixed when they are 70 or younger.

**Q I knew I liked your definition of young.**

**On what do you base your conclusion that it is readily apparent that Dr. James was unaware that Mr. Jones was still ambulating with crutches, had limited range of motion of the left knee, had no ability to extend the left knee, had persistent pain and swelling in his left knee and was still on pain medication? It's at the bottom of Page 9 if that is helpful.**

A So, these were the findings that were present as of December 3rd of 2015; and again, Dr. James did not provide any follow-up of Mr. Jones to assess whether he was recovering from his injury of November 14th of 2015. Dr. James was unaware of Mr. Jones' persistent symptoms even three weeks after his injury.

**Q And you base that conclusion on what? Did Dr. James write that in his notes somewhere?**

A So, the second time Dr. James evaluated Mr. Jones was on December 8th. Clearly based on the nursing notes of December 3rd of 2015, Mr. Jones was still having these issues with his knee. Dr. James

provided no follow-up after he ordered the MRI -- excuse me -- the x-rays of Mr. Jones' left knee and so because there was no follow-up, Dr. James was completely aware that Mr. Jones was still doing quite poorly with his left knee up until December 8th of 2015. When he saw him on December 8th of 2015, he found that he was doing poorly. That the x-rays showed findings that were consistent with the patellar tendon rupture and then he had a hypermobile patella and persistent left knee pain and swelling.

**Q Are those the same facts on which you base your conclusion that Dr. James never scheduled Mr. Jones for reexamination or checked his progress after evaluating Mr. Jones on November 16th?**

A Well, based on his signing of the nurse's note which he signed on November 30th where he asked to see him on an as-needed basis. Which in my mind is ridiculous when you have a suspicion for an acute patellar tendon rupture and you order a study to evaluate for that injury and you don't bother to follow up with the findings of the study you ordered.

**Q And again, you don't know within the setting of Sheridan Correctional Center what Dr. James means when he says an as-needed basis, correct?**



A Well, I think that is the same for all physicians. It's follow up as needed. I don't need to see you back but if you got a suspicion for an acute patellar tendon rupture and you order a study and that study is abnormal and it's consistent with your suspicion for an acute patellar tendon rupture, you better see that person back. At least, if anything, to go over the x-rays with the inmate.

**Q And you don't know anything about the scheduling process within Sheridan Correctional Center, correct?**

A Scheduling for what?

**Q Medical scheduling?**

A To see a physician?

**Q Correct. For an inmate to see a physician or an inmate to see a nurse?**

A I do not but I do know as a physician if I order a test, I am obligated to follow up on that test.

**Q On what do you base your conclusion that Mr. Jones returned to the infirmary on his own accord on December 3rd of 2015?**

A Because he was still having pain, swelling and limited motion and an inability to extend his knee and inability to ambulate normally.



**Q But how do you reach the conclusion that he returned on his own accord as opposed to that being a scheduled appointment?**

A I believe that's in the medical records. Clearly on November 30th, Dr. James said follow up PRN, as-needed, only.

**Q And on what do you base your conclusion that without a doubt Mr. Jones was told that he had a patellar tendon rupture by Dr. James as documented in his December 29th of 2015 grievance?**

A In his grievance, Mr. Jones says it's been two months since I ruptured my patellar tendon. I need to get my MRI scan. I need to get this fixed. So, clearly someone told him that he had a ruptured patellar tendon and I don't think it was the nurse. I'm pretty confident it was Dr. James because that's what Dr. James was suspicious for on multiple visits and evaluations of Mr. Jones.

**Q So, you're basing your conclusion that Dr. James knew at least by December 29th of 2015 that Mr. Jones had a ruptured patellar tendon? You're basing that conclusion on the grievance that Mr. Jones wrote?**

A Well, sure because I don't think Mr. Jones



self-diagnosed himself with a patellar tendon rupture that occurred two months ago; and clearly, Dr. James was suspicious from the day that he examined Mr. Jones, he had a suspicion for a patellar tendon rupture. When he came back to be seen, Mr. Jones came back to see Dr. James on November 8th. Again, not only did he have a high suspicion for patellar tendon rupture, but he had more clinical exam findings consistent with a patellar tendon rupture including a displaced patella.

**Q On what do you base your conclusion that Dr. Verma, "Had to perform a second surgery on Mr. Jones' left knee."?**

A Well, I don't think Dr. Verma had to do anything. Dr. Verma was there to evaluate Mr. Jones for his complications as a result of the treatment of his neglected left patellar tendon rupture. Dr. Verma's job was to tell him what his treatment options were and Mr. Jones elected to proceed with surgical intervention.

**Q When you use the words Dr. Verma who had to perform a second surgery, you don't mean it was a required surgery? You mean it was one of the possible treatments that Mr. Jones could have received?**

A Correct, and eventually he did in fact have a

second surgery to treat the complications of his first surgery.

**Q That was an elective surgery by Mr. Jones, correct?**

A Yes.

**Q Tell me what you know about Wexford's policies?**

A Nothing.

**Q So, which of the policies -- which of Wexford's policies was Dr. James following in his treatment of Mr. Jones?**

MR. FLAXMAN: Object to the question. The witness just said that he doesn't know anything about their policies. Now, you are asking him which ones were violated. That's not --

MS. BYRD: I didn't say violated. I asked what was he following.

MR. FLAXMAN: But he just said that he doesn't know anything about the policies. That's not a productive question.

