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COMMONWEALTH OF MASSACHUSETTS

NORFOLK, ss. SUPERIOR COURT DEPARTMENT
CIVIL ACTION NO. 02-01159A

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MARCIA RHODES, HAROLD RHODES, INDIVIDUALLY, HAROLD RHODES, ON BEHALF OF HIS MINOR CHILD AND NEXT FRIEND, REBECCA RHODES,
Plaintiffs

VS.

CARLO ZALEWSKI, DRIVER LOGISTICS, PENSKE TRUCK LEASING CORP., and BUILDING MATERIALS CORP. OF AMERICA d/b/a GAF MATERIALS CORP.,
Defendants

****

BEFORE: DONOVAN, J.
AND A JURY

****

September 10, 2004
Norfolk Superior Court
650 High Street
Dedham, Massachusetts 02026

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APPEARANCES:

M. FREDERICK PRITZKER, ESQUIRE
MARGARET PINKHAM, ESQUIRE
On behalf of the plaintiffs,

LAWRENCE BOYLE, ESQUIRE
JOHN P. KNIGHT, ESQUIRE
On behalf of defendant Zalewski,

JOHN B. JOHNSON, ESQUIRE
On behalf of defendant Penske Truck Leasing,

RUSSELL POLLACK, ESQUIRE
WILLIAM CONROY, ESQUIRE,
On behalf of defendant GAF Building Materials

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EXHIBITS

PROCEEDINGS

THE CLERK: Good morning, your Honor.

THE COURT: Good morning.

THE CLERK: The case this morning is Civil Action 02-1159, Rhodes et al versus Zalewski et al. The case is on for continuation of the trial.

THE COURT: Good morning, members of the jury.

JURORS: Good morning.

THE COURT: Good morning, Counsel.

MR. PRITZKER: Good morning, your Honor.

MS. PINKHAM: Good morning, your Honor.

MR. BOYLE: Good morning, your Honor.

MR. KNIGHT: Good morning, your Honor.

MR. CONROY: Good morning, your Honor.

MR. JOHNSON: Good morning, your Honor.

MR. POLLOCK: Good morning, your

Honor.

THE COURT: I have two questions to ask our jurors. And if your answer to either question is yes, would you kindly raise your hand, please.

From the time we suspended yesterday until this moment, has anyone discussed the case with anyone else?

No hands were raised.

Has anyone read anything about this case or listened to any form of media or seen anything on the Internet regarding this case?

No hands were raised.

We're ready to continue. We're going to continue with the deposition --

MR. PRITZKER: Yes, it should be very brief, your Honor.

MS. PINKHAM: Yes, your Honor.

THE COURT: All right. So we'll continue with the deposition of John Hille, which was being read yesterday.

DEPOSITION OF JOHN HILLE, Continued

(Read by Ms. Pinkham and Mr. Brown, as follows:)

Q "On to the next page, which is PMCA 0336. Now this is also a Penske form?"

A "Yes."

Q "And it's called a driver trip report?"

A "Yes."

Q "What's the purpose of this form as you understand it?"

A "Record mileage for tax purposes."

Q "How do drivers know they are supposed to fill this out?"

A "That's explained to them through Penske and through their company."

Q "How is it that Penske explains this to drivers?"

A "When the customer becomes a new customer, the sales person explains all the things, plus they usually take a service rep. with them for the customer and the drivers come to the location."

Q "Do you recall, going back in time, when you were working on the GAF vehicles before Penske acquired Rollins, were you ever aware of whether there was an orientation training meeting when Penske first began leasing to GAF?"

A "Yes, there was. I do not remember who was at it."
Q "Would representatives from maintenance and service be at those initial meetings?"
A "Normally, yes."
Q "And what role would they play?"
A "Service would explain the situation about the write-up books and give them the location directories and the write-up books. Plus the trip reports would be explained to them, and the sales people would just talk in general about the equipment and stuff."
Q "Does Penske require the mechanics to specify which tire or which brake or which whatever it is that needs to be replaced as they're replaced?"
A "No, they really don't. As long as they make sure that they're safe and changed when they're needed to be done. That's what they're mainly concerned about."
Q "So let me ask you this. Is there anything other than the preventative maintenance or the repair orders that Penske would look to if Penske wanted to know exactly when the last time the right number 5 brake on a trailer was fixed?"
A "The only way you would know is if it was put into

the notes on it, because usually what it is the computer only has certain things in there which are adjust brakes and repair, and it doesn't specify on how many."

Q "Which one?"

A "How many wheels there are on the vehicle, so it wouldn't specify one, two, three, four."

Q "So it's just up to the mechanic, whether the mechanic is going to punch that information into the computer?"

A "Yes. And some of them will and some of them just click on what it says in the computer."

Q "Does Penske ever get copies of driver trip reports back from drivers?"

A "They sent in to Penske Corporate."

Q "Where is that?"

A "Reading, Pennsylvania."

Q "Are all driver trip reports sent back to corporate?"

A "Yes."

Q "Excuse me. I meant inspection reports, not trip reports."

A "Inspection reports come to the location. The owning location of the vehicle."

Q "So if the vehicle that was involved in the accident

on January 9th, 2002, was domiciled in Linden, the vehicle inspection report should be in Linden?"

A "Yes."

Q "Mr. Hille, we have looked at the repair orders for the trailer. And let me ask you to look at it and hopefully you can explain it to me. Back to Exhibit 6. I am looking at the repair order for June 7th of 2001. Have you found that?"

A "Yes."

Q "The correction says a complete T1 PM was done."

A "Yes."

Q "How do I know the preventative maintenance is for the trailer? How do I know what's involved?"

A "You mean what?"

Q "Well, in the repair orders we looked at for the tractor, the preventative maintenance form from June 21st of 2001 has essentially a checklist, with either 85 or 89 items on it, depending on what type it is."

A "Yes."

Q "Is there any document that would explain to me or show me what the appropriate checklist is for preventative maintenance on a trailer instead of a tractor?"

A "Yes."
Q "And where is that?"
A "I don't see it."
Q "Are you familiar with preventative maintenance on inspections?"
A "Yes."
Q Excuse me. Strike that. -- "preventative maintenance on trailers?"
A "Yes."
Q "Are those, like the tractor, required by the federal government?"
A "Yes."
Q "And there are federal guidelines on those?"
A "Yes. The same as the ones that you just looked at on the tractor."
Q "When you say the same --"
A "Well not exactly the same. You won't have as many checkpoints on it because there isn't that much to check on a trailer compared to a tractor."
Q "What would be the most complete way of walking me through preventative maintenance on a trailer? Would it help me to look at a preventative maintenance list for tractors?"
A "Basically your trailer has tires and brakes, air

lines, lights, undercarriage, and whatever type of body it's got on it. It could be a box, it could be a tank. And those are the basic things you are looking at. You're looking at your brakes, just to make sure they are within specs., your drums are okay, the brakes are adjusted, and your air lines aren't hanging and chaffed. You've got twelve, maybe thirteen grease fittings that have to be greased on it. You've got air connections at the front of the trailer that need to be looked at, and a plug for the lights that needs to be looked at. And then the condition of the body itself."

Q "Okay. Let me interrupt you there. I have -- I just have specific questions on certain of those areas. The air connections that you just referred to, those are separate from the air lines?"

A "That's where the air lines go to."

Q "And the air connection connects the air system in the tractor to the trailer?"

A "Yes."

Q "And is that only -- the air connections, are those only concerned with the braking abilities of the trailer or is there some other system that uses air on the trailer?"

A "No, that's it."

Q "Just the brakes?"

A "Just for the brakes."

Q "So when Penske does the preventative maintenance on the trailers, when it inspects the brakes, you mentioned the drums. And the trailer man also talked about the shoes and the linings. Do those also get checked on the trailers?"

A "Yes."

Q "As part of preventative maintenance and checking the airlines and brakes, is the trailer connected to a diagnostic computer?"

A "No."

Q "So when you're doing preventative maintenance on a new trailer, for example, a model year 2000 trailer, do you connect the trailer to a diagnostic computer?"

A "Yes."

Q "And what systems does the diagnostic computer test on the trailer?"

A "The braking system on each wheel, and whether the sensors are working properly or not."

Q "Whether the anti-lock braking system is working?"

A "Yes."

Q "Does the computer measure the individual braking power of each brake?"

A "No."

Q "Does the computer measure the air pressure in the air lines?"

A "No."

Q "How does Penske check for failures in the air reservoir?"

A "In the air reservoir? There's always air in the system, and it would show that you have a leak on your gauges on the tractor."

Q "You go back to the tractor because everything runs off the tractor?"

A "You go back to the tractor because everything runs off the tractor."

Q "And how do you test the gauges on the tractor?"

A "You build up the pressure, release your brake, see how much you drop."

Q "But if there's a problem with the gauge, how do you know if there's a problem with the gauge if it isn't measuring the pressure correctly?"

A "That you would have to put a gauge in line to verify it."

Q "What do you mean by put it in line?"

A "You'd have to open up the air system somewhere in the line on the tractor, and put another gauge, to see how much pressure is going to the back."

Q "And is that part of preventative maintenance?"

A "No, it's not."

Q "So for preventative maintenance for trailers, does Penske have a form like this, a checklist for the technicians to go through and check things off?"

A "Yes."

Q "And so if the repair were from June of 2001, it says that preventative maintenance done on the trailer, there should be a checklist for it?"

A "Yes."

Q "Looking at Exhibit Number 1, on Exhibit Number 1, under violations, do you see there's about four or five different columns?"

A "Yes."

Q "One column is labeled OOS. Do you see that?"

A "Yes."

Q "Do you know from your experience in the industry what OOS stands for?"

A "Out of service."

Q "And was this truck taken out of service by the State Police?"

A "No, it was not."

Q "Does that mean -- when it says it was not taken out of service, does that mean it could not be driven from the scene of the -- strike that. Does that mean that it could be driven from the scene of the accident?"

A "Yes."

MS. PINKHAM: Your Honor, at this point I'd like to move in the trailer maintenance records. These are stipulated documents.

THE COURT: We talked about it yesterday. No objection. Exhibit 37.

(Trailer maintenance repair record received and marked Exhibit Number 37.)

MS. PINKHAM: We would also move to enter the preventative maintenance checklist for trailers as the next exhibit.

THE COURT: All right.

MR. BOYLE: No objection, your Honor.

MR. JOHNSON: No objection.

THE COURT: No objection, Exhibit 38.

(Trailer preventative maintenance checklist received

and marked Exhibit Number 38.)

MS. PINKHAM: Thank you, Mr. Hille, I have no further questions.

THE COURT: All right. We're ready to proceed.

MR. PRITZKER: Your Honor, I would like to take this opportunity to have marked the certified medical records.

THE COURT: All right.

MR. PRITZKER: It shouldn't take long.

The first set, your Honor, to be marked as a set, are the UMass Memorial Medical Center certified records.

THE COURT: Any objections?

MR. BOYLE: No objection.

MR. CONROY: No objection.

THE COURT: All right. Exhibit 39.

(Umass Memorial Medical records received and marked Exhibit Number 39.)

MR. PRITZKER: The next is the Fairlawn Rehabilitation Hospital certified medical records.

THE COURT: Any objection?

MR. BOYLE: No objection.

MR. CONROY: No objection.

THE COURT: All right. Exhibit 40.

(Fairlawn Rehabilitation medical record received and marked Exhibit Number 40.)

MR. PRITZKER: The next is the Milford-Whitinsville Regional Hospital certified medical records.

THE COURT: Any objection?

MR. BOYLE: No objection.

MR. CONROY: No objection.

THE COURT: Exhibit 41.

(Milford-Whitinsville Regional Hospital medical record received and marked Exhibit Number 41.)

MR. PRITZKER: The next is the Visiting Nurse Association certified records.

THE COURT: Any objection?

MR. CONROY: No objection.

MR. BOYLE: No objection.

THE COURT: Exhibit 42.

(Visiting Nurses' Association certified records received and marked Exhibit Number 42.)

MR. PRITZKER: The next is the Whittier Rehabilitation Hospital certified medical records.

THE COURT: Any objection?

MR. CONROY: No objection.

MR. BOYLE: No objection, your Honor.

THE COURT: Exhibit 43.

(Whittier Rehabilitation Hospital medical records received and marked Exhibit Number 43.)

MR. PRITZKER: Next is the Milford Orthopedic Associates certified medical records.

THE COURT: Any objection?

MR. CONROY: No objection.

MR. BOYLE: No objection, your Honor.

THE COURT: Exhibit 44.

(Milford Orthopedic Associates medical records received and marked Exhibit Number 44.)

MR. PRITZKER: The next are the certified medical records of Dr. Kraus, M.D.,

Tricounty Medical Associates.

THE COURT: Any objection?

MR. CONROY: No objection.

MR. BOYLE: No objection.

THE COURT: Exhibit 45.

(Dr. Krause, Tricounty Medical Associates medical records received and marked Exhibit Number 45.)

MR. PRITZKER: The next are the Sturdy Memorial Hospital, certified medical records.

THE COURT: Any objection?

MR. CONROY: No objection.

MR. BOYLE: No, your Honor.

THE COURT: Exhibit 46.

(Sturdy Memorial Hospital medical records received and marked Exhibit Number 46.)

MR. PRITZKER: Next are the Metrowest Ear, Nose and Throat Associates medical records.

THE COURT: Any objection?

MR. CONROY: No objection, your

Honor.

THE COURT: Exhibit 47.

(Metrowest Ear, Nose and Throat medical records received and marked Exhibit Number 47.)

MR. PRITZKER: The next is the Metrowest Center certified medical records.

THE COURT: Any objection?

MR. CONROY: No, your Honor.

MR. BOYLE: No, your Honor.

THE COURT: Exhibit 48.

(Metrowest Medical Center medical records received and marked Exhibit Number 48.)

MR. PRITZKER: The next is the Milford Urology medical records.

THE COURT: Any objection?

MR. CONROY: No, your Honor.

THE COURT: 49.

MR. PRITZKER: Those were certified as well, your Honor.

(Milford Urology medical records received and marked Exhibit Number 49.)

MR. PRITZKER: The next are the certified medical records of Dr. Elizabeth Roaf, R-O-A-F.

THE COURT: Any objection?

MR. CONROY: No, your Honor.

MR. BOYLE: No, your Honor.

THE COURT: Okay, Exhibit 50.

(Medical records of Dr. Elizabeth Roaf received and marked Exhibit Number 50.)

MR. PRITZKER: The next is the certified medical records of the Heart Center of Metrowest.

THE COURT: Any objection?

MR. CONROY: No, your Honor.

MR. BOYLE: No, your Honor.

THE COURT: Exhibit 51.

(Heart Center of Metrowest received and marked Exhibit Number 51.)

MR. PRITZKER: The next are the certified medical records of TriRiver Health Center.

THE COURT: Any objection?

MR. CONROY: No, your Honor.

MR. BOYLE: No, your Honor.

THE COURT: Exhibit 52.

(TriRiver Health Center medical records received and marked Exhibit Number 52.)

MR. PRITZKER: The next are the certified medical records of Longview Orthopedic Center.

THE COURT: Any objection?

MR. CONROY: No, your Honor.

MR. BOYLE: No, your Honor.

THE COURT: Exhibit 53.

(Longview Orthopedic Center medical records received and marked Exhibit Number 53.)

MR. PRITZKER: The next are the certified medical records of Eric Woodward, M.D.

THE COURT: Any objection?

MR. CONROY: No, your Honor.

MR. BOYLE: No, your Honor.

THE COURT: Exhibit 54.

(Medical records of Dr. Eric Woodward received and marked Exhibit Number 54.)

MR. PRITZKER: Your Honor, as indicated previously, we're going to have a binder with certain excerpts from these records, which hopefully will be available shortly, and when it is, I request that they be distributed to the jury.

THE COURT: All right.

MR. PRITZKER: Thank you, your Honor.

THE COURT: Are we at this point suspending with the plaintiff's case?

MR. PRITZKER: We're going to suspend, by agreement, with the plaintiff's case, in order to accommodate the defendants --

THE COURT: Right.

MR. PRITZKER: -- because of a witness availability problem.

THE COURT: Right, correct. Okay. Who's calling the witness for the defense?

MR. CONROY: I am, your Honor.

THE COURT: All right, Mr. Conroy.

MR. CONROY: May I proceed, ma'am?

THE COURT: You may.

MR. CONROY: Dr. Mattson.

THE CLERK: Would you raise your

right hand, please. Do you solemnly swear the testimony you shall give to the court and the jury in the case now on trial shall be the truth, the whole truth and nothing but the truth, so help you God?

THE WITNESS: Yes.

THE CLERK: Thank you, you may be seated.

MR. CONROY: May I proceed?

THE COURT: You may.

DR. JANE MATTSON, sworn

DIRECT EXAMINATION BY MR. CONROY:

Q Dr. Mattson, good morning.

A Good morning.

Q Would you please tell the members of the jury where you live.

A I live in Norwalk.

THE COURT: Why don't we have her first identify herself.

Q Dr. Mattson, would you please state for the record your full name.

A Jane Mattson, M-A-T-T-S-O-N.

Q And where do you live, ma'am?

A Norwalk, Connecticut.

Q And would you please tell the jury what you do for

a living.

A I do medical case management and life care planning.

Q And can you explain to us what life care planning is?

A Life care planning is taking an individual in whatever condition you find them and trying to develop a plan, which, over time, will allow them to be as healthy as possible, as functional as possible, and have as great a life satisfaction as possible, taking into consideration all the possibilities for problems that may occur as a result of that particular injury or illness.

Q And what is medical case management?

A Carrying out a life care plan. So you really can't do one without the other.

Q And would you briefly tell us what your educational background is?

A I have an undergraduate degree in occupational therapy from Columbia University College of Physicians and Surgeons in 1971. And I have a Doctor of Philosophy degree, a Ph.D. from the Heller School at Brandeis University in Waltham, Massachusetts, 1994, with an emphasis in long-

term care and health policy.

Q Can you tell us what your Ph.D. was about?

A My Ph.D. course work was divided into courses in medical economics, sociology of disability, and political theory regarding health policy. And my doctoral dissertation is about long-term care, using individuals with spinal cord injuries.

Q Without going into a lot of detail, can you explain to us just briefly what that is about, as far as long-term care, what the focus was.

A By the time I completed my course work, and had been doing medical case management for, at that time, probably fifteen or sixteen years, I was well aware that individuals with very severe technological problems, that is, they couldn't do anything for themselves, needed ventilators or had no hands to use, would need long-term care. And I was aware that throughout the country in my practice, very few of them did well with agencies. There were problems all along with long-term care for an individual who wanted to resume a quality of life, work, social activities, et cetera, and they did much better with hiring their own caregivers and having some control over their lives. And disability

is, for them, a state of mind as well as a state of body. And they did much better with that kind of care. So I compared people using agencies and people not using agencies, having control over their caregivers, in terms of their health status and quality of life. And the population that I used were individuals with high spinal cord injuries that had no use of their hands. C1 neck injuries, from C1 to C5.

Q And when we speak about attendant care, are you addressing the issue of whether a particular individual needs three hours of care or eight hours of care or perhaps 24 hours of care each day?

A Yes. Every human being is different, even if the diagnosis or the disability is the same, some people have greater upper body strength, some people have greater weight, some people have greater emotional needs, et cetera. So everybody's needs are somewhat different. You can't -- this is not a cookbook. We have certain guidelines that we can use.

Q And in your experience, is the level of care, the number of hours per day that attendant care may be necessary, that can have a significant effect on

what the cost is of a particular person's health care plan?

A Not only the cost. Yes, certainly the cost. And the dependency issues. The more independent a human being is, the happier they are and the healthier they are. And I've proven that both in my dissertation and also 25 years of experience of doing this kind of work. So that, if you can get somebody the ability to push a button instead of having to call for somebody to do it for them, then they have control. If they can drive a car, even with a computer, and they have no use of their hands, then they're independent, they can go where they want, they don't have to wait for another being.

Q I think you told us you've been doing this for almost twenty-five years.

A Yes.

Q During the course of your career, how many patients have you evaluated?

A Probably with spinal cord injuries, over a thousand, and I still case manage people with spinal cord injuries. And that's from C1, like Christopher Reeve, to lumbar injuries, and cauda equina, which

is even lower than that.

Q And you're familiar with Mrs. Rhodes injury to her spinal cord at the T12 area.

A Yes.

Q T12 meaning it's the twelfth thoracic vertebra?

A Right. Low back.

Q Low back. Now, let's discuss your employment history. Once you finished with your Ph.D., then if you can tell us what happened.

A Well, I didn't change my employment. I finished my Ph.D. in 1994, but I started my own business doing medical case management and life care planning, and I incorporated in 1983, and was running my own business 20 years ago.

Q Do you have publications in this area?

A Yes, I do.

Q Approximately how many?

A Probably a dozen or more. I've been issue editor of a journal -- a peer review journal called Topics in Spinal Cord Injury, and that particular issue was on life care planning and medical case management. I've written in the Archives of Physical Medicine and Rehabilitation, and a journal called Paraplegic. Both of those are peer review journals about the

findings of my dissertation.

Q And you've used the words "peer review." If I can lead you for a second on this and move this along, by peer review, does that mean that others in your field reviewed the work that you did and basically approved what you've written; is that correct?

MS. PINKHAM: Objection.

THE COURT: Go ahead.

Q Could you please explain for us what peer review means?

A Peer review, in medicine, and probably in law as well, a journal has an editorial board and on that board sits excellent people in the field. And when a journal is published, people send in articles, usually articles concerning studies, most of these things are statistical. And people on the board peer review them, that is, they look for errors, they look for readability, they look for good outcomes, in terms of good reporting, not necessarily in terms of favorable outcome, but they look for honesty, integrity, all of those kinds of things before it's published.

Q And your work was so reviewed?

A Yes. And I'm also a peer reviewer. I'm on the

editorial board. I've also written a lot of --

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q We'll move on. Dr. Mattson, did you have a chance to meet with Mrs. Rhodes?

A I did.

Q And you met with her for approximately how long?

A It was a year ago, so I don't know exactly, but typically I meet with someone between an hour and two hours.

Q And was there anything of significance that you learned from the interview with Mrs. Rhodes as it relates to your opinions in this case?

A I got quite a bit. She had not had very much rehabilitation and therefore did not have much education about spinal cord injury. And when there's a spinal cord injury, there are different categories. Complete lesions and incomplete lesions. But in any event, once a spinal cord injury occurs and the patient is stable, they may get better in terms of function, but the body is not necessarily recovering function.