MS. BYRD: So, in his report he says Wexford Health Sources whose policies Dr. James was following and Dr. James knew that Mr. Jones had a patellar tendon rupture.



BY MS. BYRD:

**Q So I'm asking, which policies of Wexford Dr. James was following that you refer to in your report?**

A So, Dr. James had to do a collegial review for further evaluation and treatment of Mr. Jones' traumatic injury to his left knee. He also had to follow Wexford's policies to obtain a specialist referral as well as authorization for surgical intervention.

**Q How do those policies differ from what you have to follow when you have a patient that needs surgical intervention and you need approval from an insurance company?**

A So, as far as a surgical procedure, there is not much difference; but again, on an urgent situation, usually that authorization is obtained within one to two days when it's urgent. I also don't need to get the blessing of another physician to pursue an MRI scan on a patient or offer surgical intervention or refer one of my patients to another specialist.

**Q But you do need to get the blessing of the insurance company, correct?**

A I don't have to.

**Q How often do you have patients undergo MRIs without approval from their insurance company?**



A Usually, it's the MRI facility that's responsible for obtaining the authorization for the MRI.

**Q And how often is that MRI completed without approval of the insurance company?**

A You would have to ask the MRI facilities.

**Q How often have you seen an MRI be performed without approval of an insurance company?**

A I don't know the billing of the MRI facilities on how they collect from the insurance companies when it's authorized or not authorized.

**Q So, it's your testimony as you sit here today that patients get MRIs without approval of their insurance company?**

A It has happened, yes. Does it happen often? No, it doesn't happen often but when you are describing an urgent situation where most likely surgery is going to be indicated and that surgery needs to be done in a timely fashion typically, and I'm just -- I'm not just talking patellar tendon ruptures but fractures for instance, you know, you explain to the person -- the patient that hey, you know, this needs surgery and we need to get this MRI scan and we'll try our best to get



the authorization; but, you know, this is something that you can't wait for.

So, it's rare but, you know, but on rare occasions patients will go ahead and get their MRI or their CT scan and, you know, and even have surgery without authorization from the insurance company.

**Q How often do you perform non-emergent surgery on patients without approval from in insurance company?**

A Well, because we pick up the phone and we call and we make an effort to get authorization within 48 hours. Usually, we can get that authorization within 48 hours, okay? So, you know again, this is one of my criticisms of Dr. James is that there was a huge time delay in obtaining this MRI scan, a huge time delay in actually getting a referral to the orthopedic specialist and an unreasonable length of -- period of time from the time of his initial injury to get authorization for surgical intervention.

**Q So, my question was, how often do you perform surgery on your patients without approval of the insurance company, non-emergent surgery?**

A Non-emergent surgery, very rare. Probably, less than once every two years but I will give you a

classic example. A pediatric fracture that's, you know, displaced and angulated, you know, is it emergent? No, but it certainly is urgent and I tell the patients, we are going to go to the operating room in two days or tomorrow and we'll try to do our best with the authorization from the insurance company but the longer you wait, the greater the risk of complications. So, you don't wait to get authorization when it puts the patient's health at increased risk.

**Q What correctional health care standards did Dr. James violate?**

A Are you talking about the deviations from the standard of care?

**Q Of correctional medicine, yes?**

A He inadequately examined Mr. Jones' left knee. He delayed the MRI scan order. There was a delay in referring him to the appropriate specialist to treat his injury and he failed to provide adequate follow up.

**Q Adequate follow up to the initial injury or adequate follow up following surgery?**

A To the initial injury.

**Q How many times have you met Mr. Jones?**

A Zero.

**Q Prior to his injury, how often did Mr. Jones**



**play basketball?**

A I don't know.

**Q When Mr. Jones was not in incarcerated, how often was he playing basketball?**

A I don't know.

**Q What other kinds of recreational activities did Mr. Jones participate in prior to his incarceration?**

A I don't know.

**Q What recreational activities is he prohibited from participating in today by his injury?**

A I'm sorry, the question again?

**Q What recreational activities does his injury prohibit him from participating in today?**

A From his treating orthopedic surgeons or what I would typically recommend to my patients with patellar tendon reconstructions?

**Q Based on your opinion?**

A No running or jumping, no high impact activities, no squatting, avoid kneeling if it's painful.

**Q And that's forever?**

A Correct.

**Q And that's for anyone with a patellar tendon rupture?**



A Correct.

**Q Do you have any opinions about Dr. James' treatment of Mr. Jones that we have not already discussed today?**

A No.

**Q And is there anything else that you want to add to your report as we sit here today?**

A No.

**Q And if the trial was today, you would testify consistently with your report?**

A I would.

**Q You wouldn't have anything else to add?**

A That is correct. Again, realizing that I didn't see his initial x-rays done on November 16th.

**Q If I could have just a minute?**

(Exhibit No. 2 marked)

(Recess had)

BY MS. BYRD:

**Q Doctor, I will just show you what we are marking as Exhibit No. 2. Do you need to see a copy? Can you look through that? It's my understanding that that is a copy -- a complete copy of your report that's dated May 8th of 2019?**

A Correct.



**Q And that's the report that you were referring to when I asked if you had any additions that you needed to make to your report, correct?**

A That is correct.

**Q And your answer to that was no, correct?**

A That is correct.

**Q Okay. Then I'll just introduce that in as Exhibit No. 2 and then I don't have any further questions for you.**

EXAMINATION

BY MR. FLAXMAN:

**Q I want to clarify a few things. There was a question way at the beginning of the deposition which I can't fully remember, but it was about the nurse seeing Mr. Jones at 8:15 p.m. on November 14th, and then I think there is a question was -- should she have scheduled him to see the doctor the next day. Do you remember a question about what she should have done the next day?**

A Will, according to the medical records, Mr. Jones was scheduled to see Dr. James on November 17th but in fact he saw Dr. James on November 16th.

**Q In the free world -- but if somebody has an injury like apparently happened to Mr. Jones and then**

goes to get medical care promptly, what -- and the nurse's physical examination is consistent with a ruptured patellar tendon, what happens in the free world? Does the nurse send the patient to the emergency room?

A Well, most of these patients end up going to the emergency room before seeing any medical provider because they can't walk and they can't straighten their knee out. They can't extend it and they have quite severe pain and they have an injury, you know.

Patellar tendons are somewhat similar to quadriceps tendons. So, you know, you can't walk without the tendon attached. So, they end up in the emergency room and then the emergency room contacts the orthopedic surgeon and then a decision is made whether or not to admit the patient to the hospital for additional testing and surgery, or does the patient follow up with the orthopedic surgeon within the week.

Q Now, when you formed your opinions, did you consider that November 14th was a Friday?

A No.

Q Did you consider that there was no doctor on-site at Sheridan on November 14th at 8 p.m.?

A No.



Q I think it was a Saturday actually. Would your answer be the same if November 14th was a Saturday?

A No change in my opinion.

Q And if November 15th was a Sunday and there was no doctor at Sheridan, would any of your -- would that affect your opinions?

A No.

Q And you talked -- You were asked questions about Wexford's policies. Is it your inference from what you read that Wexford required that the patient or that a prisoner receive an MRI before Wexford would consider sending the patient to an orthopedic surgeon?

A That's not my understanding.

Q That's all have. Thank you for clarifying.

FURTHER EXAMINATION

BY MS. BYRD:

Q Do you have any knowledge of the staffing of physicians at Sheridan?

A As far as the number or the hours?

Q The hours or the days?

A I do not.

Q So, do you know if there are physicians on duty at Sheridan on Saturdays?

A I do not know.



Q Do you know if there are physicians on duty at Sheridan on Sundays?

A I do not.

Q Do you know if the medical staff at Sheridan has the ability to call a physician into the facility if needed?

A I do not know.

Q I have nothing further.

MR. FLAXMAN: Do you want to review this?

THE WITNESS: No, I'll waive.

FURTHER DEPONENT SAITH NAUGHT

- - - - -



STATE OF ILLINOIS )
) SS:
COUNTY OF COOK )

The within and foregoing deposition of the aforementioned witness was taken before NANCY J. BLACKBURN, C.S.R, and Notary Public, at the place, date and time aforementioned.

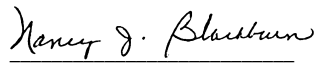
There were present during the taking of the deposition the previously named counsel.

The said witness was first duly sworn and was then examined upon oral interrogatories; the questions and answers were taken down in shorthand by the undersigned, acting as stenographer and Notary Public; and the within and foregoing is a true, accurate and complete record of all of the questions asked of and answers made by the aforementioned witness, at the time and place hereinabove referred.

The signature of the witness was waived. The undersigned is not interested in the within case, nor of kin or counsel to any of the parties.



Witness my official signature and seal as Notary Public in and for Cook County Illinois on August 23rd, 2019.



NANCY J. BLACKBURN, C.S.R.,
Notary Public

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May 8, 2019

Joel Flaxman
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Re: Johnny Jones vs. Wexford Health Sources, Inc. & Marshall James, M.D.
Court No.: 17 CV 8218
Date of Injury: November 14, 2015

Dear Mr. Flaxman:

What follows is my Medical Case Report regarding Mr. Johnny Jones. I had the opportunity to review the following medical records: those of Sheridan Correctional Center, Dr. Marshall James, Wexford Health Sources, Dr. Joseph Maides, Midwest Orthopaedic Institute, Dr. Ankur Behl, Midwest Orthopaedic Institute Physical Therapy, Midwest Orthopaedics at Rush, Dr. Nikhil Verma, Lawndale Christian Health Center, Daniel Ozinga, P.A., Dr. Amy McAuley, Schwab Rehabilitation Hospital, Valley West Community Hospital, Rush University Medical Center Physical Therapy, Oak Park Hospital, and the depositions of Mr. Jones and Dr. James. I also looked at the radiographs performed at Midwest Orthopaedic Institute and the MRI scan of the left knee.

Examination of the records demonstrates that Mr. Jones has a past medical history for gastroesophageal reflux disease, conjunctivitis, polysubstance abuse, a left Achilles tendon repair, a gunshot wound to the left femur with intramedullary nailing in 1991, right wrist and elbow pain and tendinitis, upper respiratory infections, headaches, vertigo, hypertension, chest pain, a right 5th finger injury, athlete's foot, pharyngitis, and folliculitis.

As you know, Mr. Jones is a 48-year-old gentleman who was incarcerated at Sheridan Correctional Center. He sustained an injury to his left knee while playing basketball on November 14, 2015. The earliest pertinent medical record was dated November 14, 2015. The Offender Injury Report noted that the time of injury was 8 p.m. in the gym and it was witnessed by the correctional staff. It occurred on the basketball court.