MS. PINKHAM: Objection, your Honor.

THE COURT: I think she's gone

beyond the scope. I'll sustain the objection.

Q What else did you learn?

A I learned that she was taking about two hours for her bowel program, which is at the far edge of normal. Most people take between a half hour and an hour, so she was taking a great deal of time. She was only out of bed about two hours a day, so her endurance is very, very low. Her mood was very, very low. She was not -- her quality of life was not very good. She was very dependent on others. She was doing a two-person transfer. She told me that she was very much interested in getting better rehabilitation, that she would be willing to go somewhere to get that education. That she would like to hopefully resume her antique business and contribute and to being productive.

Q You also reviewed a series of medical records concerning Mrs. Rhodes?

A I did.

Q And the records were quite voluminous?

A Yes, they were.

Q Were there significant things that you learned in reviewing the medical records concerning Mrs.

Rhodes' pre-accident status that were of significance to your opinions?

A Yes.

Q And what were they, please?

A Well, she had a disease, it's a mental disease, but it still is a fully-recognized disease called bipolar disorder. She told me, although I don't know that I saw it in the records, that she was also diagnosed as having attention deficit disorder, which often correlates with bipolar disorder. That she was actively treating for about ten years with the most prevalent kind of treatment in bipolar disorder. That is lithium and antidepressants. In her case she using SSR medications, and that she was sometimes stable, sometimes not stable.

Q Now, as it relates to the injuries that Mrs. Rhodes sustained as a result of this accident, were there certain significant things you learned from the records that related to your opinions in this case?

A Yes. First of all, she had very little inpatient rehabilitation. She had MRSA, which is a highly contagious organism causing a type of pneumonia, so she was in isolation during the period of time when she could have and should have been

receiving education, training, and therapy. So she did not get adequate rehabilitation.

Q If I can just stop you for a second there. Why was that -- or why is that significant to your views in this case?

A As much as anything else, I think it has to do with her outcome. That is, she doesn't know how to be an advocate for herself and how to do as much as she can for herself and to live quality of life.

Q I think you told us that Mrs. Rhodes, when you met with her, indicated to you an interest of in fact receiving such proper training.

A Yes.

Q I think I interrupted you. Is there anything else from the medical records dealing with Mrs. Rhodes' post-accident condition that was of interest to you?

A There was significant depression and a little bit of emotional, what we call lability, up and down, which would be typical in bipolar, and she was treating for that. She was having difficulty with what we call activities of daily living. You might hear the word ADL used, and that has to do with the ability to ambulate either in a wheelchair or

walking. The ability to do one's grooming, bathing, feeding themselves, and toileting.

Q Did you also review depositions in connection with this case?

A I did.

Q And you had a chance to review the report by Adele Pollard, who is the plaintiff's future health care planner?

A Yes.

Q Now, I think we mentioned before that Ms. Rhodes, she is a T12 paraplegic.

Q Yes.

Q And in the course of your work, you have evaluated T12 paraplegics in the past?

A Many times, yes.

Q Based upon your experience and your training and your direct work with individuals with an injury of this level, can you kind of give us an overview of what can be expected for their daily activities, as to complications?

A The overview has to be colored by the fact that the typical profile of a person with a low paraplegia, and that's how you would define her, motor and sensory complete, is that she should be able to, if

she were younger, she certainly should have been able to be independent just about in her activities of daily living. Being able to transfer by herself with a sliding board, be up all day, work, get married, have children, all of those things. And if she were an athlete, she could partake in a number of athletic activities, such as skiing, sailing, tennis -- wheelchair tennis, basketball, any of those kinds of things. Marathons. Anything like that. In other words, the thing that would be the limiting factor is that she could not have control over her bowel and bladder, and that she could not ambulate. There are people that are T12 paraplegics who do walk with braces and electrical stimulation, but the effort to do that is a great deal, and often takes away from the other part of your quality of life, which is to have leisure time to work, to enjoy family.

Q Now, you mentioned about the age, about being younger. For example, Ms. Rhodes is 48 years old.

A 49.

Q -- 49. For a person of her age, as far as activities, absent ongoing complications, what kind of activities would you expect, given your experience

and your training and directly working with people?

A Well we have to look at a woman physically in middle age. Today, as aging is changing for all of us, and the baby boomers are being more prevalent, a woman of 45 or 50 is often very active, still running in marathons or doing those kinds of things, if that's what she did before. Some women are having children in their 40s. So there may be childbearing, things like. But in her case, she was not extremely physically active. She was a bit overweight. That may be attributable to lithium, which is a typical correlation.

MS. PINKHAM: Objection.

THE COURT: Sustained.

A But she should have --

Q Let me interrupt just for a second. Dr. Mattson, are you bipolar?

A Yes.

Q Do you take lithium?

A Yes.

Q Did it have an affect on your weight?

A Yes.

Q Thank you. Please continue.

A She should be able to really do things. If her house

were accommodating, she could cook meals, she could do light housekeeping. If she had children or grandchildren, she could take of them or be with them. She could indulge in all kinds of recreational activities, depending on what she wanted to do. She could certainly run an antique business. She could do all those things that she would want to do if she were medically stable and had the education and the training and the ability to work up to these things. I mean she can't go from getting up only two hours a day to having that quality of life. There's a certain amount of rehabilitation and education and time that have to elapse for her to get into good shape.

Q Would this include driving herself?

A Oh, yes.

Q Transfers herself?

A Yes.

Q Now --

A With the transfers, she has indicated that she has some --

MS. PINKHAM: Objection.

Q Let me --

THE COURT: Sustained.

Q Let's go back to transfer issue. When you speak about transfers, I want you to explain to the jury what that means.

A Well, we don't think about it very much, but we're constantly moving around in our chairs, sitting on the left side of our bodies or the right side of our bodies, moving our legs, bearing weight differently, getting up, getting down, going to the bathroom, getting into a car, getting out of a car, we're constantly in motion. A transfer is the ability to get from one position to the next position in another appliance. That is, if she's in a wheelchair, for her to be able to get into her car. Or if she's in her car, being able to get back into the wheelchair. If she's in a wheelchair, being able to get on a couch, or being able to get into bed or into a shower chair. The ability to go from one position in one place to another.

Q Thank you. Now, based upon your meeting with Mrs. Rhodes and your review of her materials in this case, including the depositions and the medical records, have you formed certain opinions to a reasonable degree of life -- life care planning mattock of certainty, as far as recommendations

are concerned?

A Yes, I have.

Q I understand one of the recommendations you have made deals with rehabilitation, future rehabilitation; is that correct?

A Yes.

Q Would you explain to the jury what that recommendation is?

A I recommended that she go to Craig Hospital in Englewood, Colorado. Craig is a rehabilitation hospital which is entirely focused on people with spinal cord injuries and brain injuries. It has the reputation of being the best center in the world for -- or one of the two best centers in the world, certainly in the United States, for people with spinal cord injuries. They're the most forward-thinking in terms of therapy, and education, and quality of life.

Q If I could stop you just for a second. Has Mrs. Rhodes indicated she would be prepared to go to a facility or get additional training?

A Yes.

Q I think we learned -- as far as travel, do you see a problem with Mrs. Rhodes, you know, although it's

difficult for her to do it, to travel on an airplane to a different area?

A Well, I have both friends, colleagues and patients --

MS. PINKHAM: Objection.

THE COURT: Sustained. It's a yes or no question.

A No, I don't see any problem.

Q Would you please continue with what Mrs. Rhodes could expect at Craig Hospital in Denver?

A Well, I recommended that she stay in an apartment complex that's part of the hospital. So she would not be an inpatient. She and her caregiver would actually stay in a barrier-free apartment on the grounds of the hospital. And then she would have a daily program. She would have a five-day evaluation and then she would get whatever services would be recommended for her.

Q Can you tell us specifically what kinds of things she would be taught there?

A She would be -- they would be talking about equipment, about emotional status, about sexuality, about vocational issues, about bladder, the most -- the newest methods of handling female bladder and bowel problems and things like that.

So she would be exposed to a lot of education about skin, about -- about technology in general.

Q And you also made some recommendations concerning the future attendant care of Mrs. Rhodes.

A Yes.

Q And first of all, why don't you explain to us what attendant care is and what you think it should be for Mrs. Rhodes going forward?

A Well, right now, when I met with her, a year ago, she was really only -- she had some lower leg fractures, she was only out of bed about two hours a day, so her endurance and her ability to sit upright was very, very low. She needed a two-person assist for getting out of bed, which is -- which is -- I don't see that very often. Usually with a very heavyset older person who's a very high ventilator quadriplegic, they might need a two-person lift. But she was not using -- she needed other people. She had no equipment to assist her. She needed help with getting her food together. She needed help with -- she had a Foley catheter. She needed help with her bowel program. She needed help with dressing and bathing and all

those kinds of things.

Q What was your recommendation in terms of attendant care for Mrs. Rhodes going forward?

A I recommended that she continue at that level of care for a few months, while she healed. Again, my life care plan was written last year. So the idea was that she would be stable, that she would be getting some further rehabilitation and learning to do these things, which -- in which she's now dependent. This is, again, unusual for a T12 paraplegic.

Q How many hours of attendant care per day did you recommend?

A Well, I recommended after that, three hours a day, which is, again, high for that level of paraplegia. Most individuals with that level of injury are independent until they're usually -- until they're -- usually for the first 20 to 25 years after the injury.

Q So it would be three hours per day.

A Yes.

Q And was there a cost that you attributed to that hour?

A Again, yes, there is a cost. I said somewhere between 10 and $14 an hour. I don't recommend

using agencies. I never use agencies --

MS. PINKHAM: Objection.

Q Dr. Mattson, why --

THE COURT: Rephrase that.

Q -- did you recommend the number you did?

A Because that would be the highest amount in the Boston area for hiring an attendant privately. It would be more than they would -- that attendant would receive if the attendant was through an agency.

Q And that number was how much per hour? I'm sorry.

A I use an average of $12 an hour.

Q Okay. And you started to say why you don't use -- why you would not recommend not using an agency. And that is why?

A Twenty-five years of practice as a case manager, writing my dissertation, proving that people do better with hiring their own caregivers, and working with the Centers for Independent Living, including the Boston Center for Independent Living, which is one of many centers throughout the country training people with physical injuries to hire and train their own caregivers.

Q And if you use an agency, the cost would go up?
A The cost goes up, but the quality goes down because the individual would be making -- the individual themselves --

MS. PINKHAM: Objection.

Q What effect --

THE COURT: Sustained.

Q What effect, if any, is there, Dr. Mattson, if you use agencies?
A Agencies, the person works for the agency. So that if the agency suddenly has another case, they might take that individual away. If you want to have control and go out to see Jimmy Buffett up here, or to Fenway to a ball game, or go on vacation to Cape Cod, you couldn't do that necessarily with an agency. But if the people are hired by you, they're working for you, even though they're independent contractors, they're going to know you very well, they have a lot of feel for -- loyalty to you, and they fit in with the family a whole lot more, and you have fewer unmet shifts, and fewer problems.
Q Now, we talked about these three hours of attendant care per day. What is it that the

attendants do during that time period with Mrs. Rhodes?

A They would be helping her with her bowel program, they might be helping her with grooming and bathing. Really getting her up in the morning. That's -- unless she chooses to do it in the evening, and then she might have somebody for maybe an hour in the morning and two hours in the evening.

Q Another recommendation that you had dealt with a case -- with a case manager. What is that?

A Case management is what I am professionally. I am a case manager. Having someone to coordinate all the things that are in this life care plan, to be a facilitator, if you will, in working with the individual and their family to take care of any problems as they arise, to develop a plan with them that makes sense, and to change that plan over time.

Q And can you give us an example or some examples of specific things that a case manager would do to help Mrs. Rhodes going forward with her care?

A They may be of assistance in -- with her driving. They may be of assistance in having her do her aquatic program with some regularity. They may

be of assistance in doing those things that she can't -- really can't do on her own. And, in fact, she may get to a point, if she has proper rehabilitation, that she can do a lot of things and may not need this much care.

Q And you also made some recommendations concerning psychological counseling.

A Yes.

Q And what was that recommendation?

A Well, she -- she was receiving treatment for the bipolar disorder and the attention deficit/hyperactivity prior to the injury. But because of this disability and the overwhelming disability that has occurred, both mental and physical, I'm recommending additional -- additionally about 250 sessions, which is basically five years, once a week. And that could be done with a hundred and fifty sessions on her own and maybe a hundred with her husband and Rebecca. It just depends on how she chooses to use them.

Q As part of your future health care plan for Mrs. Rhodes, did you also make recommendations concerning medical costs, future medical costs?

A Yes.

Q And what kinds of items did that account for going forward?

A Well, I looked at different methods of bladder control. A Foley is what's historically the best way of handling bladder problems, and a neurogenic bladder, which is what -- a spastic bladder, that has no sphincter control. But a person that is using a Foley, that is an indwelling catheter, is more exposed to germs and more likely to have bladder infections. So there's one new system called a Vocare Bladder System. I recommended that that be considered if she's a candidate. That's like a garage door opener. Basically, one, would allow her to void, two would allow her to defecate, et cetera, et cetera, and it's an expensive system. But if it works well, she would be healthier, and again, more in control. If she couldn't use that, I also said that she could possibly use the Superpubic, which would keep her healthier and would need to be changed about once a month.

Q Your recommendations on the medical part going forward, did it also estimate costs for doctors, doctor appointments, tests for the future, nurses, counseling, things of that nature?

A Yes. I included, again, bladder evaluations every year, urology every year. In that is a cystoscopy, urodynamics and ultrasound, urinalysis, urine culture, orthopedic surgeon a couple of times a year now, and then less as time goes on. That's for her fractures. Things like flu shots, which a lot of people have, I put into this life care plan. And an annual spinal cord evaluation. You're fortunate in Boston in that you do have one of -- there are seventeen centers which specialize in spinal cord injury rehabilitation. One of them is at Boston University. So I recommend that she continue to follow up there and be part of the model -- what's called the model systems, which now has about 18,000 or 20,000 people that they've been following, some of them for 20 years.

Q You also made some recommendations of the costs of medications for Mrs. Rhodes going forward as well?

A Yes. By the way, there's also a visiting nurse in case she has a Superpubic, et cetera, or the Foley. Medications, I included Restoril, Valium, which are -- the Restoril is really, again, a psychological medication, suppositories, which she uses and

Colace, an annual allowance for antibiotics that she needs per episode. I used a statistical average that is used with the National Spinal Cord database. As well as Percocet, which is the pain medication and I think she's on two more medications now, Methamamine and again, on the Percocet. And then there are the disposable items. If she continues with the Foley, it would be catheters, one every three weeks, and insertion traches, and sterile water and all those kind of things. A screening kit in case she gets infections, wound care supplies, disposable underpants that are called Chucks. If she's going to have a Superpubic, it would be a little bit less money, because she would only have the tube changed once a month, and she wouldn't be changing tapes and things like that as often. And if she has the Vocare system, then it -- all those costs would come out.

Q Let me ask you this. You've identified a number of things. Does your future life care plan for Mrs. Rhodes account for, in your opinion, things that you're fairly certain that she will need, given her current condition and problems and going forward

what you think she's likely, and may need in the future.

A It takes into consideration everything that I think that she's going to need, both from my background and from my practice. And also taking into consideration possible problems that she'll have and possible new things that might -- may be on the horizon for her.

Q Another area of recommendation you had though is supplies. Medical supplies --

A Right.

Q The Foley catheter.

A Foley catheters, pads, gloves, paper tape. If she has a -- even if she has a Superpubic, a bag, bags to drain the urine and things like that.

Q Another area of recommendation, durable equipment.

A Okay. Durable equipment would be her wheelchair, both a manual -- she's also using an electric wheelchair. That's both good and -- it's got its good points and its bad points. She is -- if she uses the electric too much now --

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q Does your plan include the cost of wheelchairs, both manual and electric?

A Yeah, even though paraplegics don't normally use electric wheelchairs, especially at the beginning, a shower commode --

Q You err on the side of including the electric wheelchair in?

A I did, yes.

Q Okay. And you have several built into this plan over the course of Mrs. Rhodes' life?

A Yes.

Q Thank you.

A Rubber cushions, because she can't squirm around in her chair, so that's to avoid -- avoid skin breakdown. A portable ramp, batteries, an electric hospital bed, replaced as needed, which is usually about every decade. Handheld shower, grab bars, shower commode chair, a standing frame, which would be very healthy for her to get up and stand. It would keep her in place, and it would be good for her circulation, for her kidneys, for all kinds of things. And she can't do that now certainly, but that would be something for the future. A transport -- a transfer board. Something called multipodus

boots. That's something in bed she would wear so that she can avoid skin breakdowns on her heels. Wheelchair gloves, special hose, again, for circulation. Reachers, and maintenance on the equipment.

Q Another area of recommendation deals with transportation.

A Yes.

Q I think you've got a modified -- the cost of modifying a van included as well?

A Yes. The cost of a van for her would be approximately, when I wrote this, 43,500, that's including the van and the modifications, with a semi-hydraulic or hydraulic lift. Wheelchair tie downs, dual air-conditioning and heating, a drive system, hand controls, things like that. Extra heavy duty package. And what I did is I deducted the -- an estimated cost of a family vehicle or a vehicle that she might have driven, and then I amortized it over eight years, which is the general rule of thumb with people who are active using their vans.

Q So does your plan account for every eight years, the van being replaced?

A Some money every year.
Q And finally, do your recommendations also include modifications to the Rhodes' home?
A Yes. Some had been done, but I recommended some more, and I included about $20,000 additional over what had been done, for the purpose of getting the house into a really good order for her.
Q And with a properly modified kitchen for a person who is a T12 paraplegic, if the kitchen's properly modified is it accessible and can it be used by the person?
A She would be able to do almost everything, with the exception -- I would prefer, you know, as an occupational therapist, that's my background, I would prefer that she not take hot things out of a stove unless she has some training in that area, but she could certainly do all her meal prep, get into the refrigerator, take things out of the dishwasher, put them away, set the table. All of the things that we -- that are normal.
Q Can you tell us, Dr. Mattson, what the total cost was for this future health care plan that you've spoken about?

MS. PINKHAM: Objection, your Honor. May we approach?

THE COURT: Yes.

(CONFERENCE AT THE BENCH, AS FOLLOWS:)

MS. PINKHAM: Your Honor, I'm objecting because the total cost that this witness is going to apparently try to testify to is based on the calculations that she did that terminate at age 72, which apparently means that this witness has an opinion that Mrs. Rhodes is going to die at age 72. I don't believe she has any qualifications to testify as to the life span --

THE COURT: Well, doesn't it go to the weight rather than the admissibility of her --

MS. PINKHAM: I don't think so, your Honor. She's not an epidemiologist. I don't think she has -- there's nothing on the record that I believe provides any qualifications for her offering an opinion as to her life span.

MR. CONROY: I'm going to bring out how she got the 72 years old and why she used that number, which coincidentally, your Honor, is also one of the ranges that the plaintiff's expert has also used, based upon a -- based upon a letter

report from a gentleman down south who analyzes issues for counsel. So it's a fact issue for the jury.

THE COURT: For plaintiff's counsel?

MR. CONROY: Yes.

MS. PINKHAM: Your Honor, if I could, a further reason for objecting then because I have been asking for months now to find out the source of this 72 number that's in her report. As recently as last week, I was faxing letters to counsel saying please provide me the source for this apparent conclusion that says her life span is 72. I never got it. But now he's going to talk about it at trial? She's never --

THE COURT: I'm going to allow her to testify. While I have you all at side bar, I do not want to hear one expert commenting on the other expert's opinions. All right?

MR. CONROY: Yes.

THE COURT: Thank you.

(END OF BENCH CONFERENCE)

MR. CONROY: May I proceed, your Honor?

THE COURT: You may.

Q The question, Dr. Mattson, is what was the cost of

the future health care plan that you put together for Mrs. Rhodes, given all these recommendations you've accounted for?

THE COURT: This is her opinion of the cost?

MR. CONROY: Yes, ma'am.

A The total future cost, I broke it out two ways, with the Vocare system, which is expensive. The Vocare system is close to $50,000, but then the overall annual costs are lower. So with the Vocare system, during her life expectancy, the cost would be $1,191,215. And with the Vocare system -- without the -- with the Vocare system, it would be $1,239,763.

Q Now, in terms of how far into the future you made the calculations, Mrs. Rhodes is now 49 years of age?

A Yes.

Q And you have made these calculations to what age for her?

A I did this to age 72. Again, I've been involved with a very large consortium on developing standards of care and for people with spinal cord injury, and the National --

MS. PINKHAM: Objection.

THE COURT: Sustained. I think you've answered the question. Age 72.

Q What was your basis?

A The National Spinal Cord database, which has now studied over 20,000 individuals with spinal cord injuries, has very definitive data on life expectancy for everyone who has sustained a spinal cord injury, based on the level of injury, whether it's complete or incomplete, and the age they were at the time of the injury.

Q How does your number, which you've spoken about, compare with the national data for T12 paraplegics?

A I gave her the highest level that I could within the database. In other words, I erred on the side of giving her more life expectancy rather than less life expectancy because you also have to -- for the individual, as I said, there's no cookbook. I mean, everyone is different. You have to look at co-morbidity factors. Weight, cardiac history, psychiatric history, those kinds of things.

Q How -- your overall -- the overall cost of your plan, putting aside the life expectancy issue, how does

that compare with the national data for T12 paraplegics?

A It's the about two and a half times higher than a female injured at the age of 46 would be. Their figures would be about between 5 and 600,000.

Q Why, Dr. Mattson, is your number higher then than what the natioinal average is?

A Because I look at the most favorable outcome. I take into consideration the worst case scenario, and I try to give an individual as much as I can to improve their quality of life, so my numbers are usually higher than the national average.

MR. CONROY: May I approach the witness, your Honor?

THE COURT: You may.

Q Dr. Mattson, I'm going to show you a document that says life care plan, Marcia Rhodes, rehabilitation.

A Yes.

Q Is this a -- a copy of the life care plan that we have been speaking about?

A Those are charts that go with the life care plan, yes, that talk about costs in terms of category. I don't know if you have the age breakdown there too.

Q Do you want to check on the back?

A Yes, you have both of those things. So I've done it two ways. One is with a chart by category, and one is, sort of a chart by age, annual costs.

Q Thank you. And to clarify on the age issue, as Mrs. Rhodes gets older, there will be an increase in certain costs?

A Yes.

Q You've accounted for that?

A Yes.

Q And would one of the increased costs be additional attendant care beyond what you've accounted for now?

A Yes.

MR. CONROY: Your Honor, I'd move into evidence this chart.

THE COURT: Any objection?

MS. PINKHAM: I'd like my previous objection noted, your Honor.

THE COURT: You have an objection to this?

MS. PINKHAM: I have the same objection that I raised at side bar.

THE COURT: Let me see counsel at

side bar.

(CONFERENCE AT THE BENCH, AS FOLLOWS:)

THE COURT: Is your objection to this based upon the fact that it contains a breakdown of her evaluation and therefore her report's not admissible, simply because she concluded at age 72?

MS. PINKHAM: It's based on the -- all the numbers terminate at age 72. That's my basis for the objection.

THE COURT: Okay. Other than that, you wouldn't be objecting to it?

MS. PINKHAM: Correct.

THE COURT: The numbers and everything else?

MS. PINKHAM: Correct.

THE COURT: All right. I'm going to overrule your objection. We'll mark it as the next exhibit.

MR. CONROY: Your Honor, while we're having side bar, may I raise one additional issue? One of the things I wanted to ask Dr. Mattson was whether she had reviewed Dr. Pollard's report.

THE COURT: You already did.

MR. CONROY: And I was going to ask the question, but I think the answer's going to be no, and I want to make sure, is whether she agrees with Dr. Pollard's --

THE COURT: The answer is no.

MR. CONROY: Okay. I should make an offer of proof on that now or do it later?

THE COURT: Sure, sure.

MR. CONROY: I would ask --

THE COURT: What question would you ask her?

MR. CONROY: I would ask Dr. Mattson whether she agrees with Ms. Pollard's opinion of eight hours of attendant care a day, and if not, why not. And also the issue with the use of the agency. In Ms. Pollard's plan why she -- whether she agrees or disagrees with that.

THE COURT: All right, noted.

MR. CONROY: Thank you.

(END OF BENCH CONFERENCE)

THE COURT: All right. We'll mark the tables as Exhibit 55.

(Dr. Mattson's life care plan tables received and marked Exhibit Number 55.)

MR. CONROY: Dr. Mattson, thank you.

THE COURT: Any direct examination from other defense counsel?

MR. KNIGHT: Yes, your Honor.

THE COURT: All right, Mr. Knight.

DIRECT EXAMINATION BY MR. KNIGHT:

Q Good morning, Dr. Mattson.

A Good morning.

Q It's been approximately two and half to three years since Mrs. Rhodes' injury; is that right?

A Yes.

Q In your experience, can individuals who follow a life care plan, such as the one you've developed for Mrs. Rhodes, continue to make progress in the quality of their life?

A Yes. What they can't regain is actual muscle, and they can't regain actual changes in their ability to do something without technology, but yes, they can become much more functional.

Q And in your experience, is it the case that individuals with spinal cord injuries continue to

make progress well beyond the injury date?

A Yes.

Q And can you -- for a woman with the injuries such as Mrs. Rhodes, can you quantify or specify the type of progress that could be expected to be made?

A She could be happier and more emotionally stable with, again, medications looked at, and with somebody coordinating all the different medications that she's taking because those medications may, in fact, be making her sleepy and taking away her vim and vigor, even though they're, you know, maybe precluding ups and downs, and things like that. She could have a better bowel program, she could have -- in other words, make it shorter in time. She told me that she was taking two hours. That's a very long time of the day. It should be certainly shorter than that.

Q Not to interrupt you, but what would you expect of the bowel program, what period of time would you expect that to take?

A Well, each human being has a different amount of time that they devote to that, but the average might be somewhere between a half hour and an

hour, maybe a little bit more than that.

Q And would you consider a four-hour period of time for a bowel program to be excessive?

A That's more than excessive, it's not healthy. It could make her -- give her -- put her at risk for disreflexia, that is changes in her blood pressure, it could lead to skin breakdowns and all kinds of things. And it's four hours out of her day, you know, it doesn't take that long -- it shouldn't. It doesn't mean that she's not doing that, it just means that it should be doing -- she shouldn't be doing that.

Q And that would be the type of thing by additional education, rehabilitation that could be improved?

A Yes.

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q Could that be improved, the amount of time that is required through additional education and training of Mrs. Rhodes?

A Yes, yes.

Q I believe you were talking, before I interrupted you, about additional areas where progress could be made for Mrs. Rhodes.

A In her ability to drive and be independent, and her ability to cook and take care of her home and be out with her daughter and be a wife to her husband. In terms of recreation, she should be able to do more. She should be able to stay healthy. Again, using the right kind of bladder management, she should have fewer bladder infections. If she's taking good care of herself and as active as possible, hopefully she'll have fewer fractures in the future. Things like that. She should be healthier and have greater life satisfaction.

Q Would you expect Mrs. Rhodes to be able to go to malls?

A Oh, absolutely.

Q Would you expect her to be able to go to flea markets?

A Yes.

Q You spoke of the importance of independence and control. Is that critical for an individual with spinal care injuries?

A For all of us.

Q Spinal cord injuries?

A It's just not spinal cord injuries. For all of us.

Q Is that particularly important for a woman with spinal cord injuries?
A Yes, it is.
Q And is the plan that you developed for Mrs. Rhodes, does it try to give her more independence and control?
A It does.
Q Would you expect there to be benefits for Mrs. Rhodes in her relationship with her husband and her daughter through your life care plan?
A Yes. She would be a more active participant in the family. The issue of sexuality should be explored with her and with her husband. She should be able to go to -- go places with her daughter, take vacations with her daughter, et cetera.
Q And when you met with Mrs. Rhodes, did she represent to you that she did want to continue with the antiquing business?
A That's what she told me, yes.
Q And would you consider that to be a realistic goal for Mrs. Rhodes?
A Absolutely.
Q Why would you consider the Vocare bladder control system so important for Mrs. Rhodes?

A It's clean, the opportunity for -- opportunity to get infection would be much lower. She wouldn't have to take a lot of disposable things wherever she went. So she could go into a bathroom, press a button, and literally use a toilet or with a commode, she would be able to have a much better quality of life, if that were appropriate for her. The same thing with the bowel.

Q And the Vocare system actually adds to the cost of your life care plan; is that right?

A It adds to the cost, but it adds to the quality of life, if she's a candidate for it.

Q With greater independence gained by Mrs. Rhodes, will she require less dependence on personal care attendants?

A I mean ideally, I'd love to see her not have any dependence for many years, but that really has to do with her, her emotions, rather than her physical -- she should be able to be independent if she's as healthy as possible.

Q And in your experience, does the quality of the relationship between family members increase as there is less of a dependence on outside care attendants?

A Yes. And less interdependence of family members. In other words, if she can do a great deal of things for herself, she doesn't have to call her daughter, call her husband, et cetera, and say I need, I need, I need, you know, and wait for them all the time. So they're going to feel better.

Q The ability of Mrs. Rhodes to engage in rehabilitation shortly after the accident was compromised because of certain infections she had; is that right?

A Infections and also not everyone gets into the model systems. Even though we'd like to think that all people with spinal cord injuries are going to get in, they don't. So she -- you know, she had her acute hospitalization and she went to a -- basically a nursing home/rehabilitation center, which did not, you know, really -- did not have a spinal cord team, did not have what the model systems would have.

Q And is her ability to engage in that rehabilitation plan compromised by the fact that it's two and a half years since the accident?

A Not at all.

Q So the recommendation that she -- strike that. The expectation as to the goals that could be achieved

at the program at the Craig Hospital is not changed by the fact that time has passed since the accident?

A No, not at all. In fact, it may even be better because she's had two and a half years to deal with the disability. It's not fresh, it's not six weeks old. So she -- you know, she can be -- she's sort of over that, and she can address the issues that are really important as technology, bladder, health status, sexuality, all of those kinds of things.

Q And your plan allows for continuation of the rehabilitation program once she returns to the area; is that right?

A Right. For the rest of her life really. I mean, she's got to keep healthy and she's got to -- she should keep abreast of all the new technologies.

Q Is there -- does your plan recommend that she participate in a program at the Boston Medical Center?

A Yes.

Q Is that a good program?

A Yes, it's one of the model systems.

Q And is Mrs. Rhodes participating in a home program, an exercise program at home? Is that

important as well?

A She is. She's gone to a swimming program twice a week, but that's all she's doing. And she's doing some range of motion, but she's really not doing enough to increase her endurance.

Q Now, if she were to have home exercise equipment in her home, or a gym in her home, would that be the kind of thing that would better enable her to achieve independence?

A Yes. Many things. Again, achieving independence is building your body and increasing your endurance. If she propels her wheelchair, for example, she's increasing her -- she's doing aerobic exercise. But if she were to have a gym at home or do the swimming program, do the range of motion, keep active, use the standing frame, she would have a longer life expectancy and be healthier.

Q Do you consider -- strike that. In your experience with your patients similar to Mrs. Rhodes, is it common to -- for them to have a level of despondence and despair at various times?

A There has been a great deal of writing about depression and spinal cord injury.

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q Have you reviewed material relative to spinal cord patients experiencing depression?

A Yes.

Q Could you discuss that with us?

A The literature shows that a great preponderance of individuals with spinal cord lesions have a small period of depression and usually do well thereafter. The level of people depressed in the spinal cord population as opposed to the general population per age group is about five or ten percent higher.

Q In your experience, would it be unusual for a patient to feel at a certain point in their life -- and I'm going to speak up because I'm competing with a horn. An individual feeling a sense of despondence at a certain period of life, who then makes progress beyond what they expected at that time?

A Yes.

Q Is that uncommon?

A No, it's common.

Q Would it be fair to say the condition of Mrs. Rhodes, as she is right now, is not representative of what

lies in the future for Mrs. Rhodes?

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q Do you believe that the condition of Mrs. Rhodes today represents the highest quality of her life?

A Not at all.

Q And do you believe the quality of her life can be vastly improved?

A Yes.

MR. KNIGHT: Thank you.

THE COURT: Anyone else?

MR. JOHNSON: No questions.

THE COURT: All right. Cross-examination.

CROSS-EXAMINATION BY MS. PINKHAM:

Q Good morning, Dr. Mattson.

A Good morning.

Q My name is Margaret Pinkham, and I represent the Rhodes family. The life care plan that you've been discussing, the -- I want to be sure I understand the purpose of it. As I understand your testimony, the life care plan is your best effort to kind of look at Mrs. Rhodes as she was when you interviewed her a year ago and kind of forecast her future medical

conditions?

A Yes.

Q Okay. And the life care plan that you had prepared, that focuses solely on the kind of medical costs and equipment costs and supply costs for caring for her injuries?

A Everything she would need attributable to this injury.

Q Okay.

A Including some things that are not probabilities but are possibilities.

Q Okay. Like for possible complications at some --

A Yes.

Q -- point in the future. And again, focused only on the medical component of her injury.

A And the psychological as well.

Q Your life care plan is not intended to compensate Mrs. Rhodes for the emotional injuries or the emotional pain and suffering that she experienced because of the injuries, is it?

A Not at all.

Q That's a separate thing?

A Yes. This is just the damage -- the physical or psychological damages.

Q Thank you for clarifying that. Now, I understand that you were an occupational therapist at some point in your career?

A I practiced as an occupational therapist, and I still am an occupational therapist. I don't practice.

Q Okay. When did you practice as an occupational therapist?

A Oh, in the mid '70s.

Q And how long did you practice?

A Not very long. I had children, and then I started case management.

Q So it would be two or three years that you practiced as an occupational therapist, or was it five or six?

A Counting my nine months or three-quarters of a year of clinical internship, probably four years.

Q Okay. So you had four years in which you actually practiced with patients who had various injuries.

A Yes.

Q Did you have any specialized focus as an occupational therapist?

A Probably children with cerebral palsy and other physical disabilities and cognitive disabilities.

Q So is there a type of pediatric type of specialty in

occupational therapy?

A I didn't really specialize, but I -- but more of the years that I was working, I was working with the pediatric population.

Q Of the pediatric population that you worked with, did any of them have spinal cord injuries?

A Yes.

Q Okay. And in the four years in which you practiced as an occupational therapist, approximately how many children with spinal cord injuries did you treat?

A Maybe fifteen or twenty.

Q Okay. And as I understand it, you got your Ph.D. about ten years ago?

A Yes.

Q Okay. You're not a medical doctor. Your degree is for a Ph.D. in health care policy and medical economics and the things that you had testified about?

A Yes.

Q Were you ever a registered nurse?

A No.

Q So is it fair to say that your entire clinical experience in dealings with spinal cord injuries is

your four years working with children?

A No. I've had twenty-five years in the clinical experience, although not -- in management of spinal cord injury cases.

Q Okay. So let me -- then perhaps I used the wrong words. Focusing on your hands'-on treatment, where you were actually working with the patients and providing the occupational therapy, distinguished from working with patients and providing case management services.

A Yes.

Q That was the four years with pediatric?

A Yes.

Q Okay.

A Well, it wasn't only pediatrics. It was more pediatrics than adult.

Q Okay. You testified that you had reviewed Mrs. Rhodes' medical records as part of preparing the life care plan.

A Yes.

Q How -- strike that. What time period of the medical records did you review when you did the life care plan?

A How long did it take me to review them or --

Q No. Let me ask you this way. She was injured on January 9th, 2002.
A Yes.
Q The medical records that you reviewed as part of preparing your life care plan, what dates did they run through?
A From January 9th, 2002, to the last one that I originally reviewed was in early 2003. I met with her in September of 2003.
Q Okay. So I just want to be sure I understand the chronology. The medical records you reviewed were from January of 2002 until March of 2003?
A February.
Q February of 2003. So you had a little over a year of the medical records.
A Yes.
Q And then in September of 2003, you met with Mrs. Rhodes?
A Yes.
Q The approximate year's worth of medical records, are those the only medical records for Mrs. Rhodes that you had reviewed?
A When I wrote my report, that was all that I reviewed. We had some more medical records -- in

September of '93, we had some more medical records.

Q September of '03?

A Yeah. We had some more medical records.

Q Okay. So then the medical records that you had reviewed in connection -- during this life care plan went from January of 2002 to September of 2003?

A That's correct.

Q And the interview, again, was September of 2003?

A Yes.

Q Interviewing the patient, that's a standard part of preparing the life care plan?

A It's a standard, but I don't always have the opportunity to do that. Sometimes the person is not made available to me. I always request it.

Q Okay. But you did have the opportunity to interview Mrs. Rhodes?

A I did.

Q And where did this interview take place?

A At her home.

Q At her home?

A Yes.

Q And that was in Milford, Massachusetts?

A Yes.

Q When you went to Mrs. Rhodes' house to interview her, how did you get into the house?
A I don't remember.
Q Do you remember going upstairs to the front door?
A I don't remember. It was a year ago. I've done too many of those since then.
Q And you met with Mrs. Rhodes for about an hour that day?
A Somewhere between an hour and two hours. I don't remember. I'd have to look.
Q The interview that you had conducted as part of this life care plan, that was just with Mrs. Rhodes, right?
A I believe so. Again, I don't have my notes with me, so I don't remember. I don't -- I may have briefly met her daughter. I don't know.
Q Well, do you recall interviewing her husband as part of --
A I think so, but I don't remember.
Q Did you interview the personal care attendant that she had at that point in time?
A Not particularly, no.
Q Okay. So when you met with Mrs. Rhodes, you asked her about her medical condition in -- at the

time you were meeting with her, right?

A Yes.

Q And did she tell you at that point that she was still on bed rest from decubitus ulcers or pressure sores that she had suffered and started to suffer from in December of 2002?

A Yes.

Q And you understood that's why she was in bed so much and only out of bed for a couple of hours a day?

A But she was also deconditioning, she was recovering, she had some fractures as well.

Q Right. That was an additional -- the leg fractures were obviously an additional complication?

A That's correct.

Q And the fact that she was in bed for essentially ten months at the time that you saw her, you weren't surprised by the fact that she was deconditioned?

A No, I wasn't -- that's two different questions.

Q Well, let me ask you this. Were you surprised when Mrs. Rhodes told you, I feel really not as strong now, as I did before?

A No, I was not surprised.

Q And that's because she had been in bed essentially

for ten months?

A I don't know that she had been in bed for ten months, the decubitus ulcers had started in December of '03, and the fractures were later in '03. So I don't know if she had been in bed. In other words, she got out of the hospital -- the -- she went from the hospital to the nursing home/rehabilitation center, and then she was out in April of 2002. I don't know if she was actually in bed all of the time from April through December.

Q Okay. Maybe I misspoke. When you reviewed the medical records, you saw some medical records --

A Yes.

Q -- relating to the pressure sores?

A Yes.

Q Okay. And those pressure sores were diagnosed in December of 2002, weren't they?

A Okay, yes. December of 2002.

Q Okay, thank you for clarifying that.

You had also mentioned that at the time that you saw her, she had already experienced the leg fractures?

A Yes.

Q Are leg fractures a common or uncommon

occurrence in paraplegic patients?

A They're more common in the general population and more common in women who tend to get osteoporosis, and the ways again of dealing with them are standing frame, getting her up and standing and things like that. The less she does, the more -- the more she's apt to have problems causing fractures.

Q Now, when you interviewed Mrs. Rhodes in September of 2003, did you use any type of diagnostic tool or questionnaire as part of the interview?

A I've been doing it so long that I do my own questionnaire, but it is a questionnaire. I mean, I have -- I have it -- I don't know if I used it that day, but I use it in my mind when I ask questions.

Q So as part of the -- your interview for the life care plan, did you assess what level of Mrs. Rhodes' functional independence and functional assessment was in September of 2003?

A I did not do a functional assessment per se. Although I could have. If I had, her score would have been very low because she was not very independent at all.

Q And just so that the jury can understand, what is -- is there an abbreviation that functional independence and functional assessment --

A The FIM and the FAM are the functional independence measures.

Q Could you explain them to the jury, please?

A FIM is functional independence measures, and it basically is a questionnaire assessing at what point an individual is totally dependent and what point they are totally independent with all the stops in between, in all the activities of daily living, and the associated or social activities of daily living, which might be shopping, balancing a checkbook, all of those kinds of things.

Q Okay. And I believe you had testified that when you interviewed Mrs. Rhodes in September of 2003, she needed assistance with essentially all of the activities of daily living?

A With all of the five basic activities of daily living, yes.

Q And that was grooming --

A Bathing --

Q -- toileting, bathing, transferring. Which one did I miss?

A Walking or ambulation.
Q Okay. And she needed assistance with all of those in September of 2003?
A Yes.
Q So if you had done the FIM/FAM analysis, she would have gotten a low score?
A Yes.
Q And the use of a FIM/FAM analysis is to kind of track a patient's progress over time?
A Yes.
Q And occupational therapists use FIM/FAM assessments?
A Occupational therapists, physical therapists, anybody working with a whole population. Spinal cord injury, it's a whole team that might be working with it.
Q Okay. And so for example, in Mrs. Rhodes' case, when she was at the rehab. facility, in the records that you had reviewed, did any of the therapists do that type of an assessment?
A I don't know if I reported on it, but they should have.
Q Right. And again, the purpose of doing that would be to see whether Mrs. Rhodes was actually

improving?

A Yes.

Q And improving, as measured by this FIM/FAM analysis, is getting a higher score, right?

A Yes.

Q Because the lower scores are when you need more help or more assistance?

A Generally, in spinal cord injury. It's used for lots of different disabilities. But in spinal cord injuries, the lower score should be in the beginning.

Q And then -- but hopefully people will progress over time and get to the highest score?

A Get much higher, yes.

Q Dr. Mattson, you testified a little bit about the model systems.

A Yes.

Q Could you explain to the jury what the model systems is that you've been talking about.

A Over twenty years ago, it was recognized that people with spinal cord injuries had special needs over and above that of a general rehabilitation hospital, which might have a few people with spinal cord injuries, people with strokes, people with hip replacements and things like that. And

the idea was to service them by developing a team-like concept. And in this team was the physiatrist, the physical medicine specialist, maybe the urologist, maybe the orthopedic surgeon, the physical therapist, the occupational therapist, the attendants, the nurses, the psychologists, the recreational people, the family, the person, and it was a whole team. And so that if somebody had to deal with the bladder, it would be approached by everyone in different ways to accomplish the end, which is higher function. And in addition to that, it was determined that by tracking individuals with spinal cord injury over time, that it could be -- that a study could be made of how well they did and what their costs for the economic consequences spinal cord injury would be, as well as the life expectancy, as well as the ability to go back to work, et cetera. There are about 10,000 people in the United States annually who have spinal cord injuries. And that's a split between people with quadriplegia, that is neck injuries involving all four limbs, and back injuries involving only two limbs.

Q So the model systems are relatively few in number in the United States?

A They've been as low as thirteen, and they've been as high as twenty, and they're funded through the National Institute of Disability Development and Research, part of the Department of Education.

Q And the patients who actually get treated at these model systems, get treated for their spinal cord injuries?

A Yes.

Q Do they typically become part of a database --

A Yes.

Q -- on injuries?

A Yes.

Q Okay. And that database is maintained at the University of Alabama?

A It is.

Q And that database is part of what you had relied on in some of your conclusions for this life care plan?

A Yes.

Q The models that are -- strike that. One of the model systems that you specifically referenced in your life care plan is the Craig Center in Colorado.

A Yes, or it's the Rocky Mountain Spinal System at Craig Hospital.

Q Okay. And you recommend that Mrs. Rhodes go

there for some intensive rehabilitation?

A Evaluation and training, yes.

Q Okay. How long would that take? What's the typical program?

A Well, depending on what they were to decide, the evaluation would probably be five days. And then it might be longer while she's getting the educational components. They might work it out that she goes home and they do it by telephone or by tape or by computer even.

Q Okay. But it's at least five days?

A Yes, the evaluation would be five days. And that would be including urology, and bowel, all her health status issues, her medications issues, as well as psychological things, her sexuality, all of those kinds of things, and equipment.

Q And you would recommend that somebody go with her?

A Yes.

Q For this intensive rehab. And I believe you said it would be her primary care assistant or personal care assistant?

A Ideally, it would be an aide, because then the aide would get the benefit of that kind of training, but it

could also be her husband if he wanted to.

Q During your interview with Mrs. Rhodes in September of 2003, did you have any understanding of who was her primary care giver last year?

A Well, when I saw her, she had attendant care. I mean, obviously, she had paid care eight hours a day. And assistance from her husband and daughter, the other -- the rest of the day.

Q Now, if a personal care assistant was to go with Mrs. Rhodes for this training, the personal care attendant would also have to be there for the five days?

A Yes.

Q And that would also be -- the personal care attendant, I believe you testified that it's your recommendation that Mrs. Rhodes hire her own employee to be her care attendant?