EXHIBIT # 2
Deposition
8-9-19
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Mr. Jones also had an injury report filled out by the infirmary nurse at 8:15 p.m. Mr. Jones described his left knee giving out while playing basketball and he fell on the floor hitting his head. At the time, he complained of left knee and head pain, which he rated 4/10. He was unsure if he lost consciousness. The nurse did not find any left knee swelling or tenderness. There was no bruising. There was no cut or open area on his head. There was a moderate knot and swelling at the base of his head. He was provided an ice pack, prescribed Motrin for five days, and given crutches for four days.

Dr. James was notified by the nurse, and Mr. Jones was scheduled for follow up on November 17, 2015. Mr. Jones was instructed by the nurse, Kristin Torres, to elevate and rest the knee. The report was reviewed and signed by Dr. James on November 30, 2015. Most interestingly on the report, Dr. James indicated that he would like to see Mr. Jones on an as needed basis.

The first time Dr. James examined Mr. Jones was on November 16, 2015. Dr. James noted that Mr. Jones complained of an injury to his head and left knee while playing basketball. On physical exam, Dr. James found that the left lower extremity had increased knee swelling and pain. His examination of the left knee was limited at best. His assessment was left knee derangement and rule out patellar tendon rupture. Dr. James ordered x-rays of the left knee to rule out a patellar tendon rupture. Dr. James ordered crutches for six weeks and a lay-in for four weeks. He prescribed Motrin 600 mg. twice a day for two weeks.

On November 16, 2015, Dr. James provided Special Orders for Mr. Jones for no work, school, yard, gym, or day room activities. He was not to do any group therapy interactions. Meals were to be in his room for four weeks. He was allowed a low bunk and gallery for two months. He was also given crutches for six weeks for a left knee derangement.

The radiographs were performed of the left knee on the same day that Dr. James examined Mr. Jones. The x-rays from November 16, 2015, of the left knee were done for pain after a fall. The radiologist saw an intramedullary rod in the distal femur consistent with Mr. Jones' previous internal fixation for his gunshot wound and fracture. There were mild tricompartmental osteoarthritic changes and a small joint effusion. The patella was described as slightly high riding. This report was dictated by the radiologist on November 18, 2015. I do not have these radiographs to review.

Mr. Jones returned to the infirmary 17 days later on December 3, 2015. He had limited range of motion of the left knee and swelling. He complained of 5/10 pain. The nurse discovered that his active range of motion of the left knee was limited. He was referred to Dr. James on December 8, 2015. Mr. Jones was instructed to use his pain medication, apply cold to his knee, and remain non-weight bearing on the left leg. The nurse's assessment was rule out skeletal injury.

The next time Dr. James examined Mr. Jones was on December 8, 2015. This was the

first time Dr. James saw Mr. Jones since November 16, 2015, despite his concern of a patellar tendon rupture and the radiographic findings of the left knee, which were reported on November 18, 2015. Dr. James found that Mr. Jones had persistent left knee pain and swelling. He had notable displacement of the patella. On physical exam, the left knee had a probable patellar tendon rupture.

Dr. James' assessment was rule out patellar tendon rupture. He found that the x-rays were consistent with a high riding patella. His plan was to refer Mr. Jones for orthopedic intervention. He ordered an MRI scan of the left knee and prescribed Motrin 600 mg. twice a day for another four weeks. At this point in time, it was over a month since Mr. Jones injured his knee.

A week later on December 15, 2015, Dr. James documented that there was approval by Collegial Review for an MRI scan of the left knee to rule out a patellar tendon rupture. The Utilization Management record from Wexford Health Sources dated December 16, 2015, authorized the MRI scan for a fall that occurred on November 14, 2015 with x-rays showing a slightly high-riding patella.

When Mr. Jones returned to the infirmary on December 26, 2015, he was instructed to continue his present management for his left knee injury. He came back to the infirmary on December 29, 2015. He was instructed to take Motrin 600 mg. as ordered by Dr. James.

On December 29, 2015, Mr. Jones filed an Offender's Grievance. He wrote that it had been almost two months since he ruptured his patellar tendon, and he knew that it took time to get things done. He was concerned that he was being released in 156 days, and he noted that he still had not gotten his MRI scan yet. At the time, he did not even know if the referral for the MRI scan had been approved. He stated that it took four to six months to recover from the major surgery for his injury. He claimed that he needed to be at least 75% recovered upon his release for his working purposes. He was interested in trying to speed up the process to get his knee fixed. This was received by Wexford Health Sources on January 6, 2016, more than a week later.

On December 30, 2015, Dr. James, again, provided Special Orders of no work, school, yard, gym, or day room activities, no group therapy interactions, and meals in his room for four weeks. Mr. Jones had an extension of his low bunk, low gallery, and crutches for another two months for left knee derangement with possible patellar tendon rupture. At this point in time, nearly six weeks after Mr. Jones' injury, he still had not received his MRI scan.

On January 6, 2016, Dr. James documented that the MRI scheduling form was completed for Mr. Jones. The MRI scan was finally performed on January 18, 2016, more than two months after Mr. Jones' injury. The MRI scan of the left knee noted that he had an injury in November with a clinical impression of a patellar tendon rupture.