A Yes.

Q And so if that employee went with Mrs. Rhodes to the model system in Colorado, that employee would have to be paid for that time as well, right?

A Yes, yes.

Q And so that would be 24 hours a day for however long it took to travel?

A It would be a per diem rate.
Q And what's the per diem rate that would be applicable?
A A per diem rate that would be applicable would be about a hundred and fifty dollars a day today. It would have been less last year --
Q A hundred and fifty dollars a day for the personal care attendant to --
A Yes. Plus expenses.
Q Okay. The expenses part you had included as part of your life care plan, didn't you?
A Yes, but I also include the payment for the attendant.
Q In your life care plan?
A Yeah, the annual figure.
Q Okay. So the annual figure would include the week-long stay at the facility?
A Right, yes.
Q Thank you for clarifying that. Now, when you interviewed Mrs. Rhodes in September of 2003, did she tell you how many personal care attendants she had been through since she had gotten home from the hospital?
A Many.

Q Many?
A Yes.
Q So you understand that there's a turnover with personal care attendants?
A Well, she -- yes. She was using an agency, there was a turnover, and that's exactly why I don't recommend agencies.
Q And wouldn't that actually be another reason for why perhaps it shouldn't be a personal care attendant to go get the training with Mrs. Rhodes, it should be a family member instead?
A It certainly could be a family member, and if the family member were to go out and an attendant, which is certainly possible, then I would have to add other -- the food and the transportation costs.
Q Okay. But if, for example, Mr. Rhodes was going to go with his wife for this training in Colorado, he'd obviously have to be there the whole time?
A Yes. Well, not the -- I mean he would be there during the training. He could be going out and seeing Denver if he wanted to.
Q He'd be in Colorado the whole time?
A Yes.
Q And if that was the case, then they would have to

make special arrangements to have somebody stay with their daughter while they were away?

A Well, she's sixteen. Yes, she might need to have somebody stay with her, or she might stay with a friend.

Q Okay. And your life care plan doesn't address that possibility?

A No.

Q In response to one of the other questions, you had testified that you don't think there should be any issues with Mrs. Rhodes in traveling by -- by airplane; isn't that your testimony?

A Well, there are special needs that have to be addressed. She needs to -- if she's using her electric wheelchair, she needs to be able to use a gel battery, the batteries have to be taken off, et cetera, but there's no additional cost.

Q I'm actually not asking about a cost component. Just convenience, let's say.

A She would need -- bulkhead seating would be the preferable way. And it would be the cost of an attendant going with her.

Q Right. And also the actual physical things that are involved in getting on a plane these days?

A Well, in fact, I have -- I have personal experience with that because I've been in a wheelchair, and I have artificial knees, and someone with a disability gets more attention than someone without a disability.

Q And when you were in your wheelchair at the airport, did they ask you to stand up when you went through security?

A No.

Q You were able to stand up out of your wheelchair though when you went through security?

A No. At least once or twice I wasn't able to stand.

Q And to get onto the plane, they had to transfer you into a very small wheelchair?

A It's a type of wheelchair for transfers into a plane seat, yes.

Q Right. Because the aisles are so narrow.

A Yes.

Q And that is something that Mrs. Rhodes would have to go through as well if she were to travel?

A Yes.

Q Dr. Mattson, isn't it true that there's a model spinal cord system center in Boston?

A There is. There are, I think seventeen of them.

One of them is in Boston.
Q Right. One of them is right here in Boston.
A Yes.
Q In what is now the Boston Medical Center?
A Correct.
Q And since they are a model spinal cord system, they also have a very good rehab. program?
A They have a good rehabilitation program.
Q And that would be a suitable place for Mrs. Rhodes to go for this intensive rehabilitation?
A It would be suitable, but they are not necessarily set up to do a re-evaluation of someone two or three years after their injury. They don't have apartments. She'd have to be an inpatient probably.
Q Well, do you know how long it would take to drive from her house in Milford to Boston Medical Center?
A She could possibly drive it. They don't have a day program either. So they're not set up the way Craig is set up.
Q But in any event, if she went to the program at Boston Medical Center, she wouldn't have to go to the airport, she wouldn't have to go through

security, she wouldn't have to be transferred into the small wheelchair to get into the seat. She wouldn't be sitting on a plane for four and a half, five hours, and she wouldn't be away from her family, right?

A That's correct. But she may not also have the --

Q Thank you.

MR. CONROY: Excuse me, your Honor, I object.

THE COURT: The question asked for a yes or no answer.

Q Dr. Mattson, one of the things you had said was the subject of your conversation with Mrs. Rhodes was her aquatic therapy, I think is what you had said.

A Yes.

Q And is another word for that pool therapy?

A Yes.

Q Mrs. Rhodes wasn't actually going to pool therapy in September of 2003, right?

A Yes, she was. At least that's what she was telling me. I'd have to look.

Q Well, in any event, Dr. Mattson, if Mr. Rhodes has not yet started a pool therapy program, you would agree that that's a good thing for her to do?

A Any kind of exercise is a good thing. If she likes swimming and likes the water, certainly swimming is a good aerobic -- both aerobic and anaerobic benefit.

Q And are you aware that actually pool therapy has been prescribed for her by one of her doctors?

A I think so.

Q And that would be her treating physiatrist?

A Generally, yes.

Q Okay. Can you explain to the jury what a physiatrist is?

A Physiatrist is an individual that has either an MD or a DO, Doctor of Osteopathy or Doctor of Medicine, and has done a residency in physical medicine and rehabilitation. Above that, there are some doctors who are physiatrists who have done fellowships, which is more training in brain injury or spinal cord injury or something like that. And they -- their goal is or their job is to coordinate all the care for someone with a spinal cord injury or with a brain injury.

Q Thank you. And you are aware from your review of Mrs. Rhodes' medical records that she had been treating with a physiatrist since her injury?

A Yes.
Q And that's an appropriate care provider for Mrs. Rhodes to see?
A Yes. If that -- particularly if that person is a specialist in spinal cord injury. A physiatrist might be a specialist in bones.
Q All right. Well, especially if, for example, a physiatrist is Board certified in spinal cord injuries, that would certainly be a good person for Mrs. Rhodes to continue to see?
A Yes.
Q Yet your life care plan doesn't include any component for Mrs. Rhodes to continue to see a physiatrist, does it?
A Yes, it does.
Q Well, could you show me where on that?
A Spinal cord evaluation once a year.
Q Oh. So spinal cord evaluation means physiatrist?
A Physiatrist and a team of people that physiatry usually works with.
Q Once a year?
A Yes.
Q From your review of the medical records, did you become familiar with how often Mrs. Rhodes had

been seeing her own physiatrist?

A She was seen that person several times a year. Again, she was having complications.

Q Right. And so if Mrs. Rhodes were to continue to experience complications, she would need to see her physiatrist or have a spinal cord evaluation once a year? More than once a year?

A She might see a physiatrist. I've got urology and orthopedic and internist in here, too.

Q Right.

A So the physiatrist might take the place of one of those. But I have, probably all together, one, two, three, four, five appointments with physicians.

Q So --

A Not including the psychiatrist.

Q Sure. So under your plan, Mrs. Rhodes gets to see five doctors a year one time?

A Or five appointments a year.

Q Five doctors' appointments a year, that's all your plan provides for?

A Yes.

Q Okay. You had mentioned you have the orthopedic surgeon in here. And again, that's once a year that you think Mrs. Rhodes should see an orthopedic

surgeon?

A If she's healthy, yes. And that could be replaced by the physiatrist.

Q Okay.

A But if she's got fractures, no.

Q Right. But in any event, these five doctors' appointments per year that you've allotted her, that's the total of doctors' appointments, five per year?

A Yes.

Q And whether she sees the orthopedic doctor five times, if she needs to, she could see that orthopedic doctor five times under your plan?

A Under my plan, it would be the physiatrist and the spinal cord evaluation, and certainly the urologist, and then -- and then it would be -- it would be the orthopedic surgeon and the internist, as needed.

Q Right. But up to a level of five per year?

A Yes.

Q Okay.

A Which is, again, much higher than the national average.

Q But the five per year of appointments that we're discussing is actually only one appointment every

year for a spinal cord, one appointment every year for the urologist, one appointment a year --

A Having to do with the spinal cord.

Q One appointment a year for the orthopedic surgeon?

A Again, having to do with the spinal cord.

Q Right.

A Or they all should deal with the spinal cord.

Q Dr. Mattson, from your review of your medical records, did you become aware of how many times Mrs. Rhodes has seen her orthopedic surgeon just in the past year?

A She has been seeing orthopedic surgery a great deal because she had a lot of complications.

Q Right. So just last year she saw her orthopedic surgeon alone. She saw him five times.

A I was aware of that.

Q Okay. And so under your life care plan, the costs that you calculated, she would have run through that entire doctor budget just on the orthopedic surgeon; isn't that true?

A Yes.

Q Okay. And so if she -- for example, using last year again, had seen physiatrist, Dr. Roaf, four times,

your life care plan wouldn't have included any funds to pay for that doctor visit, would it?

A If she were continuing to have complications and not improving at all, then her life expectancy is much shorter. So I mean I think that's the correlation --

MS. PINKHAM: Your Honor, I move to strike that.

THE COURT: That may go out. Just answer the question, please.

A No, my life care plan does not consider having her have a bad outcome and need, you know -- with a lot of complications.

Q Oh, I thought you said -- you testified previously that your life care plan, you assumed the worst case scenario, that the patient would have a higher level of protection.

A The worst case scenario in terms of needs, not in terms of complications.

Q Okay. Well --

A If she -- I mean, I did not assume that she's going to stay the way she is, because I can't -- I can't do that.

Q Right. You assumed actually under your life care

plan that after three months, after a 90 day period, she was going to progress to such a point that she would go from needing forty hours of a personal care attendant a week down to about twenty hours of a personal care attendant, right?

A Yes.

Q And so you have assumed, the underlying assumption of your life care plan is that in the next three months, Mrs. Rhodes is going to improve a great deal and become much more independent and much more healthy and therefore need less care?

A I would hope so, yes.

Q And I think we would all hope so, Dr. Mattson. But it's true, is it not, that your whole life care plan is based on an assumption that after three months she is going to be much healthier and much more independent?

A Yes.

Q Dr. Mattson, let's focus on the personal care attendant now, because under your life care plan, you've said that after this three-month adjustment period where Mrs. Rhodes could continue to have forty hours of a personal care attendant, the

weekly hours at some point to fall down to twenty-one; is that correct?

A Correct.

Q Because under your plan, after this three-month period, she's only going to need three hours of personal care attendant each day?

A She may progress to the point that she needs none, but I allowed for three hours a day.

Q Okay. And again, all based on this initial three-month period where she's going to progress a great deal.

A Yes.

Q Okay. So the personal care time. I think you had said that there are some things that Mrs. Rhodes is probably always going to need assistance with. For example, she may always need assistance, for example, with pool therapy. Someone has to be with her in the pool.

A Well, the therapist needs to be with her in the pool, yes.

Q Okay. And since Mrs. Rhodes doesn't drive, someone is going to have to drive her to the pool therapy, right?

A Well, I think she indicated to me that she wanted

to learn to drive. There's no reason why she couldn't drive.

Q She definitely wants to learn to drive, that is true, right, Dr. Mattson?

A Yes.

Q Okay. But as we sit here today, she is not driving, is she, Dr. Mattson?

A Yes, she's not -- well, as of a year ago, she was not driving.

Q Okay. And you can take my word for it that as of today she's not driving.

A Okay.

Q Okay. So since she's not driving, if she were to go to pool therapy, someone would have to drive her there, right?

A Yes.

Q And the pool therapy, how long does that usually take?

A A little less than an hour.

Q Okay. And so if she has to drive there, does she have to change into any type of a bathing gear for the pool therapy?

A Sure.

Q Okay. So she has to get to the pool therapy, she

has to change into a bathing suit, she has to get transferred into the pool, do the pool therapy. When she gets out of the pool, she's obviously going to be wet, right?

A Yes.

Q And that's a very dangerous condition for her to be in, in a wet, slippery pool?

A For anybody.

Q Right. And so she's likely going to need assistance in drying herself off and getting undressed?

A Today she would --

Q Right.

A -- but many people with that level injury are totally independent in getting dressed and undressed.

Q Right. But Mrs. Rhodes, as she --

A Today --

Q -- as we sit here today, right?

A That's correct.

Q Because I think you had said when you first took the stand, that your life care plan, you take the patient in the condition that you find them?

A Yes.

Q Okay. So as we find Mrs. Rhodes today, she needs assistance with all of those activities.

A Yes.
Q And then somebody is going to have to drive her back home after the pool therapy.
A Yes.
Q And so couldn't just going to pool therapy itself take three hours out of Mrs. Rhodes' day?
A Well, going to the gym could take three hours out of your day as well. I mean --
Q Right. Well, --
A -- if you're able-bodied, that's what it takes.
Q Let's stick with the pool therapy.
A Yes.
Q Couldn't the pool therapy alone take three hours a day?
A Yes.
Q Okay. So under your life care plan, Mrs. Rhodes would be all out of having help because it would have been consumed entirely just in going to the pool therapy, right?
A Generally the therapist is the one that helps if there needs to be help in getting the person in and out of the pool, dress and undress.
Q Okay. But still someone's going to have to drive her there and then drive her home, right?

A Today, yes. Today, yes.
Q And tomorrow that is still going to be the case, isn't that true?
A Until she uses hand controls, yes.
Q And so just the pool therapy visit alone could consume three hours of a personal care attendant's time, right?
A Yes.
Q Then if on a different day she wanted to go to the gym and use her weights, it's the same routine, isn't it? Someone's going to have to drive her there.
A She could have a gym at home. She could either have a gym membership at the pool, or she could have a gym in her own home.
Q Okay. And so did you account for having a gym in her home as part of the modifications in your life care plan?
A I thought that she wanted the social benefits of belonging to a club that would have a gym and a swimming pool.
Q Did you include the cost of the gym in Mrs. Rhodes' home in your life care plan?
A I don't believe so. It was one or the other.

Q Okay. So the answer is no.
A No.
Q Okay. So then somebody has to drive her to the gym again?
A Today, yes.
Q Right. And tomorrow someone's going to have to drive her as well?
A Yes.
Q Okay. And so she goes to the gym and she goes through the exercise routine that the physical therapist has prescribed for her. If she can't reach the weights, someone's going to have to help her with that?
A Well, she would go to a gym that was -- that would have the ability for her to reach the weights, yes.
Q Well --
A I would not anticipate that she go to a regular gym where the weights -- where she would need one-on-one care.
Q Well, at the time you were talking with Mrs. Rhodes she hadn't yet started to go to the gym, right?
A She hadn't gone to the gym as of yet, that's correct.
Q But the gym that she had been going to that's

referenced in your life care plan is one in which some of the equipment she needs help with. And so, if Mrs. Rhodes can't reach the equipment, someone's going to have to help her with it?

A Yes.

Q And after she's done doing her workout, in order for her to get home, someone would have to assist her in getting home?

A Yes.

Q Okay. And that in itself could take three hours, couldn't it?

A Yes.

Q Okay. And so just for Mrs. Rhodes to go to pool therapy or to go to the gym or to go to a doctor's appointment, those little individual discreet things that she does everyday could, in and of themselves, consume the entire three hours of personal care time that's included in your life care plan?

A If she chooses not to drive, yes.

Q Okay. Do you believe that she is choosing not to drive right now, Dr. Mattson?

A I think so, yes.

Q Part of your life care plan included evaluation for

driving.

A Yes.

Q You didn't include any of the cost of driving lessons though, did you, in your life care plan?

A Usually driving with hand controls is part of the evaluation, and I did not include this at the time because usually people who know how to drive learn to do that in one day. I mean, if they're much younger and haven't driven before, it might take longer.

Q Okay. Well, would it surprise you to learn that Mrs. Rhodes has actually taken fourteen driving lessons so far?

A It wouldn't surprise me, but I'm not sure why.

Q Okay.

THE COURT: I think we'll suspend for our morning recess at this point. We'll take a fifteen-minute recess.

(Morning Recess)

Q Dr. Mattson, before we broke we were talking about the personal care, the ten hours that you recommended for Mrs. Rhodes under your life care plan. In addition to needing assistance in just getting out of the house at this point in her life,

your life care plan -- one of the reasons why you included a personal care attendant at all was because she needs assistance in transferring onto the commode and into the shower and for things of that nature?

A Yes.

Q And so you agree then with me that Mrs. Rhodes does need assistance in transferring from her bed to her wheelchair?

A Yes.

Q And she -- she was at least at the lowest level of assistance, which would be contact guard.

Q Contact guard.

A It's called contact guard, yes, by therapist.

Q Okay. And she similarly would need assistance in transferring from the wheelchair onto the toilet.

A As I saw her a year ago, yes.

Q Okay. And similarly, more assistance in transferring from the toilet to a wheelchair and then to a shower?

A Yes.

Q And she would need some assistance in dressing her lower body?

A Yes.

Q And that process of getting her ready for the day could itself take three hours, couldn't it?
A It could. If her bowel program takes four hours, then it would be even longer.
Q It certainly would take longer if she continues to have the four hour bowel program, right?
A Yes.
Q But if she ever gets to the point where her bowel program is significantly on the smaller part of time, then even then she'd need three hours of a personal care assistant to help her get out of bed, do the bowel program and get dressed for the day?
A Again, given her age, if she were physically conditioned, at the level of her injury, she should be independent in all of her activities of daily living. If there's a secondary physical condition, and she isn't, then she would need more. I've given her three hours because she's been so dependent.
Q Okay. And one of the reasons why she is so dependent and why she has remained so dependent over the past two and a half years is because she's overweight; isn't that right?
A She's not that overweight right now. I think a year ago she was a hundred and eighty pounds at five

foot four.

Q And do you know what her weight is today?

A No, I don't.

Q Would you agree with me -- well, how tall is Mrs. Rhodes?

A Five foot four.

Q Okay. And would you agree with me that a hundred and eighty pounds is considered overweight for a woman at age forty-nine who is five foot four?

A Yes. About twenty percent over; twenty, twenty-five percent overweight.

Q In fact --

THE COURT: Could you keep your voice up a little bit?

A Yes, it is overweight.

Q Okay. Isn't the ideal weight for a woman who is five foot four a hundred and twenty pounds?

A It depends. There's probably fifty different ideal weights, depending on who's doing them, but it depends on her body type, et cetera.

Q Okay. Well, in your experience as a case manager, are you familiar with, you know, standard or reasonable body weights for the patients that you treat?

A Well, it depends, if they're very muscular, they're going to weigh more than somebody who is more -- more flabby, and I -- the ideal body weight for somebody of a medium build might be between at the age of 46 -- would be between probably a hundred and thirty and a hundred and fifty.

Q Okay. In any event, based on your experience, Mrs. Rhodes' weight is considerably more than average or ideal for her right now?

A Yes.

Q And it's very challenging for people who are paralyzed to lose weight, isn't it?

A It's challenging for everyone to lose weight, yes.

Q And especially more so for someone who has no use from the waist down?

A If they're not exercising, yes.

Q And now in your earlier testimony, you were talking about what people could expect or should expect if, for example, they ran marathons before being injured, there's no reason why they couldn't compete athletically in a wheelchair, was that some of your testimony?

A Yes.

Q Mrs. Rhodes was not an athlete before she was

injured, was she?

A No.

Q She was a middle-aged woman who was overweight at the time of her injury, wasn't she?

A Yes, and she was probably not exercising.

Q And so don't those factors make it even more difficult for Mrs. Rhodes to get into condition now, especially two and a half years out from the injury?

A No. If she wants to, she can. I mean it's really a degree of desire to look better, feel better and be better.

Q Dr. Mattson, do you know how long Mrs. Rhodes has been dieting since you last saw her?

A I have no knowledge of the last year.

Q Okay. So you don't have any opinion as to whether the weight loss that she has achieved to date over the past several months is typical or average for a paralyzed woman?

A Again, there's no data on typical or average. Her highest weight before the injury was 227, and her weight when I saw her she said was 180.

Q And did you ask her about the weight lost program that she had actually had before the injury?

A She said she had been dieting off and on for many

years.

Q Okay. And you agree though that it would be a good idea for Mrs. Rhodes to become more active?

A Yes. Irrespective of weight, it would be life sustaining if she could be active.

Q Okay. And that's the reason why you have included in your life care plan a gym membership?

A Yes.

Q You would agree that in addition to helping her -- strike that. It will make her feel better if she's more active?

A Feel better and be better.

Q It will help her lose weight if she's more active?

A Probably.

Q And so in your opinion, how much weight -- assuming that Mrs. Rhodes is say 200 pounds today, how much weight should she lose in order to get to what you would consider to be a healthy, active lifestyle?

A I don't know that she -- I have no knowledge of her being 200 pounds. If she were a hundred and eighty, I would recommend that she lose thirty.

Q Okay. And so you would recommend that she get to a hundred and fifty pounds, whatever her current

weight is?

A If possible, yes.

Q Okay. Yet your life care plan doesn't include any component for a nutritionist to help with her diet, does it?

A I believe -- yes, there's a one time cost in there, I think. There should have been. If there isn't, there should have been.

Q Okay. So you would agree with me that your life care plan for Mrs. Rhodes does not even include a consultation with a nutritionist to help her with her diet?

A That's correct.

Q Okay. And similarly, it does not include any type of weight or endurance training for her to improve her physical condition?

A The gym and the swimming are considered both aerobic and anaerobic or weight training.

Q Okay. But there's nobody there to give her expertise in how to do that, right?

A Well, there would be somebody there in the initial period, yes.

Q Okay. But your life care plan doesn't actually include that, does it?

A No.
Q And you understand that Mrs. Rhodes was not very physically active before the injury?
A Yes.
Q So she would probably need assistance in figuring out the appropriate program for her to follow to become more active?
A Well, again the people at the spinal cord evaluation should give her a program, the therapist there. And then it should be monitored at least initially by the staff at the -- wherever she goes.
Q Okay. And so you would agree that that would be additional types of medical appointments that she would have, these follow-ups, if it's going to be monitored?
A Well, it wouldn't be follow-up. If she's going to a swimming program, there's going to be somebody at the swimming program that's going to supervise her. I did not recommend physical therapy.
Q Thank you. Would you agree with me though that it would be a good idea for Mrs. Rhodes to continue to have physical therapy?
A For a short period of time physical therapy and then possibly a trainer.

Q Okay. And yet that's not part of your life care plan?

A No, it isn't.