The radiologist read a small tear in the posterior horn of the medial meniscus. There was no chondromalacia. There was a complete tear of the patellar tendon at its origin off the patella. A 1.6 cm. defect was observed consistent with a superiorly retracted patella. The patella was high riding and subluxed 4 mm. laterally. There was minimal edema seen in the inferior aspect of the patella. Low-grade chondromalacia of the patella was described along the medial facet.

The torn patellar tendon appeared thickened, compatible with retraction, and showed mild changes consistent with a contusion or chronic tendinopathy. There was questionable posttraumatic edema or tendinitis of the distal quadriceps tendon. It was felt that an intrasubstance tear was less likely involving the quadriceps tendon. A small joint effusion was observed as well as an 8 mm. Baker's cyst.

Dr. James saw Mr. Jones when he returned back from Valley West Community Hospital after his MRI scan. On exam, he found left lower extremity swelling and painful range of motion. Dr. James' assessment was rule out patellar derangement and rupture versus dislocation. His plan was possible follow up with orthopedics if the MRI scan was abnormal. Mr. Jones had a refill of his Motrin 600 mg. twice a day for two months.

Mr. Jones was instructed by Dr. James to return after his MRI scan results. On the same day, January 18, 2016, Dr. James filled out a Medical Special Services Referral and Report to Midwest Orthopaedic Institute for a left knee MRI scan which was consistent with a complete tear of the patellar tendon at its origin. It appears that Dr. James was aware of the MRI scan findings that day.

On January 23, 2016, Mr. Jones had his ibuprofen prescribed again 600 mg. twice a day. He was given 50 tablets. On January 25, 2016, the nursing staff documented that Mr. Jones was using two crutches and his left knee had restricted range of motion due to a previous injury. He had a recent fall after his right knee buckled. He fell onto his buttocks and injured his right shoulder.

On January 26, 2016, Dr. James was provided approval by Collegial Review for Mr. Jones' orthopedic consult. On January 27, 2016, Utilization Management of Wexford Health Sources approved a new outpatient office visit regarding the January 26th request for orthopedic consultation related to a patellar tendon disruption after an MRI scan showing the same. This was approved by Dr. Ritz in collegial conversation with Dr. James.

Mr. Jones returned to the infirmary on February 2, 2016. He was requesting an extension to his Special Orders for meals in his room. The nurse spoke to Dr. James and Dr. James denied the extension. Dr. James felt that Mr. Jones had two crutches and was able to use them for ambulation. It is unclear why Dr. James refused to extend Mr. Jones' Special Orders which he had done since November 16, 2015, and given the fact that Dr. James at the time was aware of the MRI scan findings showing a complete patellar tendon rupture. In light of Mr. Jones' recent fall with injury the

previous week, there appears to be no reasonable medical justification for Dr. James' actions.

On February 2nd a Specialty Appointment Document Request for a home exercise program was filled out by Dr. James. The Collegial approval was dated January 27, 2016. There was a notification of medical furlough to Midwest Orthopaedic Institute for February 8, 2016.

Mr. Jones was finally evaluated by Dr. Behl of Midwest Orthopaedic Institute on February 8, 2016. Mr. Jones had a chief complaint of a left patellar tendon rupture. The date of injury was listed as November of 2015. The injury occurred three months prior while playing basketball in prison. He went up for a shot, felt his knee pop, and ever since the injury Mr. Jones had excruciating pain, which was sharp in the quadriceps tendon. He rated his pain 10/10 and he was on ibuprofen for the pain. Mr. Jones had increased pain with walking, flexing, and use. He had inability to extend and bend his knee at his kneecap. Ever since the patellar injury he had atrophy and pain in the quadriceps region.

On physical exam, Mr. Jones could not actively extend his left knee. Passive range of motion was 0° to 90°, but he could not hold the left knee extended. He had diffuse, severe quadriceps atrophy. His kneecap was high riding. He was only able to flex to 90°. He had no resistance against "extension". In reality Dr. Behl meant to say "flexion", meaning that Mr. Jones could not extend his knee against it being bent or flexed. Radiographs were performed, which showed an intramedullary nail in the left femur with a bullet fragment in the posterior bone. Mr. Jones had a very high-riding patella with an Insall-Salvati ratio of 2.25. There was sclerosis seen of the tendon and inferior aspect of the patella. There was no arthritis.

I reviewed these x-rays from February 8, 2016 which included bilateral AP and PA standing views, a lateral radiograph of the left knee, and bilateral sunrise views. These clearly demonstrated that the left patella was high riding and had migrated superiorly as compared to the right patella. Furthermore, there was evidence of an avulsion fracture involving the inferior pole of the patella with the fracture fragment displaced roughly 2 inches inferior to the patella. The lateral x-ray showed patella alta (an abnormally high positioned patella). The knee did not exhibit any significant arthritic change. These findings are consistent with a complete rupture of the patellar tendon.

Dr. Behl's assessment was a left chronic patellar tendon rupture. He found that Mr. Jones had a very atrophic quadriceps muscle with inability to extend the knee and very limited range of motion. Dr. Behl opined that the outcome with this long of a delay, no matter if Mr. Jones underwent operative or non-operative management for his patellar tendon rupture, would be affected.

Dr. Behl noted that non-operative treatment would not allow Mr. Jones to extend the knee. Operative intervention would involve open tendon repair, and if not feasible due to the delay in treatment, possible reconstruction of the extensor mechanism and

patellar tendon. Dr. Behl recommended surgery and Mr. Jones indicated that he wanted to pursue the surgery. Dr. Behl stated he would have to wait for the approval from Wexford Health Sources.