Q Now, one of the other things that you had mentioned that for socialization, it's a good thing for people with spinal cord injuries to go out into the community. I think you had mentioned that in connection with the gym membership.

A She indicated that she was feeling very isolated because, in fact, she's been in bed most of the time.

Q Right.

A But if she so desires to be with other people, rather than work out in her own home, it would be a good thing.

Q Okay. And if, for example, she were to go food shopping, that would be a good thing for her to go out and about and do things that she used to do before the injury?

A Yes.

Q Okay. But when she goes food shopping, isn't it true that she needs assistance to get things from the upper shelves, or to reach into the very back of the display cases?

A My experience has been in dealing with people with spinal cord injuries and in my own supermarket is that there are people -- there are special scooters or wheelchairs, and there's a special person assigned to them in my supermarket.

Q And so your answer is yes, she would need assistance in order --

A Yes.

Q -- to reach things that are up high --

A Yes.

Q -- or in back of the display case?

A Yes. But not a paid caregiver, at least in my experience.

Q And in your experience when you go to your grocery store, you can call somebody to get something from the top shelf for your?

A I'm short. Yes, I do, all the time.

Q And so you have to wait for them to come?

A Generally a minute or so, or less.

Q Really. What grocery store do you go to?

A Stop and Shop.

Q All right. I'll have to switch. Now, Dr. Mattson, part of your life care plan, we had talked about a

little bit before is this 90-day period in which Mrs. Rhodes is going to undergo this intensive rehab. program at a spinal cord center.

A Yes.

Q And then become much more educated about her ability and disabilities, and then she's going to become more independent. This 90-day period I want to focus on.

A Yes.

Q Okay. That 90-day period, this adjustment period, apart from the at least five days of evaluation at a model spinal cord systems center --

A Yes.

Q -- what else is going to happen in this 90-day period?

A Exercise, possibly trying different equipment, learning about her bladder issues, learning about her bowel issues, changing around the way she does her bowel program, changing around medications, all those kinds of things.

Q Okay. Is she going to lose about 50 pounds in the next 90 days?

A She shouldn't.

Q That's not healthy, is it?

A No.
Q Okay.
A That would not be my recommendation. It wouldn't be anybody's recommendation.
Q And so part of the challenge that Mrs. Rhodes faces in becoming more independent is the fact that she -- she weighs more than her arms can lift, isn't that true?
A I don't know that.
Q Okay.
A She's overweight, but, you know, I didn't measure as an occupational therapist the strength of her arms.
Q Okay. But your life care plan, its forecast is that once she gets this special training and exercise, she's going to be much more independent?
A Yes.
Q Even if it doesn't involve any weight loss?
A Well, hopefully it would simultaneously involve some weight loss. I mean, if she were away for three months, I would assume that she would lose fifteen to twenty pounds during that time.
Q Okay. But that's still not close to -- let's even assume she weighs a hundred and eighty pounds,

that's still not going to be close to the hundred and fifty that you think she should be at?

A Ideal for her heart and for her body would be a hundred and fifty, but if she stayed at a hundred and sixty-five or a hundred and seventy, she's not going to be grossly obese.

Q I'm sorry. I actually didn't hear one of the weights that you had said. Did you say ideal was a hundred and fifty or a hundred and fifteen?

A A hundred and fifty.

Q Okay, thank you. Focusing still on this personal care attendant that your life care anticipates, the three hours a day or twenty-one hours a week, your opinion is that it's better for patients to hire their personal care attendants directly as their own employees, right?

A Yes.

Q Okay. And that's also less expensive than using an agency, isn't it?

A It could be. Sometimes it is and sometimes it isn't.

Q Okay. And you said that the hourly rate that you think Mrs. Rhodes could find a personal care attendant is twelve dollars an hour?

A Between ten and fourteen dollars an hour.

Q Okay. But the number that you used when you did your calculations in your life care plan?
A Is twelve.
Q Twelve dollars an hour. And could you find that part of your life care plan for me?
A Yes, I have it.
Q And could you tell me, what's the source that you used to identify a twelve dollar an hour figure for a personal care attendant?
A Lots and lots of cases in Connecticut, Massachusetts, Rhode Island, Maine, are dealing with people with attendants.
Q So there's no database of personal care attendants that you went on to to see what the current rate was in Massachusetts?
A There's no database, but the agencies are charging anywhere from fifteen to twenty-one or twenty-two dollars an hour, and the attendant usually gets 50 percent of that.
Q So then you came to the twelve dollars and hour figure just by going on what the agencies charge?
A Going on what the agencies charge, less than half is still lower, it's a lower amount. So the average attendant in Massachusetts is earning between

eight and eleven dollars an hour.

Q And what's the source for that information you've just quoted me?

A Well, most of the agencies, the Visiting Nurse Association and several other agencies, they are the -- I don't have exact sources right now, unless I look in my chart. I don't have which agency, but I've used agencies in Boston --

THE COURT: You have to keep your voice up because I think you're dropping off and people cannot hear you.

A I've used agencies both in Boston and Central Massachusetts and Western Massachusetts.

Q And the agencies typically charge nineteen or twenty dollars an hour?

A Between -- between fifteen and twenty-two dollars an hour has been my experience.

Q Okay. But there's nothing in your plan that identifies how it is that Mrs. Rhodes is supposed to find somebody in the Milford area to come and provide care for her for three hours a day at twelve dollars an hour, is there?

A If she were to work with the Center for Independent Living, they would train her, it would

be at no cost to her, to be involved in that, and she would learn how to hire her own caregivers. The case manager would also help her initially.

Q Okay. But first we would have to have some idea that there are actually people who live around Mrs. Rhodes who would actually do this job for twelve dollars an hour, wouldn't we?

A There are.

Q And, but I'm asking you where is she supposed to find them since you haven't identified a source in your life care plan?

A She can find them by advertising, she can find them through a registry, she can find them through the church, she can find them a myriad of other ways. Generally, I have my individuals that I work with place an ad in a local paper.

Q Okay. And you would agree though that whoever it is that would provide care for Mrs. Rhodes would need to have some type of medical training?

A Not necessarily. I've hired caregivers many times, and the whole idea of spinal cord injury rehabilitation is to educate your caregivers.

Q Okay. Mrs. Rhodes is not in a position to educate her caregiver on how to change a Foley catheter, is

she?

A I have nurses in my life care plan for that.

Q And Mrs. Rhodes is not in a position to educate a personal care attendant on how to dress a pressure sore that Mrs. Rhodes needs a mirror to see, is she?

A That would be part of what she should have learned in the initial 60 days of rehabilitation. That's what rehabilitation is, to train you to look at those things and to train your caregivers. I don't know of any other rehab. program that doesn't do that.

Q So your testimony is that after Mrs. Rhodes goes through this rehabilitation program, that she's going to know how to care for her own sores on her bum?

A I didn't say that. I said she can train caregivers to do that. And if she were to have decubitus ulcers, then she may need a nurse to come and change dressings.

Q Well, but I don't understand how she's supposed to train her own personal care attendant if she doesn't know how to do it herself?

A Part of the rehabilitation that she should have

learned when she had this injury was how to do it herself. And that's what is expected in the rehabilitation for the three months.

Q So your testimony is that after she goes through this rehabilitation, Mrs. Rhodes is going to be trained and able to dress her own pressure sores?

A I didn't say that. To find them and how to do them. If she -- then she can train people in what needs to be done. She should be the architect of her own body, in terms of knowing what kind of care she needs, even if she can't do it herself.

Q Dr. Mattson, you said you're familiar with care providers in Connecticut and Massachusetts, and that's part of the experience that you're relying on in identifying the twelve dollar an hour wage for a personal care attendant, right?

A Yes.

Q Can you tell me then, are you familiar with what the reimbursement rate is that Mass. Medicaid provides to care providers in Massachusetts?

A As of last year Mass. Medicaid was at about eleven dollars an hour.

Q Well, isn't it true, Dr. Mattson, that Mass. Medicaid reimburses its providers at fifteen dollars an hour?

A Agencies, not individuals.
Q Fifteen dollars an hour is the going rate for Massachusetts Medicaid?
A Yes, then the individual probably only gets seven fifty an hour.
Q And the individual care providers that you believe is better for patients, based on whatever research you did for your dissertation, how does -- what is Mrs. Rhodes supposed to do when her employee whom she's waiting for, to help her out of bed calls in sick?
A There's not only going to be one caregiver. There will probably be at least two or three in a pool, and my experience has been -- and I did research on this when I did my dissertation --
Q I'm sorry. What is --
A When I did my --
Q What is she supposed to do when her caregiver calls in sick?
A Usually they have one appointed caregiver that coordinates the care, and she may be independent and it may not be as important if she's independent in her activities of daily living, but generally they'll call the other caregiver and the other caregiver will

come in. Many times with an agency, there will be an unmet shift, and the statistics for unmet shifts --

Q Thank you, Dr. -- thank you, Dr. Mattson.

MR. CONROY: Judge, I would object. The witness is trying to explain her answer. She was asked to explain it. She's being interrupted.

THE COURT: She was asked what does she do.

A She would then have the -- the attendants would call each other and get a replacement.

Q Okay.

A And once in a while she might be without an attendant.

Q All right. So actually I guess under your plan, Mrs. Rhodes doesn't have to find just one personal care attendant, she needs to find one, and then a backup and then a backup for the backup?

A And somebody might work five days, and they might work every other weekend, and then she might have three people.

Q So yes, your answer is yes, she's supposed to --

A My answer is yes.

Q Okay. -- identify a number of people to act as her care provider?

A Identify and hire and train, yes.
Q Okay. And isn't it true though if she uses an agency, if the provider calls in sick, all Mrs. Rhodes has to do is call the agency and typically under that contract, they'll have somebody there within a certain amount of time?
A No, as a matter of fact, in that kind of case, approximately twenty-five percent of the time there's an unmet shift because the agency doesn't have a replacement.
Q But somehow these two or three individual people who work random shifts are going to always be able to provide coverage?
A Mostly ninety-five percent of the time that's been my research.
Q And that was the research that you did ten years ago with quadriplegic patients?
A Yes.
Q And where was -- what was the -- strike that. And part of the additional cost of hiring a personal care attendant directly that's included in your life care plan is the cost of taxes and workers' compensation, and any of type of accountant or professional who would have to assist Mrs. Rhodes

in making sure that she was complying with all of the laws; isn't that true?

A It's fairly simple, yes.

Q Okay. And so that's added -- that added layer of paperwork we'll call it has a cost associated with it, doesn't it?

A I've allowed for that.

Q Right. And that cost itself is almost two dollars an hour?

A I didn't -- I didn't work it out, but it's possible.

Q And so even under your life care plan, if Mrs. Rhodes were to be able to find people who would work a few shifts here and three, three hours or just on the weekends as you had suggested, she's going to have to pay more than twelve dollars an hour, isn't she?

A There's direct costs and indirect costs, right.

Q And so when you add those two together, even under your plan, it's more than twelve dollars an hour?

A Yes.

Q Dr. Mattson, you talked about a lot of the equipment that Mrs. Rhodes needs because of her injuries, including, for example, I think you said a

power wheelchair and a manual wheelchair and grabbers, and there's a lot of things that someone who's paralyzed needs to help them with activities of daily living; isn't that true?

A Yes.

Q Okay. And you're aware that when you went to visit Mrs. Rhodes, that she had already been going through an extensive period of recovery from pressure sores?

A Yes.

Q Okay. And the more medical term for the pressure sores is decubitus ulcers?

A Yes.

Q And isn't there a special mattress that people who are paralyzed can use so that they will be more protected from developing pressure sores?

A Yes. She already has such a mattress. Some people who are paraplegics prefer regular mattresses with maybe an egg crate foam under it. Other people need a -- would prefer to use or need to use an air mattress or a special mattress. She already had a special mattress when I saw her.

Q Right. Because she had already had such a serious experience with pressure sores, right?

A That's correct.
Q And the air mattress that Mrs. Rhodes had at the time that you saw her, that's called a Pegasus air mattress?
A Yes.
Q And in your review of the medical records, you learned that Dr. Roaf had actually prescribed that mattress --
A Yes.
Q -- for Mrs. Rhodes?
A Yes.
Q And did you ask Mrs. Rhodes whether she and her husband had bought the mattress or whether they were just renting it?
A I don't think they bought it. I think it was being -- monthly payments.
Q And that's pretty common because the mattresses are so expensive?
A Not in my practice, but I -- unless somebody has a very short life expectancy, I always buy them.
Q And you always buy the Pegasus air mattresses?
A Whatever -- there's 50 different types of mattresses.
Q Okay. Well, let's stick with the Pegasus air

mattress because that's what Mrs. Rhodes had. How much is a Pegasus Air mattress?

A I don't know right now.

Q It's well over $10,000, isn't it?

A Possibly.

Q Yet you didn't include any cost for a special air mattress for Mrs. Rhodes in your life care plan, did you?

A No, I did not.

Q You would agree, however, that that's an appropriate thing for her to use to help protect her from skin breakdown?

A If she again, is deconditioned and doesn't get -- doesn't have the ability to get up and move around, and if she -- if she continually gets skin breakdown, yes.

Q Now, one of the other pieces of equipment that you had talked about that's very important to Mrs. Rhodes is the van that she and her husband bought and modified so that she could leave the house.

A Correct.

Q And that is something that you'd agree is appropriate for her to have?

A If she -- again, if she uses a power wheelchair, she

needs to use the van. If she doesn't use the power wheelchair, many people with spinal cord injuries in the thoracic region like a two-door car.

Q Could you try to keep your voice up, please?

A Yes.

Q Well, at the time you saw Mrs. Rhodes in September of 2003, you were aware that Dr. Roaf had prescribed a power wheelchair for her?

A Yes. It was on order.

Q And your review of the medical records, you saw that Mrs. Rhodes had developed tendinitis and bursitis, and was having pain in her shoulders and elbows?

A Yes.

Q Okay. And that's a very common thing for people who are paraplegics?

A Yes, but usually that kind of thing happens much later on, and fifteen, twenty years after the injury.

Q But she had it right after the injury, didn't she?

A Yes.

Q Okay. And that was the reason why the power wheelchair was prescribed, wasn't it?

A Yes.

Q Because while Mrs. Rhodes was experiencing the

pain in her shoulders and elbows, it would be painful for her and not healthy for her, to continue to use the manual wheelchair?

A Correct.

Q Now, the power wheelchair, that's not something that Mrs. Rhodes can fold up and toss in the back seat of a car, right?

A That's correct.

Q How much do they weigh?

A They can weigh anything from a hundred and fifty to four hundred and fifty pounds.

Q They're basically a big piece of equipment, aren't they?

A Yes.

Q And because she had a power wheelchair, that's why you had said that it's appropriate that a van be modified so that she can get out of the house.

A Yes.

Q Because clearly the power wheelchair doesn't fit in the car.

A Correct.

Q Yet when you did your life care plan, you didn't include the total cost of buying the van, you only included the cost of making the modifications to

the van; isn't that true?
A No.
Q Well, I thought you had testified in your direct examination that since you buy a lot of vans for your patients through your case management that the cost of a van is approximately $43,500?
A It's approximately $22,000, $23,000, depending on which van you get, and exactly where you buy it, but then the cost of renovations and modifications would be about $17,000.
Q And that brings the total cost --
A 43,500.
Q I'm sorry?
A 43,500, unless she wants a better stereo or a better -- nicer seats or something like that.
Q Okay. And so the total cost of buying the van and then making all the modifications is $43,500?
A Yes.
Q Okay. But that's not the cost that you included in your life care plan, is it?
A I offset that by a $16,000 vehicle that she would have driven anyway.
Q That she would have driven anyway?
A Would have been driving anyway.

Q Okay. Well, Dr. Mattson, are you aware that Mrs. Rhodes was involved in a motor vehicle accident and that's what caused her injuries?

A Yes.

Q Okay. And are you aware of the fact that the car that she had on the date of the injury was completely destroyed in the crash?

A If that's the case, then she would have collected for that car.

Q In any event, it's clear that Mrs. Rhodes would need to buy a new car, that in this case actually a van, correct?

A Yes.

Q And that the cost of the van is something that is appropriate for her care because her power wheelchair doesn't fit in a car, right?

A That's correct.

Q Okay. And so you would agree with me that a reasonable cost for a life care plan for Mrs. Rhodes, addressing the handicap van, would be $43,500, wouldn't it?

A Absent the payment that she got from the insurance company for the price of the car.

MS. PINKHAM: I move to strike, your

Honor.

THE COURT: That may go out.

Disregard that, members of the jury.

Q Dr. Mattson, you've -- in your testimony you've included references to Mrs. Rhodes', you know, bowel program and the bladder program that she needs to use now because she has lost all functioning from the waist down. Do you recall that testimony?

A Yes.

Q The -- one of the components that you had included is something, this Vocare Bladder System?

A Yes.

Q Okay. And that's the thing that you likened to a garage door opener?

A Yes.

Q Okay. And that's part of your life care plan?

A Yes.

Q A couple times you had indicated that you would recommend that if appropriate for Mrs. Rhodes.

A Yes.

Q Was that your testimony?

A Yes.

Q Because the Vocare Bladder System is not

appropriate for paraplegics, is it?

A Or quadriplegics, no.

Q Right. And if, for example, her own doctor had discussed any type of electrical stimulation system for her bladder and decided it wasn't an appropriate use for her, you would not disagree with that, would you?

A No.

Q Now the Vocare Bladder System you have in your life care plan have indicated that Mrs. Rhodes would have to go to New York for the Vocare Bladder System?

A When I -- if the Vocare Bladder System is FDA approved, that the -- there was no one in Boston using -- doing that technique at the time I wrote this life care plan.

Q Okay. Do you -- and the research that you did on the Vocare Bladder System, do you recall when it was that the Vocare Bladder System was approved by the FDA?

A When?

Q Yeah.

A It was approved, I think, two and a half years ago, but I'm not positive.

Q Okay. And the -- part of the Vocare Bladder System involved implantation --

A Yes.

Q -- of electrodes into the patient?

A Yes.

Q And there is a transmitter that is also part of this system?

A Yes.

Q And the way it works is that when the patient presses a button on the transmitter, the electrodes are activated, and that will stimulate the bladder to open and release?

A The sphincter, yes.

Q Okay. But there aren't any hospitals in Massachusetts that install Vocare Bladder Systems?

A There weren't again last year. There was nobody specializing in it.

Q When the Vocare Bladder System was approved by the FDA, did your research indicate how many patients had actually used this.

A Well, it's been used in Europe for twenty years, the precursor of the Vocare system, it's call the Finley system. And --

Q Dr. Mattson, did your research indicate how many people had used it at the time that it was approved by the FDA?

A I don't know the total number of studies.

Q Okay. Well, isn't it true that only 29 patients had had the Vocare system implanted in the U.S. at the time it was approved?

A It may be.

Q Okay. And that the bulk of the people, the 50 other people, have used the Vocare Bladder System was in Great Britain?

A Well, I have patients in Switzerland and France that have them, and they've had them for a number of years.

Q Okay. So it would be fair to say that the other 50 people who have used the Vocare Bladder System are not in the United States?

A It's many more than 50.

Q And isn't it true, Dr. Mattson, that the Vocare Bladder System is not even being marketed in the United States anymore?

A That's not true.

Q Isn't it true, Dr. Mattson, that the Vocare Bladder System is only being marketed in Great Britain

today?

A I don't know that.

Q Well, you didn't check to see whether it was still being marketed before you included it in your life care plan?

A It's still being used in -- I recommended that she go to Mt. Sinai. It's still being implanted there.

Q Well, Dr. Mattson, if it's not being marketed in the United States, it's not being used anywhere in the United States; isn't that true?

A No, that's not true. Marketing and use are two different things.

Q Well, Dr. Mattson, the research that you did as part of the life care, didn't you learn that in addition to the fact that the Vocare Bladder System is not even being marketed in the United State now, if it is marketed in the United States in the future, the closest place to Boston that Mrs. Rhodes would go to to get it would be Cleveland, Ohio?

A Cleveland, New York, Philadelphia.

Q And again, if this was an appropriate thing for Mrs. Rhodes, that would require travel?

A It could. If it were appropriate. I included that in my costs.

Q Okay. And there would be follow-up typically in this type of a system?
A Follow-up, but a lot of that is done by monitoring over the telephone and readings.
Q And if there's ever a problem with the electrodes or the transmitter, isn't it true that that would require travel as well to address the problem?
A It could if there had to be surgery.
Q And actually it's surgery that's required to implant it, isn't it?
A Yes.
Q Another part of your life care plan is for -- addresses the modifications that you thought were appropriate to Mrs. Rhodes' home.
A Yes.
Q And although you couldn't remember which way you had entered the house when you went to interview her in September of 2003, that was part of your analysis, that was part of the reason of going to the house, wasn't it?
A Yes. And she had two entrances and exits, I believe, that were wheelchair accessible when I was there.
Q In 2003?

A Yes.
Q Did you look at both of them?
A I believe I did.
Q Well, isn't it true that in September of 2003, there was only one ramp into and out of the house?
A I think there were two. That would be code, and the renovations had been done and everything inspected.
Q In September of 2003, renovations had been done?
A Yes.
Q And the renovations that had been done was to put a ramp in the garage that entered the house, that had been done by the time you were there?
A Yes.
Q Because you do want to look to see if the house is accessible as part of -- you know, that's of interest in doing a life care plan?
A And as an occupational therapist.
Q Okay. And one of the other changes or modifications that had been done when you were at the house was the bathroom that was on the first floor was big enough for Mrs. Rhodes to get in and shower?
A Yes.

Q Right. And you had checked that as part of your --

A Yes.

Q -- visit, right?

A Yes.

Q Now, when you visited Mr. and Mrs. Rhodes, do you recall that the bedroom that she had was in the front corner of the house?

A Yes, it had been the library.

Q Was there actually, to your knowledge, did there used to be a piano in that room?

A I don't know.

Q In any event, that room wasn't designed to be a bedroom, was it?

A No.

Q It had been for something else before the accident, right?

A Yes.

Q And it wasn't a very big room, was it?

A It was adequate. I don't think I measured exactly, but it was adequate.

Q Okay. It was adequate for her hospital bed.

A And it gave her enough wheelchair accessible in terms of turn radius, both for the power chair and a manual chair.

Q It was adequate for the power chair?
A Yes, it was adequate.
Q But she didn't have a power chair at the time that you saw her, did she?
A No, but I know what the radius, the turning radius of different power chairs is.
Q And it was your opinion that that was adequate?
A Yes.
Q It didn't have a closet, did it?
A I don't remember.
Q Well, one of the things you had testified as part of your life care plan is there's a lot of supplies that Mrs. Rhodes is going to need like gloves, creams, Chucks, bedliners, catheters, there's a lot of things that she needs on a daily basis?
A If she uses the Foley, yes. If she uses the Superpubic or the Vocare, no.
Q Okay. And now since she has the power wheelchair, she still has the manual wheelchair, that's more equipment that she needs?
A Yes.
Q You had also referenced an EasyStand as part of your life care plan?
A Yes.

Q Could you describe for the jury what an EasyStand is?
A Basically, a standing frame or standing table that would allow -- once she is strapped into it, would support her so that she could stand, even though she's not bearing -- she's bearing weight, but she can't feel it, but it would keep her in a standing position for a period of time.
Q And Mrs. Rhodes actually already has one of those as we speak. I don't think -- she didn't have one when you visited her in September of 2003, did she?
A I think she had one that she was ordering.
Q Okay. In any event, all of the medical equipment and supplies that Mrs. Rhodes needs now because she is paralyzed, it takes up a fair amount of space, doesn't it?
A Yes.
Q And it would be appropriate for her bedroom to have a closet in it to store all of these supplies?
A Yes.
Q And it would be appropriate to have enough space so that all this various equipment could be stored?
A It depends. If you want to store it or use it. If she

can't -- if her life is going well, she's going to use both wheelchairs during the same day, she's going to use the standing frame, and there's very little storage for anything else except supplies.

Q Okay. And so sticking with both wheelchairs, you had mentioned earlier the turning radius of the wheelchair?

A Yes.

Q It's important that in order for Mrs. Rhodes to kind of fully be engaged in her daily life again, that she have enough room to maneuver around her house, right?

A Yes.

Q And I think you said code requires two ramps in a house?

A Two entrances and exits.

Q Okay. And that's for safety reasons, right?

A Yes.

Q Okay. So if there was ever a fire, it would be safer to have more than one way for Mrs. Rhodes to leave the house, right?

A Yes.

Q Okay. So it would be a good thing for her to have a number of entrances from the house where she

could safely evacuate the house if she needed to?

A Two entrances and exits would be appropriate.

Q Two?

THE COURT: Could you keep your voice up, please?

A Two entrances and exits would be appropriate.

Q Okay. The -- when you were at the house in September of 2003, do you recall where the bedroom was -- where the bedroom was located in reference to the bathroom that you had seen?

A Well, it's not that huge a house. I think it's diagonally across?

Q Yeah, it was pretty much on the opposite corner of the house?

A Right.

Q Okay. And in order for Mrs. Rhodes to get into the bathroom from the room that was being used as her bedroom, do you remember what room she had to go through to get there?

A Probably the main living area.

Q Okay. And so she didn't have a lot of privacy when you went there in September of 2003, did she?

A I don't know. I don't know what you mean by that. If she's got an attendant, she's not going to have

privacy to do things.

Q Well, just privacy in terms of just if she needed to go to the bathroom, she would have to go through another room and potentially see other people who were in the other part of the house on the way to her bathroom?

A Sure.

Q Okay. And wouldn't it typically be better for a patient to have more privacy in connection with going into and out of the bathroom?

A She's living with her husband and one daughter, I don't know where the privacy issue -- I don't consider it, no.

Q So you don't think that privacy in getting to and from the bathroom is an important consideration?

A No. Most ground floors of houses don't have bathrooms in every room, so that it would be -- what you just asked me about privacy.

Q Okay. You did learn though that the Rhodes have a -- well, when you went there, a fourteen year old daughter?

A She was fifteen, I think.

Q Okay, a fifteen year old daughter.

A Yes.

Q Okay. And so if, for example, her daughter had friends over after school one day and Mrs. Rhodes needed to go to the bathroom, Mrs. Rhodes would likely have to go through wherever her daughter and her friends were gathered to get to the bathroom?

A Yes.

Q And that might be something that would be a little embarrassing to Mrs. Rhodes because clearly the girls would understand she needed to do something in the bathroom?

A Most houses you have to go through a room to get to the bathroom. I really don't understand.

Q Okay. So if your answer no, you don't think --

A No.

Q -- it would be embarrassing for her?

A No.

Q Okay. You said that the first floor of the house was pretty small I think was the phrase that you had used.

A Yes.

Q Did you measure the room to see if -- excuse me. Strike that. Did you actually make any effort to estimate the size of the first floor when you were

there?

A I don't remember the square feet of the house. I may have asked, but I don't have it in my report.

Q All right. In any event, just based on your experience in doing the case management for all these years, is it fair to say that the first floor of the Rhodes' house wasn't even 750 square feet when you were there in September of 2003?

A It may be, but I didn't have that feeling. I thought it was more than that.

Q Okay. Now, one of the recommendations in your life care plan is to make modifications to the kitchen.

A Yes.

Q Do you recall kind of checking out the kitchen at the Rhodes' home?

A Yes, I do.

Q And in order for Mrs. Rhodes to use the kitchen fully and safely, certain things would have to be done, right?

A Yes.

Q What types of things would have to be done to the kitchen to make it handicap accessible?

A It could have a counter that was hydraulic, that

would go up and down. She would just have a pump to go up and down. And she'd have a kitchen that the sink was lower, the cabinets should be basically below the counter height, not above, and the refrigerator should be accessible and there should be a safe turning radius.

Q Okay. And what about the stove?

A I generally recommend a wall -- a low wall oven and a cooktop on the lowered surface.

Q Okay. And where would the knobs have to be on the cooktop in order for Mrs. Rhodes to use the stove?

A They would be in the normal place. She's able to use them. They're not above her head.

Q They'd be on top of whatever surface of the cooktop was?

A No, they would be on the side, on the vertical, as they are on most ovens. Or at least the ones I've seen.

THE COURT: I think we're talking about two different things.

Q Yes. Did you say a cooktop?

A The cooktop, is that what you're asking me?

Q Well, I --

A The knobs for the cooktop would be on -- not on the cooktop, would be on the -- below it.
Q Okay. On the -- if I call it the front of the counter?
A Yes.
Q Okay. So the knobs on whatever stove she uses should be on the front?
A Yes.
Q Okay. And that's for the obvious reason of not burning herself?
A Yes.
Q And you included a cost of those kitchen modifications in your life care plan, right?
A Yes.
Q And you estimated that it would cost about $20,000 to make all those changes to the Rhodes' kitchen, right?
A Yes.
Q And that was the only cost for modification that you included in your life care plan, wasn't it?
A I didn't include the costs that they had already spent.
Q Okay. Yet, you agree that it's necessary for a woman who's paralyzed, a necessary, reasonable modification is to build a ramp into the house,

right?

A Yes.

Q And that costs money, doesn't it?

A Yes.

Q Okay. And the necessary and reasonable modification for a woman that's paralyzed to make would be to have a handicap accessible bathroom if the house hadn't had one before, right?

A Yes.

Q Okay. And another reasonable and necessary modification for the home of a woman who had become paralyzed would be to widen all the doorways, right?

A If there were doors that were architectural barriers, yes.

Q Okay. And because in order for the wheelchair to fit through, how wide do the doorways need to be?

MR. CONROY: Your Honor, they already covered it once already. I object to it.

THE COURT: The objection is overruled. You may answer.

A They're about four inches larger than the typical which is 29 inches. It would be about 30, 32, 33 inches.

Q Okay. Would it be -- would it have to be any wider for a power wheelchair?

A It depends on the power wheelchair. It depends on whether the tires -- there's about -- a lot of different kinds of power wheelchairs.

Q Okay. In any event --

A It shouldn't be significantly wider for a power chair.

Q Okay. But it has to be wider than the standard just so the chair can get through?

A If it's a certain type of chair, it has to be -- there has to be -- the passage way has to be longer because of where the batteries are on the chair. There are some chairs that are compact, and others that are fairly long.

Q Okay. In addition to maybe widening the doors, some of the other necessary and reasonable modifications that would have to be done to a home for a woman who had become paralyzed would be to lower all the light switches?

A It could be, but again, most light switches are accessible from a wheelchair.

Q Well, if the Rhodes' house before didn't have accessible light switches, it would be reasonable

to lower the light switches so she could use them?

A Yes.

Q And it would be a reasonable and necessary accommodation for a woman who has been injured, became paralyzed, if she needed to have additional space to maneuver a wheelchair around, that would be something that you would typically recommend?

A Well, that her bedroom be big enough for that, and the other rooms be big enough as well.

Q Well, you would agree with me, Dr. Mattson, that it wouldn't be -- it shouldn't have been necessary for Mrs. Rhodes to have her bedroom stay in the room that didn't even have a closet, right?

A Again, I'm not aware that there wasn't a closet or anyplace to hang her clothes, but I would generally recommend that there be a room with a closet.

Q Right. And then probably another closet to store supplies?

A It depends. Most of my patients don't store their things in closets, or if they do, it's just a few of the things because they're using everything.

Q Okay. In your years in which you've done case management and done life care plans, you've

included recommendations like this many, many times, haven't you?

A Yes.

Q And again, because it's kind of obvious that if a person lived in a home that's not handicap accessible and then becomes paralyzed, significant modifications are going to have to be made to the home, right?

A Yes.

Q And in fact, you've done life care plans where you've actually recommended that a single level house be purchased for someone who is paralyzed and make modifications to that too, right?

A Yes.

Q And in fact, you've done life care plans where you've recommended that a woman living alone have a house that had fifteen to eighteen hundred square feet of space so that she had adequate room to maneuver and use the house, right?

A Yes.

Q Yet, you didn't make any of those recommendations in the life care plan for Mrs. Rhodes, did you?

A No, I didn't because the house had been modified,

she was living in it with her husband and a teenage daughter, and it seemed like it was adequate.

Q And again, at the time you went to the house in September of 2003, the only modifications that had been done were to put the ramp into the house and to have one bathroom that was handicap accessible, right?

A I believe so.

Q Okay. And other than that, the house that you said was kind of small, was otherwise adequate in your opinion?

A It could be adequate, yes.

Q Dr. Mattson, the modifications that you did not include in Mrs. Rhodes' life care plan, things that we just went over, widen doorways, lower switches, number of entrances, things like that, those are expensive, aren't they?

A Well, it depends. I can't answer that question the way you've asked it.

Q Well, you would agree that just fixing the kitchen by itself would be $20,000, right?

A If she wanted to use good materials and really redesign the kitchen, yes.

Q Okay. And so obviously if she had to make

modifications in other rooms of the house, it was going to be well more than $20,000, right?

A I didn't think there needed to be significant other modifications in other rooms of the house. She seemed to be able to get into the bathroom and in and out of the bedroom adequately, and the living space seemed adequate.

Q Thank you. But again, it would cost a lot more than $20,000 to make all of the modifications that you've recommended in other life care plans, wouldn't it?

A It depends. I've recommended buying whole houses for certain kinds of patients. So, I mean, each case is different.

Q Right. And in the cases where you've recommended to buy a house for a woman who has been injured in an accident and became paraplegic as a result of the accident, it cost well over a hundred thousand dollars for the estimate to buy that house and make the modifications; isn't that true?

A Yes, it has.

Q Dr. Mattson, the life care plan that you have prepared for Mrs. Rhodes, you said that you

organized it two ways. You have done it by category of cost, and then you've done it by time. Do you recall that?

A Yes.

Q Okay. And the time component of the life care plan is the one in which you offered your opinion that for the 90-day period, some 90-day period when Mrs. Rhodes gets a lot of therapy and becomes stronger and more educated about her disability, that's more expensive, that time period is more expensive than the rest of your plan, isn't it?

A Yes.

Q And so for the first year of your life care plan, you've estimated the cost at approximately $75,000?

A Yes.

Q And then for each year thereafter you estimated the cost of the life care plan to provide for three hours of personal care per day is $44,000, isn't it?

A $44,400, yes.

Q Okay. And when you ran out the calculations and did the math to get the really big numbers, the 1 million in this, or the 1.2 million if there was a Vocare system --

A Mm-hmm.
Q -- the math that you did, the calculations you did, was based on taking your annual figure of $44,400?
A 406.
Q Okay. -- and multiplying it by a certain number to get that -- the total.
A Correct.
Q And that the number that you multiplied it by was basically the number of years that you think Mrs. Rhodes is going to live, isn't that --
A The statistical probability, yes.
Q And so in your life care plan, you did all your math based on the assumption that Mrs. Rhodes is going to die at age 72.
A Yes. Or before.
Q Or before age 72.
A Yes.
Q Dr. Mattson, what's the average life span or life expectancy for a white woman in the United States?
A At what age? It's different at every age.
Q At Mrs. Rhodes' age.
A It's about 81.6 I believe.
Q And what do you base that testimony on?

A U.S. life tables.
Q And the life care tables, those are published by the Center for Disease Control?
A No.
Q The National Vital -- well, then tell me, what's this one?
A Which figures are you asking about, the spinal cord figures or the regular?
Q The regular average life span for a white woman.
A Department of Treasury.
Q Department of Treasury?
A Yes.
Q Okay. And so you said the typical life expectancy for a white woman is 81. --
A 6, I think.
Q -- 6. Can we round it up to 82?
A Okay.
Q Okay. So the average life expectancy for a white woman is 82 years old?
A Yes.
Q Yet your life care plan assumes that Mrs. Rhodes is only going to live to age 72.
A That's correct.
Q And why is it that you think Mrs. Rhodes is going to

die at age 72 instead of at age 82?

A Because there are multiple factors for someone with a spinal cord injury, namely skin, lung, bladder, that cause earlier morbidity. And the statistics that have been kept for the last twenty-plus years by the National Spinal Cord Database have shown a preponderance of people, that is a great majority of individuals injured at a certain age with her level of injury have a life expectancy much lower than the norm, that is the normal population of the United States.

Q Okay. And so you relied on the data from the National Spinal Cord --

A Database.

Q -- National Spinal Cord Database. And this is actually something that we had talked about a little earlier. The National Spinal Cord Database, isn't that what is created or kept, when all of the people who are injured and go to these model spinal cord centers that you talked about earlier become part of this database?

A Yes.

Q Okay. And the -- how many model spinal system centers are there in the United States?

A I believe there are seventeen this year.
Q Okay. So if there's seventeen hospitals, and if someone who has a spinal cord injury gets treated at one of those seventeen hospitals, they get entered into this database?
A Correct.
Q And that database was originally started in the early 1970's, wasn't it?
A Yes.
Q And so back in the 1970's, epidemiologists started to keep track of the statistics for injuries and recovery and life span and all kinds of things for people with spinal cords?
A Yes.
Q And what's an epidemiologist, Dr. Mattson?
A It's a Ph.D., or it could be an M.D., but they would also need a Ph.D., who studies statistics and occurrences. In other words, what is the normal course of a particular disease, what's the social trajectory of that disease, and all the factors that go along with it. What is the prevalence in a population.
Q Okay. And the data that you had relied on to conclude that Mrs. Rhodes is more likely to die at

age 72 than she is to reach 82, where exactly did you get that number, 72?

A From the National Spinal Cord Database in their most current facts and figures.

Q From the facts and figures?

A In Birmingham, Alabama, yes.

Q Okay. Did you ever review an analysis that Dr. DeVivo of the University of Alabama had done?

A For this case?

Q Yes.

A I don't believe I have his, but he's the head of the Spinal Cord Database, and I -- I speak with him frequently.

Q Okay. Have you reviewed the study that he did for this case?

A No.

Q So how -- so again, I -- where exactly did you get the number 72?

A From the published data.

Q Okay. And the published data is broken down in what way?

A It's broken down two ways, age and incident, and type of spinal cord injury. Age are classed A, B, C or D. And whether is paraplegia, quadriplegia

and/or high quadriplegic or below paraplegia, there would be cauda equina.

MS. PINKHAM: May I approach, your Honor?

THE COURT: You may.

Q Dr. Mattson, I'm showing you a document and ask if you recognize it.

A No, I don't recognize this.

Q Okay. The database, the model systems database that was started in 1973 --

A Mm-hmm.

Q -- how many people are in that database right now?

A I think there's over -- I think it's around 20,000. I'm not positive.

Q Well, isn't it true that of last year there were approximately 36,000 people in that database?

A There may be.

Q Okay. Well, you're familiar with Dr. DeVivo who runs the database?

A Yes.

Q And so it wouldn't surprise you to know that there are 36,000 people in the database now?

A No. But I don't know how many people are actively being tracked.

Q Okay. And isn't it also true that those 36,000 people that are in the database, again, those 36,000 people are fed into the database from just those seventeen hospitals around the United States?

A Yes. Sometimes there have been as high as twenty hospitals.

Q Okay. But in any event, I think you had testified earlier that approximately 10,000 people a year receive spinal cord injuries; is that one of the things that you had said earlier?

A In the United States, yes.

Q Okay.

A That's the epidemiology.

Q Okay. So every year, on average, there are 10,000 people in the United States who have spinal cord injuries and become paralyzed?

A Yes.

Q Okay. But not all of those 10,000 people get entered into this database, right?

A Correct.

Q Because it's only the people from the --

A Model systems.

Q -- sixteen or seventeen model systems centers,

right?

A Yes.

Q So of the people that are in the database, it's just a very small percentage of the actual entire population of people living with spinal cord injuries; isn't that true?

A I don't know how small a percentage it is, I don't know that.

Q Okay. Well, what's your understanding of how many people are living in the United States with spinal cord injuries right now?

A Probably somewhere under 300,000.

Q Okay. Would you agree that about $250,000 -- excuse me -- 250,000 people is a reasonable estimate?

A Between 250 and 300.

Q Okay. And so if there are between 250 and 300,000 people with spinal cord injuries in the United States, and there's only 36,000 people in this database, what percentage of the population is actually covered by the data base?

A Ten to fifteen percent.

Q Okay. So the database that is maintained at the University of Alabama is based on only ten to

fifteen percent of the injured population.

A Correct.

Q Okay. And isn't it also true that of the 250 to 300,000 people in the United States who have spinal cord injuries, that the overwhelming majority of them are men?

A Yes.

Q And isn't it also true that men have shorter life expectancies than women?

A Very, very little difference today. The last most recent data is that the life expectancy at the same age for a white male would be -- would be something like 80.6. So it's the difference of about one or one and a half years now. It's narrowed because of women being in the workforce and things like that.

Q Dr. Mattson, I'm going to show you a document and ask if you recognize it.

A Yes, it's the life table from the Department of Vital Statistics, the Department of the Treasury.

Q Okay. And so this is what you were talking about before. This is the source that you relied on for the --

A Yes.

Q -- average life expectancy?
A Yes.
Q Okay. And the table that you're looking at is for a white female?
A Yes.

MS. PINKHAM: I'd like to offer this, your Honor.

THE COURT: Any objection?

MR. CONROY: No objection your Honor.

THE COURT: All right. It will be marked Exhibit 56.

(Life Expectancy Table, white females, received and marked Exhibit Number 56.)

Q Dr. Mattson, I'm going to show you another document.
A It's the same table for males for the year 2000, four years ago.
Q Is this the type of table that you would rely on in looking at the average --
A Yes.
Q -- expectancy for males?
A Yes.

MS. PINKHAM: I would offer this document, your Honor.

THE COURT: Any objection?

MR. CONROY: No objection.

THE COURT: None?

MR. BOYLE: No objection, your Honor.

THE COURT: All right. Exhibit 57.

(Life Expectancy Table, white males, received and marked Exhibit Number 57.)

Q Dr. Mattson, I'm going to hand you back Exhibit 56, and could you tell me, Mrs. Rhodes is now 49 years old. Could you tell me what the typical life expectancy is for a white woman who's 49 years old?

A Thirty two point nine years, I believe.

Q So she has approximately a life expectancy of another --

A For the average -- for someone who is 49, she would have a life expectancy to 81.9.

Q Okay. And can we call that 82, if it's 81.9?

A We did before, yes.

Q Okay, thank you. And that was, I believe, what you had testified to before --

A Yes.
Q -- correct? All right. And now, looking at Exhibit 57, could you tell me what the life expectancy is for a white male who is age 49?
A It would be 79.
Q Okay. And so the answer to my previous question, isn't it true that men typically have shorter life spans than women, the answer --
A Yes, by about 2 percent.
Q The answer is yes?
A Yes.
Q Okay. And so if the population of the database that you had relied on to form your opinion that Mrs. Rhodes is likely to die at age 72 is overwhelmingly male, doesn't that drag down the life expectancies?
A By about 2 percent, which is why the first table that you showed me suggested the life expectancy for her to 70, and I extended it to 72.
Q And so did you rely on -- which table were you referring to?
A The first one, the spinal cord table that you --
Q This one?
A Yes.

Q Okay. So what is your understanding of what this document is?

A There is only -- there's less than -- let's see.

Q I'm sorry, Dr. Mattson, do you have an understanding of what the table is?

A I do, but I'm trying to explain it to you.

Q Okay. Well, if you could first just -- what is your understanding of what's on this document?

A On this document?

Q Yes.

A This is probable life expectancy and survival probability for individuals from today at the age of -- - at the age of 46 I would think, or 48. From 46, the survival probability that she would live to be 82 would be less than 1 percent.

Q Isn't that 10 percent, Dr. Mattson?

A No. It would be at the age of -- what are we going to use 46 or 48?

Q Actually, if we're going to talk about this, it should be 48.

A Okay. So 48, she would have to live to be 70, which would be 22 years, is not on here.

Q Well, do you see years from today? The first column?

A 28. 28 is the lowest. So I don't know what age this is -- this is part of a table, so I can't give you --

Q Okay. And this is what we had said before, you can't really identify this document.

A It's part of a table. I don't know when it starts.

Q Okay. So in any event, the database that you have relied on, the spinal cord database that is about, what 10 to 15 percent of the entire population of people with spinal cord injuries?

A Yes.

Q That is 80 percent male?

A Yes.

Q Has a lower life expectancy --

A Than what I gave her.

Q Right. Because it's based on men?

A Yes.

Q Okay. Now, Dr. Mattson, the life care plan that you had prepared that includes for three hours personal care attendant time per day, that life care plan is essentially one plan for the rest of Mrs. Rhodes' life, right?

A That's correct.

Q And it's your best estimate to kind of forecast what she's going to need throughout the rest of her life?