When Mr. Jones returned back to Sheridan Correctional Center on February 8, Dr. James documented that he was evaluated at Midwest Orthopaedic Institute for a left knee patellar tendon rupture. Dr. Behl recommended surgery as soon as possible. Dr. Behl had written on the Medical Special Services Referral and Report that Mr. Jones had no ability to extend his knee. He had limited flexion and his assessment was a chronic left knee patellar tendon rupture. He recommended a repair or a possible reconstruction as soon as possible. Curiously, Dr. James on his physical exam found that the left lower extremity had a left knee deformity which is the first time he made this observation after the tendon rupture three months earlier. A referral for left knee surgery was submitted.

On February 10, 2016, Dr. James wrote that Mr. Jones' surgery was scheduled for February 16th. A record from Wexford Health Sources Utilization Management dated February 11, 2016, showed that his surgery was approved for the February 10th urgent request for patellar tendon repair by orthopedics due to a complete tear of the patellar tendon at its origin with 1.6 cm. separation between the inferior patella and the superior aspect of the torn tendon.

On February 16, 2016, Mr. Jones underwent surgery at Valley West Community Hospital. Dr. Behl's pre- and post-operative diagnosis was a left chronic patellar tendon rupture. Mr. Jones underwent reconstruction of the left chronic patellar tendon rupture using two swivel lock anchors and a semitendinosus tendon allograft. Dr. Behl was assisted by his partner, Dr. Steve Glasgow. Dr. Behl indicated that Mr. Jones injured his left knee three months prior, in November of 2015, while playing basketball in prison. Ever since the injury he had pain and inability to extend and bend the knee at the kneecap. Radiographs and the MRI scan were representative of a chronic patellar tendon rupture.

Intra-operatively, there was a large palpable gap of the patellar tendon which was easily felt. There was chondromalacia of the lateral femoral condyle and the lateral femoral trochlea. Dr. Behl excised one cm. of scar tissue from the patellar tendon and tried to mobilize the patella. However, there was a lot of scarring down of the patella to the femur. Dr. Behl had to cut out triangular areas of the retinaculum just in order to advance the retinaculum and free up the adhesions, so that he could mobilize the patella inferiorly enough to get a better closure of the extensor mechanism.

Eventually, Dr. Behl was able to mobilize the patella with a rake pulling down on it inferiorly, so that at 90° of flexion the patella and patellar tendon appeared to be re-approximated. Multiple releases were necessary, and at that point Dr. Behl felt that he could attach the semitendinosus tendon allograft and placed it mainly medially where the best fixation was available. The graft was passed through the middle of the patella.

An anchor was placed in front of the mid patella, and he placed fiber wire suture into the tibial tubercle with the knee flexed to 30°. The patella was anchored down. A second anchor was used in the tibial tubercle. He had to make multiple passes of the tendon graft through the remnant of the patellar tendon distally and then folding it over into the quadriceps area. Range of motion of the knee was 0° to 70° of flexion, without significant tension on the reconstruction.

Dr. Behl then closed the retinaculum and again excised a triangular portion of the retinaculum which was "all scar". After closure of the retinaculum, range of motion of the knee was 0° to 90°, without significant tension. The extensor mechanism was closed with the remnant of the patellar tendon closed to the remnant of the patellar tendon still attached to the patella. The graft was anchored to the patella.

Mr. Jones was placed into a cast and Dr. Behl elected to keep him non-weight bearing for 10 to 14 days. A femoral nerve block was performed, and he was instructed to follow up in 10 to 14 days for removal of the cast and the surgical staples. Dr. Behl's plan was to obtain x-rays at that time and see if he could get Mr. Jones' knee into a brace where he could gradually get some flexion (although initially he erroneously said extension). Dr. Behl also stated that he would like Mr. Jones to do physical therapy at that point in time as Mr. Jones was limited on when he could see Dr. Behl.

The deposition of Dr. James occurred on December 14, 2018. Dr. James testified that his initial knee exam of Mr. Jones showed that his left knee was slightly swollen and that there was a little laxity of the patella. (However, this was not documented anywhere in the medical record.) He examined the right knee, and he felt that it was similar in presentation. (However, again, this was not documented in any of his medical records.) Mr. Jones had 8/10 pain. He provided Mr. Jones some pain medication (which in actuality was ibuprofen). At the time, Dr. James felt conservative treatment was appropriate. (However, rarely, if ever, is conservative treatment appropriate for a patellar tendon rupture in an active individual with no known functional limitations.)

Dr. James stated at his deposition that he had elected to treat Mr. Jones with pain medications, complete rest, and non-weight bearing on the left knee unless he could present it to his superior at a collegial review. After the radiograph interpretation, Dr. James continued conservative treatment at the time with bedrest and physical therapy. (However, there was no evidence that Mr. Jones ever had physical therapy at Sheridan Correctional Center.) On December 8, 2015, Mr. Jones had persistent and significant pain and was not able to have any weight bearing on the knee after Dr. James had him rest for about four weeks.

Dr. James also specified at his deposition that he believed that Mr. Jones received surgery in a timely fashion, and he thought that Mr. Jones received surgery a lot quicker than those in the private health sector. Dr. James testified that Mr. Jones was not very cooperative with the recommendations at the time regarding physical therapy after surgery. Dr. James pointed out the rehabilitation recommendations which Mr.

Jones did not abide by "at all". (However, there was no evidence of this in the medical record and it was documented in the medical record by multiple people at Sheridan Correctional Center that Mr. Jones was doing his exercises on his own in the infirmary.)

Dr. James also indicated at his deposition that after the surgery, it was recommended that Mr. Jones keep his knee brace on throughout the day and on several occasions he had taken it off. (In fact, the only time it was documented in the medical record that Mr. Jones took his knee brace off was while he was in bed. It was clearly shown in the medical record that he used his brace while out of bed.) Dr. James claimed that it was reported by the nurses and all personnel that Mr. Jones hardly wore the knee brace as often as he should have.

Dr. James testified that using the brace would have decreased Mr. Jones' left knee postoperative stiffness. In reality using the brace all the time would have increased his stiffness as it would have been more restrictive and allowed less mobilization of the joint. Before Mr. Jones' surgery Dr. James made and printed out rehabilitation recommendations that, according to Dr. James, Mr. Jones did not abide. (However, it was clear that Mr. Jones could not have followed all the physical therapy or rehabilitation recommendations made by Dr. James as he had a complete rupture of his patellar tendon.)

Dr. James claimed at his deposition that he made recommendations about staying off the knee before Mr. Jones' surgery by which Mr. Jones did not abide. (However, this was not documented at all in the medical record. Certainly, Dr. James removing Mr. Jones' privilege of having meals in his room did not help Mr. Jones to keep off or help protect Mr. Jones' injured knee.)

It is my opinion that Dr. Marshall James deviated from the standard of care in his evaluation and treatment of Mr. Jones' acute patellar tendon rupture. The medical records show that Dr. James had an immediate concern about a left knee patellar tendon rupture from the first date that he examined Mr. Jones on November 16, 2015. This initial suspicion was despite Dr. James' inadequate examination of Mr. Jones' left knee after his traumatic injury, as seen in his documentation of November 16, 2015.

Dr. James did not document Mr. Jones' inability to extend his knee, his active range of motion of the injured knee, any tenderness to palpation in the knee, his inability to perform a straight leg raise, any defect in the patellar tendon, or the presence of an effusion or hemarthrosis. Dr. James simply noted that Mr. Jones had pain and swelling in his left knee. Dr. James, in my opinion, performed an inadequate physical exam of the knee, which lead him to believe that there was no severe or urgent injury to Mr. Jones' left knee. Had Dr. James performed an adequate physical exam of Mr. Jones' left knee on November 16, 2015, there would have been no doubt about the severity of his injury and the need for urgent surgical consultation.

Despite his inadequate examination, Dr. James did have a concern about an acute

patellar tendon rupture. If one loses the ability to actively extend the knee, can't weight bear on the leg because of severe weakness in the knee, and has severe pain at the patellar or quadriceps tendons in the knee after an injury, then this is an urgent medical condition and most likely requires prompt surgical intervention. Dr. James failed to meet the standard of care when he failed to order expeditious surgical treatment for Mr. Jones' acute patellar tendon rupture. This was imperative for an optimal recovery.

Dr. James also deviated from the standard of care by not ordering an MRI scan of Mr. Jones' left knee to evaluate for a patellar tendon rupture when this was obviously his primary concern. Radiographs, although supportive of a potential patellar tendon rupture, are not diagnostic or confirmatory for such an injury. The standard of care dictates that the appropriate test to evaluate for a suspicious patellar tendon rupture is an MRI scan.

It is my opinion that the urgent request for an MRI scan of the left knee should have been made by Dr. James on November 16, 2015. Furthermore, if Dr. James appropriately examined Mr. Jones' left knee and came to the conclusion of a patellar tendon rupture, then he should have sent Mr. Jones for an immediate orthopedic consultation. These acts or omissions deviated from the standard of care.

Just as egregious, after the radiographs were obtained on November 16, 2015, Dr. James never bothered to follow up on this testing that he ordered. It is clear from the medical record that Dr. James never sought the radiologist's report of the x-rays until he saw Mr. Jones again on December 8, 2015. This was a deviation from the standard of care. As a result, Dr. James did not order an MRI scan of the left knee until nearly 24 days after Mr. Jones sustained his patellar tendon rupture. This was another deviation from the standard of care. All of these shortcomings from the standard of care were so egregious that they constituted no treatment at all.

Further evidence that Dr. James ignored the obvious risks to Mr. Jones was seen by his signing of the nurse's injury report from November 14, 2015. Dr. James signed the report on November 30, 2015, stating that he would like to see the offender only on an as needed basis. It is plain that he had not even reviewed the radiographic findings by this date.

One would hope that, if Dr. James was concerned enough to order x-rays and initiate special orders for Mr. Jones up to two months for his knee derangement, he would have reexamined Mr. Jones more than on an as needed basis. It is also readily apparent that Dr. James was unaware that Mr. Jones still was ambulating with crutches, had limited range of motion of the left knee, had no ability to extend the left knee, had persistent pain and swelling in the left knee, and was still on pain medication.

Even in light of his concern regarding a patellar tendon rupture, Dr. James never scheduled Mr. Jones for re-examination or checked on his progress after he evaluated Mr. Jones on November 16, 2015. Dr. James failed to provide appropriate follow up

of Mr. Jones' left knee injury in the month of November 2015 and again deviated from the standard of care. Mr. Jones returned to the infirmary on his own accord on December 3, 2015, after he still had pain, limited motion, and swelling of his knee. All of the above shortcomings led to a delay in the ultimate diagnosis and appropriate treatment of Mr. Jones' left knee injury.