A That's correct.
Q And again, you based it all on this calculation that ends at age 72, right?
A Yes.
Q So if Mrs. Rhodes lives longer than 72, under your life care plan, she's not going to have any more money to take care of her spinal cord injuries, is she?
A If she has -- no, under my life care plan on a per annual basis, she would not. But if there's a sum of money that's put away, she would have enough for -- until she dies.
Q Okay. And Dr. Mattson, if Mrs. Rhodes lived to age 75, under your plan, she's going to be out of money for three years, money to take care of her spinal cord injuries; isn't that true?
A Yes.
Q And if she makes it to age 82, she's going to have been without funds to take care of her spinal cord injuries for ten years, under your plan; isn't that true?
A Yes.
Q Now, Dr. Mattson, if you took your average annual cost of care for Mrs. Rhodes, we won't talk about

the first year, we'll talk about the remaining years, which I think you said was 44,400 and --

A Six dollars.

Q -- 6 dollars. And if you go ahead and run that out for another ten years, wouldn't your life care plan have a bigger number?

A Yes.

Q Okay. And it's a pretty straightforward calculation, isn't it?

A Yes. Without using economic principles and present values --

Q Sure.

A -- it would be straightforward.

Q But if you multiplied the $44,406 per year times ten, under your life care plan, that would provide another $444,406 to Mrs. Rhodes to take care of her spinal cord injuries; isn't that true?

A Yes.

Q And your life care plan doesn't address whether Mrs. Rhodes is actually going to require more care as she gets older, does it?

A No.

Q And isn't it true that all of us are likely to get less strong with age?

A Yes.
Q And possibly develop a need for assistance as we get older?
A Yes.
Q And that's especially true for people with spinal cord injuries, isn't it?
A Yes.
Q Yet your life care plan doesn't make any modification for say when Mrs. Rhodes reaches age 65 or 70, for the personal care hours to increase, does it?
A No.
Q Your life care plan also -- strike that. When we just looked at the life care tables, the average life care tables --
A Yes.
Q -- you didn't rely on the average life care tables when you did the plan, right?
A No. Spinal cord database tables.
Q Okay. But isn't it true, Dr. Mattson, that, for example, on this database, spinal cord systems database that was started in 1973, aren't there people who are still on that database who entered the database 30 years ago?

A Yes. But that's -- they entered it at a much younger age.
Q And they're still there?
A It's all -- it's done -- it's done by age and type of injury, but, you know, for paraplegics, more than 99 percent of the people that they have studied would have a lower life expectancy than normal.
Q Well, isn't it true, Dr. Mattson, that over time, since 1973, when the database was started, that the life expectancies of people with spinal cord injuries have been increasing?
A Only slightly.
Q Isn't it true that the life expectancies for people with spinal cord injuries has been increasing?
A For some, yes. And for some, no.
Q And isn't it true that the life expectancy for people with spinal cord injuries is approaching that of the able-bodied population?
A No.
Q Dr. Mattson, have you ever seen this textbook before?
A Yes.
Q What do you recognize this textbook to be?
A I forget the title. It's Principles and Practices of

Spinal Cord Medicine.

Q And what do you recognize this book as?

A It's a textbook about spinal cord injuries.

Q And is it something that you yourself have referred to from time to time in the 20 --

A -- 5 years.

Q -- 5 years that you've been a case manager?

A Yes. I have an older version of that, and I've looked at different chapters of that one online.

Q Okay. And isn't it true that the textbook on spinal cord medicine says -- I'm going to point this out, and you be sure if I'm reading it correctly, okay?

A Okay.

Q Are you ready? Okay. "Because life expectancy after SCI" -- and SCI means spinal cord injury?

A Yes.

Q -- "after SCI approaches that of the able-bodied population, the vast majority of infections occur long after the injury." Did I read that correctly?

A I don't -- I don't know. You asked me the last sentence in a paragraph about someone I don't even know.

Q Did I read it correctly?

A You read it correctly.

Q Thank you. Now, Dr. Mattson, men have lower life expectancies than women?
A About 2 percent.
Q Okay. And your life care plan that provides for the three hours of a personal care attendant times during the day, once Mrs. Rhodes has used up that three-hour allotment that you've provided for under your life care plan, if she needs assistance, it's going to be somebody else in her family who's going to have to provide it, isn't that true?
A If she needs assistance, yes.
Q Okay. And under your life care plan, if Mrs. Rhodes needs more than three hours of assistance at some point in the future, it would either be her husband or her daughter or somebody else to help her in her activities of daily living?
A Yes. If she were to be dependent and need more hours.
Q All right. Now, isn't it true that if something happens to Mr. Rhodes, Mrs. Rhodes would not be able to rely on him for assistance in the future should she need it?
A Yes.
Q And isn't it true that Mr. Rhodes, as a white male,

is going to, on average, have a lower life expectancy than the average white female?

A Yes.

Q And so isn't it true that if Mr. Rhodes predeceases his wife, she will not have a husband there to provide assistance in the event that she needs it?

A Yes.

Q And isn't it true that your life care plan makes no modification or doesn't take that into consideration at all?

A It depends on whether she becomes dependent or not. The average paraplegic long into their late 60s or early 70s is independent.

Q And isn't it true, Dr. Mattson, that if Mrs. Rhodes, when she's age 65, or age 70, is a widow, her husband will not be there to provide assistance to her.

A Yes, that scenario would be true.

Q Thank you.

MS. PINKHAM: If I may just have a moment, your Honor.

THE COURT: You may.

(Pause)

MS. PINKHAM: I have nothing further,

your Honor.

THE COURT: All right. Redirect.

MR. CONROY: Could I have the chart marked as an exhibit having to do with the 23 year life expectancy.

MS. PINKHAM: --

MR. CONROY: May I approach, your Honor?

THE COURT: Yes. Did you want something marked?

MR. CONROY: I thought it was already marked. I think it's not. It's the chart that was shown to the witness with the 24.4 year life expectancy.

MS. PINKHAM: Your Honor, that was a document that the witness could not identify.

THE COURT: She couldn't, that's right.

MR. CONROY: May I approach again, your Honor?

THE COURT: You may.

REDIRECT EXAMINATION BY MR. CONROY:

Q Dr. Mattson, I think you told us that looking at that chart by itself, you were not able to identify the

source of that chart?

A Well --

MS. PINKHAM: Objection.

THE COURT: The objection is overruled.

A I was not able to -- I know the source is probably from the National Spinal Cord Database, but I don't know what year it was plugged in as the first year.

Q Are you familiar with a letter sent by this Dr. DeVivo that counsel mentioned, to counsel's firm?

A I was told of it, I haven't seen it.

Q Let me show you if I can --

MR. CONROY: May I approach again, your Honor?

THE COURT: You may.

Q This is a letter dated April 30th, 2003; am I correct?

A Yes.

Q And that letter is addressed to Ms. Carlotta Patten, being an associate of counsel's, plaintiff counsel's?

A Yes.

Q And it's from a Michael DeVivo?

A Yes.

Q Would you take a moment to read that letter,

please?

A Excuse me?

Q Would you take a moment, please, to read that letter?

A Yes. Okay.

Q Dr. Mattson, that letter was prepared at the request of defense counsel?

A Yes.

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q Who requested Dr. DeVivo to prepare that letter?

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q Does that letter indicate the probable life expectancy of Mrs. Rhodes?

A Yes.

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q Dr. Mattson, you were questioned about your life care plan in terms of some things that you did include and didn't include. Do you recall that?

A Yes.

Q And I think you told us that with what the cost and present dollars of your plan, it's around 1.2 million

dollars?

MS. PINKHAM: Objection, your Honor.

THE COURT: The objection's overruled. You may answer.

Q Is that correct?

A Yes.

Q And if that's reduced to present value, that number's actually lower, correct?

A Yes.

Q And was the goal of your plan to try and look to the future and identify what you thought the needs would be?

A Yes.

Q And, for example, this Vocare bladder program that you suggested be looked at, you're trying to improve Mrs. Rhodes' life quality with this?

A Yes.

Q If she's a candidate for it, correct?

A Yes.

Q And that increased the cost of your plan by doing that?

A Yes.

MS. PINKHAM: Objection, your Honor.

THE COURT: Sustained. This is your

witness.

A Yes.

Q And the issue with going to Colorado, the reason why you requested that, that you looked at was what?

A Because it's the best place in the country.

Q Do you think that if there's some downsides to the travel part of it, is that -- are the potential benefits to it outweighed?

A Significantly, in my opinion.

Q And you accounted for what the cost would be?

A Yes.

Q You were asked some questions about the attendant care issue and how many hours and costs in your plan versus potential higher numbers, correct?

A Yes.

Q With your plan, Dr. Mattson, are you assuming there's hopelessness for Mrs. Rhodes?

A No, I'm assuming almost independence.

Q Well, when you prepare a health care plan, should you assume that there's just no hope for a patient getting better when you're trying to project out say 24 years?

MS. PINKHAM: Objection.

THE COURT: Sustained.

Q What assumptions should you make when you're projecting out through the course of 24 years what a patient's condition should be?

A You're looking at the optimum level of function. That's what I do. I look at how they -- what it's going to take to get them to be as functional as possible, as active and as productive as possible, as healthy as possible. Then I look at the potential complications, and then I -- there's eleven or twelve different categories, and I -- of things that I recommend, in order to help them achieve that level. That's over and above what a noninjured or nonill patient -- person would need during the course of the same years.

Q And I think you've told us that there were some complications Mrs. Rhodes got into?

A Early on, yes.

Q They weren't her fault, right?

A No.

Q And your goal was to have her recover from those and have her improve in the future?

A And not have them reoccur again.

Q You were also questioned about the issue of weight loss?
A Yes.
Q That would be a good thing for Mrs. Rhodes?
A Yes.
Q And it may take longer than three months, correct?
A It should take longer than three months.
Q Conditioning, that she should be -- she should get the optimum physical conditioning available?
A Yes.
Q And all this increases her independence?
A Yes.

MR. CONROY: That's all I have. Thank you, ma'am.

THE COURT: Any further examination? Based upon the cross-examination? I'm sorry, on redirect. Based on the redirect.

MR. KNIGHT: Nothing further, Judge.

MS. PINKHAM: I have no further questions.

THE COURT: Thank you. You may step down.

WITNESS STEPS DOWN

THE COURT: We'll resume with the

plaintiff's case?

MR. PRITZKER: Yes, please, your Honor.

THE COURT: All right.

MR. PRITZKER: Your Honor, with the Court's permission, I would like to distribute to the jury the books containing the subset of the --

THE COURT: Counsel all have gone over these?

MR. BOYLE: No, we haven't seen them yet, judge.

THE COURT: All right. We'll have to do that after lunch then.

MR. PRITZKER: I represent, your Honor, these are the subsets of what's already been marked.

THE COURT: I understand, but they have to have an opportunity to go over them. All right? So we can pass those out.

Who's going to be the next witness?

MR. PRITZKER: Dr. Elizabeth Roaf.

MS. PINKHAM: Dr. Roaf.

THE CLERK: Would you raise your right hand, ma'am, please.

Do you solemnly swear the testimony you shall give to the court and the jury in the case now on trial shall be the truth, the whole truth and nothing but the truth, so help you God?

THE WITNESS: Yes, I do.

THE CLERK: Thank you, you may be seated.

THE COURT: You may proceed.

DR. ELIZABETH ROAF, sworn

DIRECT EXAMINATION BY MS. PINKHAM:

Q Good afternoon.

A Hi.

Q Could you state your professional name for the jury, please.

A I'm Elizabeth Roaf.

Q Is Marcia Rhodes one of your patients?

A She is.

Q And you're a doctor?

A I am a medical doctor.

Q Now, what's your area of specialty?

A Well, I have three areas of specialty actually. I'm Board certified in three areas. Physical medicine and rehabilitation, internal medicine, and spinal cord injury medicine.

Q And could you explain -- let me step back. Dr. Roaf, could you just briefly summarize your medical training?

A I went to medical school in Vermont, at the University of Vermont. Then I had a dual residency training, two residencies in internal medicine and rehabilitation. That was in Boston at the Tufts combined program. Then I went on to teach at -- after I finished my residency training, I went on to teach at Boston University School of Medicine and practiced there.

Q What did you teach?

A I taught medical students and residents about physical medicine and rehabilitation.

Q When did you graduate from medical school?

A 1992.

Q And when did you finish your residency?

A 1997.

Q And after teaching at the -- you said you had practiced there as well?

A I did.

Q What was your -- what did your practice consist of at Boston University?

A I had kind of an unusual practice, in that I

practiced both in the Department of Internal Medicine in the Geriatrics Division, and I practiced in the Department of Rehabilitation Medicine. And what I did was, I provided -- the internal medicine component of it actually not only included the geriatrics, but it also included providing primary care for adults with severe disabling conditions, so they all had quadriplegia, paraplegia, or triplegia, three limb involvement paralysis from either a spinal cord injury or brain injury or another cause for that. I provided primary care for the people. In addition to that, what I did in the Department of Rehab. Medicine was clinically I did consultations in the intensive care unit. Boston University Hospital -- the University Hospital and the City Hospital merged together to be Boston Medical Center, and they -- it's a Level 1 trauma center for Boston. They have a lot of the traumas go there, so I did consultations on the spinal cord patients, the brain injured patients that were in the intensive care unit and on the floors there.

Q If I could ask a question. What's a Level 1 trauma center?

A You have to have certain -- reach certain criteria in

order to be a Level 1 trauma center. I don't know all the specifics of the criteria not being an administrator, but one of them is that you have to be able to have the capacity to handle heavy duty traumas, gunshots, motor vehicle crashes where people are severely injured, that sort of thing.

Q Including spinal cord injuries?

A That's right.

Q And so how long did you have this practice or did you work at BU?

A I was there about three years.

Q Where did you go after BU?

A I went out to the University of Massachusetts.

Q Any particular part, the medical center or the medical school?

A Right. At both actually. I have an academic appointment that I still have at the University of Massachusetts Medical School, and that carried with me when I left the clinical practice there. I have a -- I had a clinical practice at the University of Massachusetts Medical Center in the Department of Orthopedics.

Q And when you say a clinical, is that essentially patient care?

A Taking care of patients.
Q Okay. And what was your academic position at UMass?
A Assistant professor.
Q And what did you teach?
A I taught medical students and some residents. They were orthopedic residents, not rehabilitation residents.
Q When you first started to explain your training, you said that you have three subspecialties?
A That's correct.
Q Okay.
A Three specialties.
Q Three specialties, thank you. Are you certified in those specialties?
A I am. I'm Board certified in each of those specialties.
Q And what does it mean to be Board certified in a specialty?
A It means -- it's a -- it means that you go on to take extra testing and -- it's an added qualification that you're proficient in that area.
Q And what's the Board that actually administers this test that you have to pass, to be Board certified?

A I don't understand the question.
Q Who gives you the test that you need to pass in order to become Board certified in a specialty?
A There's a structure called the American Board of Medical Specialties, and each medical specialty has a board within it, within the American Board of Medical Specialties. So each specialty area of medicine has their own testing that they do in order to be a specialist in that area.
Q And so could you describe, Doctor, the timing of the various Board certifications in your different specialties?
A Mm-hmm. I received my Board certification in internal medicine in 1996, my Board certification in physical medicine and rehabilitation in 1998, and then Board certification in the subspecialty of spinal cord injury medicine in 2000.
Q And what year was that subspecialty in spinal cord medicine first offered?
A I believe that it actually was offered the year before, in '99.
Q Is that a relatively new subspecialty in medicine?
A The certification is new.
Q Okay. And it's a subspecialty of what area?

A Well, actually you can -- it's a subspecialty of spinal -- of physical medicine rehab., neurology, or you can also get grandfathered in from other specialties as well, but mainly the physical medicine rehabilitation and neurology.

Q Dr. Roaf, in the course of your training and practice, have you ever published any materials that discuss care of patients with spinal cord injuries?

A Yes, I have.

Q Could you just briefly summarize what those are?

A I wrote a chapter on initial assessment and consultation of spinal cord injury patients. I can't remember if there's anything else on spinal cord. I have unpublished data on it, too.

Q Okay. To date, Dr. Roaf, approximately how many patients with spinal cord injuries have you provided treatment for?

A I don't count the number of patients that I see.

Q Well, let's turn back to when you were at Boston Medical Center working at the Level 1 trauma center. Any approximation just from that period of time?

A Well, the primary care practice that I participated

in, we had over 200 severely disabled individuals. Now, they weren't all spinal cord patients. And we followed them longitudinally for primary care, and then during the consultation phase. So there were dozens. And then -- maybe more than that. I just don't -- I don't count the number of patients. I just take care of them. Then in the consultation area, there were -- I don't know how many more. I can't say how many more.

Q Okay. Of your practice, can you give us an approximation of how many of the patients that you've seen over the years are patients with spinal cord injuries?

A The numbers or percentage?

Q Just an approximation. Yeah, percentage.

A How many of the patients I have seen?

Q Yes.

A Maybe -- maybe 20 percent of the patients over all I have seen during my practice.

Q And the others would have some other type of --

A Disability.

Q Okay. Now, Dr. Roaf, before you were here, there was some testimony about physiatry. And I'm going to ask if you could explain what physiatry is

in medicine.

A It's a subspecialty of medicine that is based on providing care for individuals with disabilities. So it's a broad specialty that involves care of people, perhaps with spinal cord injury, perhaps brain injury, stroke, amputation. It goes on and on. Anyone with a level of debility or disability may be seen by a physical medicine/rehabilitation specialist.

Q And how do you refer to yourself in your practice?

A Physiatrist.

Q Do you refer to yourself as a physiatrist?

A I do.

Q When did you first begin treating Marcia Rhodes?

A In 2002, when she came to Fairlawn Rehab. Hospital for her rehabilitation inpatient.

Q And you had testified previously that you had worked at UMass and taught at UMass. At what point in time did you become affiliated with Fairlawn?

A When I moved out to work at UMass Medical Center. In fact, the position at Fairlawn was part of that position. So I moved out there in -- I think it was 2000, the spring of 2000 I moved out there.

Q Okay.
A And so that was part of my position at UMass Medical Center.
Q That was clinical care?
A Clinical care.
Q At Fairlawn?
A Yes.
Q Okay. And what was your role in providing care for Mrs. Rhodes when she became a patient at Fairlawn Hospital?
A I was the rehabilitation consultant on her, on her care.
Q And who did you consult with?
A Dr. David DeGrand was the primary doctor there, and I was a consulting physician.
Q Okay. And so what was your role as a consulting physician for Mrs. Rhodes?
A To work with Dr. DeGrand and with the therapists and nursing staff, and the patient and her family, to put together a rehabilitation plan and to work on putting forward her rehab., putting forward her functional abilities, helping to educate her about her injuries, that sort of thing.
Q What was your understanding of the injuries that

she had sustained before she came to Fairlawn?

A She had a T12 first fracture, causing the complete paralysis. And she had rib fractures on both sides. One of them was broken in two places, which is called a flail chest. She had a small bleed in her brain, small area of bleeding in her brain.

Q And what's -- is there a medical term for that?

A It's called subarachnoid hemorrhage.

Q And what causes that, if you're aware?

A Presumably the accident.

Q And is that about the sum of the injuries to your understanding that she had suffered?

A Those were the injuries.

THE COURT: All right. Why don't we suspend at this point for our luncheon recess. We'll resume at two o'clock. Members of the jury, would you be back in the jury room at ten minutes of two, please.

(LUNCHEON RECESS)

MR. PRITZKER: Your Honor, before Dr. Roaf retakes the stand, the defendants have now looked at the book of excerpts. They have no objection.

THE COURT: No objection. All right.

The court officers will help pass these out to the jurors.

MR. PRITZKER: Could I have one marked either as an --

THE COURT: Exhibit.

MR. PRITZKER: -- exhibit or identification.

THE COURT: We'll mark it as an exhibit.

MR. PRITZKER: An exhibit? Fine, your Honor. Thank you.

THE COURT: So that will become Exhibit 58.

MR. PRITZKER: 58, your Honor.

(Book of medical records received and marked Exhibit Number 58.)

THE COURT: All right. We'll have the doctor resume the stand.

ELIZABETH ROAF, Resumed

(By Ms. Pinkham)

Q Good afternoon, Dr. Roaf. Before we broke, you summarized briefly the injuries for which Mrs. Rhodes had been treated at UMass before she was

admitted to Fairlawn. What was Mrs. Rhodes' physical condition upon her admission to Fairlawn? Just generally speaking.

A She was -- she was paralyzed. She was a paraplegic. So she had suffered a spinal cord injury when the bones at the T12 level broke. That bone broke into a lot of little pieces, the vertebral body and the bone attached, at the whole entire, and it severed the spinal cord.

Q And approximately where is the T12 vertebra located?

A It's down sort of in your low, mid back. Here. I don't know if you can see that. Shall I stand up? Right around this area.

Q And is that approximately at the same level where the bellybutton or umbilicus is at the front?

A Well, in terms of sensation, actually the sensory level for that is lower. You can answer that question a couple of different ways.

Q The paraplegia that she is suffering, is there a medical definition of paraplegia?

A There is. Paraplegia means that you don't have movement of your -- of two limbs, of your two lower limbs. There are different ways that it can be

classified. When you have an injury to the spinal cord, it can be classified, one of the ways that it's classified is it's called the ASIA classification. That's a shortening for American Spinal Injury Association classification. And it's classified under ASIA level A, you don't have any sensation below that level that was injured, and you don't have any motor power below that level that was injured. That's what the classification is, Level A. B, ASIA B you have some sensation below that level, but no motor power. Now, the -- you may also have sensation of bowel and bladder function if you're ASIA B. And some sensation of sexual function if you're ASIA B. You may have some of those or all of those.

ASIA C means that you have motor power below that level, you can move the muscles below that level, but not move them up against gravity. You can maybe move them a little bit, but you can't bring them up against gravity. And then ASIA D, you can move greater than -- you can move some of them against gravity. So you may have an injury up at this level, but may be able to move some of the muscles below it against gravity. And

ASIA E is actually a complete sensory motor recovery, even though you've had a spinal cord injury.

Q And what level was Mrs. Rhodes' injury classified?

A It was a T12, she had a T12 fracture, and that was an ASIA A level. So an ASIA A classification rather, so she didn't have any sensory function below that level, no bowel or bladder. No ability to control her bowel or bladder or feel it, and she couldn't move anything below that level, which is -- comes around to her lower abdomen.

Q Would she, as an ASIA A paraplegic, could she control any of her stomach muscles?

A Yes. She could control most of her stomach musculature, based on that she -- neurologically, she should have been able to, yes.

Q And what type of functions would she still be able to accomplish having maintained some of the stomach muscle function?