Without a doubt, Mr. Jones was told that he had a patellar tendon rupture by Dr. James as documented in his grievance of December 29, 2015. This was even before he obtained his MRI scan of the left knee confirming that he had a patellar tendon rupture. Dr. James, suspicious that Mr. Jones had a patellar tendon rupture, should have sent him for an immediate orthopedic consultation after his first evaluation of Mr. Jones on November 16, 2015. Dr. James' disregard of Mr. Jones' serious medical need is again seen in that Dr. James knew Mr. Jones had a patellar tendon rupture and did nothing to accelerate Mr. Jones' evaluation, treatment, or referral to the proper medical specialist.

Dr. James' wait and see approach for more than two months to obtain an MRI scan of the knee after having an initial clinical suspicion for patellar tendon rupture, after radiographs were consistent with a patellar tendon rupture, and after Mr. Jones had obvious clinical exam findings consistent with a patellar tendon rupture during this two month period was gross medical negligence and was so egregious that it constituted no treatment at all.

Wexford Health Sources, whose policies Dr. James was following, and Dr. James knew that Mr. Jones had a patellar tendon rupture, as seen by the indications for the MRI scan, and took an unreasonable amount of time to appropriately refer Mr. Jones to an orthopedic surgeon for his traumatic injury. As a result they ended up delaying his surgery to the point it negatively impacted his clinical outcome from his left knee surgery.

I would dispute Dr. James' claim that Mr. Jones had surgery in a timely fashion. No orthopedic surgeon would feel more comfortable treating a patellar tendon rupture greater than three weeks old. Most, if not all of these injuries, should be acutely diagnosed and treated with surgery urgently, preferably within three weeks of the date of injury, and optimally within 10 days. Surgical repair of a patellar tendon rupture should be done within three weeks, as there is an incremental decline in the clinical results and the success rate of such a repair beyond this time period.

The reasons for such urgency are several. The body starts to heal the injury with a large amount of scar tissue around the ruptured patellar tendon, quadriceps tendon, kneecap, distal femur, the torn retinacula (ligaments) on either side of the knee, and the overlying soft tissues. This contributes to severe stiffness, loss of motion, and chronic swelling, pain, and dysfunction. It also makes repair and/or reconstruction of the tendon that much more difficult as the knee structures are encased in scar and mobilization of the tissues very difficult.

In addition, the complete rupture of the tendon allows for the quadriceps muscle to contract unopposed, thereby causing significant shortening of the extensor mechanism with the kneecap and quadriceps tendon being pulled up the thigh. As a result, there is severe weakness of the quadriceps muscle. Eventually over time, this leads to significant contracture and atrophy of the muscle. This causes further difficulty in surgery to pull the kneecap and quadriceps tendon far enough down the leg so that they can be restored to their normal position in the knee. This will contribute to post-operative loss of motion, particularly flexion, potentially maltracking and/ or degenerative changes of the patellofemoral joint (arthritis), and chronic weakness, pain and dysfunction.

Certainly, it is a deviation from the standard of care to have this injury surgically treated three months after it was suspected. This was supported by Dr. Behl who diagnosed a chronic (not an acute or even subacute) left patellar tendon rupture. Dr. Behl could not do a primary repair of the torn tendon and had to do an extensor mechanism reconstruction with tendon allograft (cadaver) due to the delay in treatment causing significant scarring and contracture of the soft tissues. This is a longer, more complex, and less successful surgery than primary repair of the patellar tendon.

Furthermore, this was also supported by Mr. Jones' other treating orthopedic surgeon, Dr. Verma, who had to perform a second surgery on Mr. Jones' left knee because of the poor outcome as a result of the delay in the treatment for his patellar tendon rupture. Dr. Verma performed a second knee surgery in the hopes of improving Mr. Jones' pain, range of motion, function, and strength. This necessitated rather extensive physical therapy over the course of 4 months after Dr. Verma's surgery. Dr. Verma confirmed the deviation from the standard of care as seen in his record of October 11, 2017, when he described Mr. Jones' left knee condition as status-post patellar tendon reconstruction for a chronic, neglected patellar tendon disruption.

Because of the delay in surgery, Mr. Jones has developed severe stiffness, scarring, weakness, and quadriceps atrophy which in my opinion are irreversible. Clearly, the delay in treatment has caused Mr. Jones to have persistent and chronic pain, limited range of motion, dysfunction, and inability to use his left leg as he did prior to the injury. It is also highly unlikely that he will ever return back to the basketball court or participate in recreational activities as he did prior to his prison injury.

Should you have any further questions or concerns in regards to this Medical Case Report, please do not hesitate to contact me. My Curriculum Vitae and recent deposition and trial testimony list are attached. I am being paid for my work at a rate of $350 per hour. I have spent approximately 21 hours on this report. My fee for depositions is $1,800 for the first two hours, prorated thereafter in 15 minutes increments. For trial testimony the fee is $4,000 for the first two hours, prorated thereafter in 15 minute increments, portal to portal.

I do declare under penalty of perjury under the laws of the United States of America that the information contained within this report was prepared and is the work product of myself and is true and correct to the best of my knowledge and information. The opinions rendered in this report are made within a reasonable degree of medical and orthopedic surgical certainty.

Sincerely,

Vincent P. Cannestra, M.D.