A Well, the stomach muscles are actually important in sitting balance, the stomach and the back muscles are important in sitting balance. They allow you to be fairly stable when you're sitting upright, and also when you have a -- when you

develop an upper respiratory infection and a cough, a cold, what have you, you actually need the stomach muscles to help brace you in order to cough. So it's -- so she had those abilities, for balance and coughing.

Q Now, the functions that she had lost. She lost motor function. She lost sensory function.

A Right.

Q And what does it mean to lose sensory function?

A That means she can't -- she cannot feel when you touch her below that level of injury. She cannot feel it. She can't feel pain, she can't feel light touch, she can't feel burn. She can't feel those things. She just doesn't -- the nerves in the legs aren't communicating up to the brain because the spinal cord is not properly transmitting the things because it was so badly damaged.

Q Now, is there any expectation that she will ever recover any of those functions?

A No, there is not.

Q Given the permanent nature of the injury that she has suffered --

A Mm-hmm.

Q -- what was the goal of her stay at Fairlawn

Rehabilitation Hospital?

A Well, the goal was to have her become as functional as possible, to be able to do as much for herself as possible, in order to hopefully have her be discharged to home. You know, learning to take care of yourself when you can no longer walk, when you can no longer pee on your own or have a bowel movement on your own spontaneously, and you can't control it, when you have to learn how to get yourself out of bed and get your clothes on and you can't move your legs to get your clothes on and you're having trouble moving your body around, there are a lot of different things, you know, in terms of mechanics and also of understanding spinal cord that goes on in rehabilitation. So it wasn't to make her walk again or to restore the things that she couldn't get back. But it was rather to allow her to understand what she was going to need to do, and also to gain strength and recovery. She had had a spinal fusion at that -- you know, her spine had been fused after the bone -- after the bone fracture, in order to provide some stability, so it wasn't sliding back and forth. So she had to recover from that. She had pain from that -- from

the rib fractures rather, not from that fusion.

Q Dr. Roaf, is there any difference in the -- based on gender, in a person's ability to recover or at least adapt to life as a paraplegic?

A I don't think there's -- I'm not aware of data on that, but I can tell you that as a doctor, when patients come to see me in the office, what my clinical experience has been is that women have a more difficult time in performing a lot of the upper body activities that they have to when they lose the ability to walk because they just don't have the strength across and through the upper extremities that a lot of men do.

Q While she was at Fairlawn, were there any impediments to her participating in her rehabilitation?

A Yes.

Q Can you describe what some of those impediments were?

A Well, she had had rib fractures on both sides, and she had to wear this thoracolumbosacral orthosis, which is the big brace that she'll have to wear. And that was to help the fusion area heal. You have to wear that. So she had the brace that she

had to wear, and it was pushing against her ribs that were broken, so the brace was painful for her.

Q All right, Dr. Roaf. I'm showing you what's been marked as Exhibit 28. Do you recognize what this is?

A That's the orthosis.

Q That's what Mrs. Rhodes was wearing at Fairlawn?

A That looks small to me. I don't think that's the one she was wearing. I think hers was larger than that.

Q And that is adjustable with the velcro straps?

A It's adjustable with velcro straps.

Q And there are some braces that are even longer?

A Yes, yes.

Q What -- apart from pressing on her ribs and causing her pain, did the brace that she was required to wear interfere with any other part of her rehabilitation therapy?

A It did. In order to provide adequate rehabilitation, it has to push against bone, so that you try to put it against the pelvic bone and up against the front of the rib cage in order to provide a -- sort of a tube-like stability. So it actually, when we are lying down and you're wearing something like that, it's in a different position than when you are sitting up

and wearing something like that. It can actually push against the thighs and ride up. And hers did that. It was riding up and chaffing against her arm, her armpit areas, and she was getting discomfort from that. So that was a -- that was a barrier.

Q And how did the staff respond to the chaffing and the discomfort that she felt?

A Well, we had -- we had the brace maker come in and make modifications to it and put padding in through there. It's still not the most comfortable thing to wear. I mean it was pushing against the ribs and that sort of thing, so that was one of the barriers, the bracing and the -- with the rib fractures.

Q Did she have any experience with swelling when she was at Fairlawn?

A She did. She developed a clot in one of her legs when she was at the acute care hospital. And probably because she had that bleeding in her brain, so they didn't want to have her on a long-term -- a long-term blood thinner, which is what you -- put her on a long-term blood thinner. But she couldn't be on that because of the bleeding in her brain. And so they had put this thing called a

Greenfield filter in, which is a big filter they put in the vein. It looks like a little cage, a little screen. It looks like a little screen that's shaped like an umbrella, and that prevents the blood clots from traveling up to your lungs, but it doesn't prevent you from getting blood clots. So what happened was she developed a blood clot. And then frequently when you have one blood clot, you'll get one on the other side if you have a Greenfield filter because it can travel up and then the other leg can get it too. So she ended up actually with her -- both of her legs quite swollen with fluid because they were -- the blood clots make your legs more swollen with fluid, and also the paralysis, the inability to move our legs, makes you -- makes them more swollen. So they became quite swollen and heavy, and it made her even -- made it even more difficult for her to transfer.

Q And why did the swelling in her legs make it more difficult to transfer her?

A Well, they had a lot of fluid in them, and so they became very, very heavy. And it's just more weight that you have to transfer.

Q Did she need assistance with the transfers while

she was at Fairlawn?

A Yes. She needed -- when she first got there, she needed assistance with absolutely everything. And she was actually what -- there's a way that you can rank how much assistance, and she was dependent, and she began to become more and more -- require less and less rather, assistance during her stay.

Q While she was an inpatient at Fairlawn, approximately how often would you see her?

A On an average, I think it was a couple of times a week.

Q And have you continued to see and treat Mrs. Rhodes since her discharge from Fairlawn?

A Yes.

Q When was the last time she came to your office?

A She came in in August.

Q And in the past year, approximately how many times roughly have you seen her?

A I see her every three months or so, I think. Approximately.

Q So let's get back to while she was still inpatient at Fairlawn. Did you have the opportunity to observe her moods at any point in time?

A Yes.
Q Actually Doctor, I'm going to hand you a binder that's been marked as Exhibit 58. And ask if you could turn to Tab 8 in that binder. Have you found Tab 8, Dr. Roaf?
A Mm-hmm. I think I'm on the right one.
Q The fourth paragraph, about halfway through the fourth paragraph, do you see any reference to Mrs. Rhodes' being tearful?
A Could I just clarify? This is the note from 2/20/02 that you're talking about?
Q Yes.
A Okay.
Q Thank you for that clarification.
A Right.
Q Could you -- and this is your notes?
A Yes.
Q Could you read what you wrote that begins with "she agreed"?
A "She agreed to that but was frequently tearful, saying that she feels like she has no control over anything in her life, especially with this spinal cord injury."
Q And on that same page, Dr. Roaf, you also made a

note under the category of rectal. And what note did you make there?

A She remains incontinent, oozing stool.

Q Now, previously, at the beginning of your testimony, you made reference to bladder and bowel function. Did Mrs. Rhodes have control over any of those functions after the injury?

A No.

Q And what does it mean to be incontinent?

A It means that you cannot hold your urine or your stool, and you pee on yourself, or you have bowel movements on yourself.

Q And is that something that -- strike that. Was a bowel program something that was a focus of the rehabilitation at Fairlawn?

A Yes.

Q And the reason why you wanted to teach patients about a bowel program is?

A They need to be able to evacuate their bowels.

Q Apart from the notes that you made on Tab 8 that we had just looked at, do you recall any instances of her moods while she was at Fairlawn?

A I -- I think it was a very stressful time for her.

Q Is that typical in your experience?

A Yes, it was very typical.
Q Is there a standard reaction among people who receive spinal cord injuries who become paralyzed?
A It's like grieving over any loss. People become very sad, then they may become angry. They may be in denial for a period of time. I mean, people go through phases of -- of coming to grips with things and coping with things.
Q Was that something that was also dealt with during her stay at Fairlawn?
A Definitely.
Q Now, Dr. Roaf, apart from the discomfort that Mrs. Rhodes felt wearing the brace and the blood clots that she developed in her legs, were there any other impediments to her rehabilitation at Fairlawn?
A There were -- she had developed a pneumonia while at the hospital. Something called a staph pneumonia. It's a type of bacteria. And her -- the particular type of bacteria that she -- that she had was resistent to some antibiotics. And when -- it's called methicillin resistent staph aureus or MRSA. And when people have that kind of resistent bacteria in their body, you don't want to have it

transmitted to -- around. Because we only have so many antibiotics. So she -- she had the pneumonia and she needed treatment for that. And then on top of it, she had -- was colonized with bacteria. So she had had to stay in her room for a large part of her rehabilitation stay, she couldn't go out in the main part of the hospital because of that bacteria.

Q And having a patient required to stay in their room, is that a goal of therapy?

A Certainly not.

Q Why not?

A You want to have people become as functional as possible and as -- you know begin to think about getting integrated into the community and interfacing with people and being able to use the -- you know, propel the wheelchair around the hospital and get stronger and up and down ramps and use different equipment, that sort of thing.

Q Approximately how long was she confined to her room while she was at Fairlawn?

A Over a month.

Q Is that uncommon?

A Most patients don't end up confined to their room for over a month.

Q As a result of the fact that she had been confined to her room for a month, did you make any suggestions about the length of her stay?

A We extended her length of stay as a result of -- in part because of that.

Q And was there any other reason why you wanted to extend her stay?

A We just wanted to make sure that she would be as functional as possible, and she -- she just had a -- it was just slow for her. It was -- she had a tough time. So we extended her. We didn't want to send her home too soon.

Q She was anxious to go home?

A She really wanted to go home.

Q Apart from the staph pneumonia that she had that required her to be in isolation, did she have any other infections while she was at Fairlawn?

A She did. She had something called clostridium difficile colitis, which is an infection in the -- in the gut. And it's related actually to being on antibiotics. It's another bacteria that's in the body, but it overgrows and you can become very ill from it. So she had developed that, and that's one of the reasons why she was oozing stool when she was

there because of this infection that she had in her gut. So that was treated. And then she also had another bacterial that was resistent to antibiotics in her -- in her gut too.

Q And that did that require a separate course of treatment?

A It was a colonization, and it required her to be -- also to be in her room, in addition to the other bacteria. The two of them together, it was like a double whammy. It didn't make her sick, it was just that she was colonized with it, it just was there, so once she stopped oozing stool, then that became less of an issue and she was able to go out of the room.

Q And once she was allowed to leave the room at Fairlawn, she could participate more fully with therapy?

A Yes, mm-hmm.

Q What are some of the basics that a patient who is in rehab. at Fairlawn, what are the basic skills that you want to teach them while they're there?

A Bathing, dressing, getting out of bed, propelling yourself, wheelchair ambulation or -- bathing, dressing. Independent -- some people do more

independent stuff like navigating outside.

Q Did --

A Uneven terrain is very different. When you're outside, it's uneven, it's not like being inside, so it's actually a different skill to be able to use a wheelchair outside, believe it or not.

Q Did -- do you recall whether Mrs. Rhodes progressed to the level where she was training on uneven terrain outside?

A I don't think she was. She was propelling indoors though.

Q Doctor, if you can turn to Exhibit Number 12 -- Tab Number 12 of Exhibit 58 before you. Have you found it?

A Is that April 5th, '02?

Q April 16th, '02, a discharge summary.

A Yes.

Q And this is the discharge summary for Mrs. Rhodes when she left Fairlawn?

A Mm-hmm.

Q And again that was April --

THE COURT: You have to answer yes or no.

A Yes.

Q Okay. And it's dated April 16th.
A Yes, it is.
Q And the date of admission is also on this record?
A Yes, it is.
Q So approximately how long was Mrs. Rhodes an inpatient at Fairlawn?
A More than two months.
Q If you could turn to the page that is stamped at the bottom 001318. Did you find this document, Dr. Roaf?
A Mm-hmm.
Q Does this page just briefly summarize some of the complications that you have just testified about?
A Yes, and it actually talks about a couple of others that we haven't mentioned yet.
Q Okay. And what others haven't we mentioned yet?
A We haven't spoken about the anemia.
Q What's anemia?
A Anemia is a low blood count, so the low red blood cell count.
Q And what -- did that have any affect on Mrs. Rhodes?
A Anemia can make you tired, among other things. She had -- she had had a bleeding in her abdominal

cavity, which probably was the cause of this.

Q And was there any other thing that was on here that you wanted -- that we have missed?

A Um, it talks a little bit about constipation, which is an issue with the bowel when you can't -- when your bowel isn't working properly, constipation can be an issue, and quite serious.

Q She had problems with that while she was at Fairlawn?

A Mm-hmm. Yes, she did. Yes.

Q Turning to the next page where you have a section -- or there is a section on rehabilitation techniques. Dr. Roaf, what -- at the time of her discharge, on April 16th of 2002, what could Mrs. Rhodes do?

A Well, she could use a slide board for transfers with the assistance of one person. Her wheelchair -- she could propel herself in a wheelchair more than 250 feet independently, without -- without help. She required minimal assistance for bed to chair transfers, meaning that she required somebody to help her, about 25 percent of the work being done by somebody else. She required moderate assistance for moving in bed, bed mobility. For bathing and dressing of her lower body.

Q So what is moderate? Is there a percentage associated with moderate?

A Yes. That means that she could do 50 percent of the work to move herself in bed. She could do 50 percent of the work to bath and dress her lower body.

Q And the other 50 percent?

A Somebody else had to do.

Q And when she was discharged, continue onto the next page, there's a list of outpatient and home services that were provided, including physical therapy.

A Yes.

Q Why is physical therapy part of the treatment as an outpatient?

A The outpatient treatment is a continuation of the inpatient care that is given. It's given either in an outpatient setting, or at home, and is very helpful for people in order to maximize their independence at home. It's a different -- the home is a different setting than the hospital. A hospital bed is very different from your bed at home. A chair at home is very different. Propelling through the thresholds at home is different. It is just very different than

being in the hospital.

Q So at the time of her discharge from Fairlawn, she hadn't yet learned anything she needed to learn?

A No, she hadn't.

Q Why would a home health aide be part of the home services that were recommended for Mrs. Rhodes at the time of her discharge?

A Home health aides help -- is someone that helps with getting bathing and dressing and that sort of thing, so that was to assist with those -- those skills.

Q And is there another phrase for home health aide? Are there different terms that are used?

A I don't know. I'm not sure what you're looking for.

Q Is a home health aide the same thing as a personal care attendant?

A Yes, it is.

Q She also needed nursing follow-up when she was discharged?

A She did.

Q Why?

A She was on -- at that time, she was on a blood thinner, to help because of the clots in her legs, she was far enough out at one point that we could

start her on a blood thinner that we didn't feel it would endanger her brain, you know, cause more bleeding. So she had been put on a blood thinner, so she needed blood draws for that. We also had wanted her to work on a self-catheter program. She had a Foley catheter in.

Q Now, a Foley catheter is a catheter that stays placed inside the bladder?

A That's correct.

Q And what's self-catheterization?

A That's when you have a catheter and you don't have anything in the urethra or bladder, you take the catheter and you stick it into the urethra and then the bladder in order to empty the urine out. There's no bag attached to it. You just insert it in, allow the urine to drain out, and then discard it and use another one the next time you need to evacuate the urine.

Q And why did you want a nurse to begin working on self-catheterization with Mrs. Rhodes?

A I try to have as many of my patients as possible on a self-catheterization program rather than on a Foley catheter.

Q Why?

A There are higher risks with an indwelling catheter, a catheter that's in your bladder all the time. There risks of -- an increased risk of infection, there's increased risk of bladder stone, and ultimately, there's an increased risk of bladder cancer. There's also, in women, the urethra, which is the tube that connects the bladder to the outside, can become dilated from the -- from the catheter constantly against it, so it can be a problem where people just leak after a while with a Foley catheter in.

Q But at the time of her discharge, she was using a Foley catheter?

A Yes, she was.

Q Is she still using a Foley catheter?

A Yes, she is.

Q Dr. Roaf, when she was discharged from Fairlawn on April 16th of 2002, where was she discharged to?

A She was discharged to home.

Q And are patients routinely discharged to home from Fairlawn?

A Many are discharged to home.

Q If Mrs. Rhodes had been a single woman, living by

herself, would she have been discharged to her home?

A Probably not.

Q Where would she have been discharged to?

A She probably would have had to go to a nursing home for a period of time.

Q So what was it about her home or her personal situation that made it possible for her to be discharged there?

A She had family to help her.

Q And was it expected when she was discharged from Fairlawn that her family would assist her in some of her activities of daily living?

A Yes.

Q Did you speak with Mrs. Rhodes after she had been discharged?

A Yes, I've treated her on an ongoing basis.

Q All right. What about -- did you ever have any -- did you ever speak with her very close to the time of the discharge?

A I did. I did. I think I called her a day or two -- maybe the next day after she was discharged to check on her because I was concerned.

Q And what's your understanding of how her

discharge to home went?

A I think it was incredibly stressful for Mr. Rhodes and Mrs. Rhodes.

Q And did you discuss that with both of them?

A I did.

Q And is it -- in your experience is the transfer to home a big adjustment?

A Absolutely. Absolutely.

Q And that's why the physical therapy, home health aide and nursing were recommended as follow-up?

A Yes, that's why.

Q Dr. Roaf, you had mentioned that you typically like to have your patients do self-catheterization. Has Mrs. Rhodes attempted self-catheterization?

A She has.

Q Is she able to do it?

A She isn't able to do it. We've tried it actually on multiple occasions. She just isn't physically able to do it.

Q Is there any particular reason that you think of that --

A It's her size, it's her body habit, and she just can't get down there and see what she's doing in order to catheterize herself. I think she's tried very hard,

it's --

Q Have you had other discussions with her about alternative ways for her to -- to control her bladder?

A I have.

Q And apart from a self-catheterization that she can't do, what else is out there?

A Well, there's the Foley catheter that she's using now. There's another type of catheter that's inserted directly into the bladder that's called a Superpubic tube. It's very much like the Foley, except it's actually surgically inserted through the abdomen, the lower abdomen. And that also can empty the bladder. It's not appropriate in all patients, and certainly you don't want to have somebody have surgery if they don't need it, you know. So that's one -- another option. There are other -- there are other surgeries that can be performed in order to help, you know, with bladder emptying.

Q Dr. Roaf, are you familiar with a device that uses electrical stimulation to empty the bladder?

A I'm familiar with electrical stimulation to empty the bladder.

Q Is that something that you would recommend for Mrs. Rhodes?
A No, it absolutely is not.
Q Why not?
A It's not something that's a standard treatment. It's more of an experimental kind of treatment, and what was happening with the electrodes, when people were starting to do research on this, they would -- they implanted them in the arms, and in the legs.
Q Implant an electrode?
A Electrodes, yeah, in paraplegics and quadriplegics, in their arms and legs, and what they found is that electrodes were breaking as the muscles were contracting, and then the electrodes were left in the muscles. So it wasn't very favorable. The bladder has also been looked at, but the bladder also is a muscle, and so you're sticking electrodes into it, there's a risk of infection. It's basically an experimental treatment. I don't think it's well enough proven to recommend it to my patients, so therefore I won't.
Q Now, what about for the bowel program? Mrs. Rhodes testified that she uses digital stimulation.

Is that what she was taught at Fairlawn?
A That is.
Q And apart from the digital stimulation, is there any other method that she can use to empty her bowel?
A Well, she's used a variety of different medications. You can also alter your diet, you can change the amount of water that you intake, and then there are devices, we have discussed one device that is possible for her to use, and then other than a device that you -- there is surgery. You can actually have a colostomy and empty your bowels that way.
Q Is that something that's recommended for Mrs. Rhodes?
A Not at this time.
Q Is she having success with her bowel program?
A She isn't.
Q And what about it is not successful?
A In a bowel program, you want to have the individual be continent when they're out and about, when they're not moving their bowels.
Q When you say continent, Dr. Roaf, you mean you don't want them to have accidents?
A Don't want them to have accidents. So that's one

of the goals. And she hasn't had a lot of accidents, so in that way it is successful. But the other thing about a bowel program is you really don't -- you have to have it -- the goal is to have it be an hour or less trying to evacuate the bowel, an hour or less. And hers has been quite protracted, taking hours. More than an hour, two hours, up to four hours, you know. So it's very long. So in that way, it hasn't been particularly successful for her.

Q Has she tried different medications?

A A variety of medications, yes, she has.

Q Doctor, could you turn to Tab 30 in Exhibit 58, please. It's a letter dated September 5th, 2003. This is not one of your medical records, is it, Dr. Roaf?

A No, it is not.

Q Do you know who Donna Kraus, M.D. is?

A Yes, that's her primary care physician.

Q That's Mrs. Rhodes' primary care physician?

A Yes.

Q And is it common for primary care physicians to deal with a number of different specialists?

A Very common.

Q Especially in Mrs. Rhodes' case?

A Absolutely.
Q And this is a letter from the Milford Gastroenterology Associates?
A Yes, it is.
Q Dr. Roaf, turning to the second page of Tab 30, the last very full paragraph, it begins, "In summary," one of the sentences states: "The issue is what is going to be our best regimen to promote bowel evacuation without causing her problems of incontinence and risk chronic laxative use." What is the risk of chronic laxative use?
A Chronic laxative is damaging to the interior of the gut, to the inside of the gut.
Q And so at some point after it becomes chronic, is there -- what about it makes it damaging, or what effect does it have on the patient?
A You know what, I'm not a gastroenterologist.
Q Okay.
A I can give you my rehab. doctor's take on it, but I'm not --
Q All right. As a rehabilitation specialist dealing with a spinal cord injury, do you want your patients to avoid chronic laxative use?
A Yes.

Q Dr. Roaf, after Mrs. Rhodes was discharged from Fairlawn, and after she was -- had surgery on her gallbladder, did she ever develop problems in her shoulders, her upper body in general?

A Yes, she did.

Q And what was the problem that she developed?

A She developed tendinitis of her shoulders, which is from overuse. It's very common in people with paralysis who have to use their arms to do their transfers and their wheelchair propulsion. You're basically constantly using your arms in order to propel yourself and to push yourself off for pressure relief and to keep pushing yourself as you transfer yourself over.

Q And so what -- what did you recommend that she do to treat the tendinitis and bursitis?

A An important part of treating tendinitis and bursitis is resting, which for someone that uses their arms for propelling their wheelchair and for transferring themselves out of bed, resting them is like putting them on bed rest, it's very, very difficult for the patient. I also recommended that she obtain an electric wheelchair to provide some rest for her arms from constantly propelling her wheelchair.

Q Has she ultimately gotten an electric wheelchair?
A She did.
Q Do you expect that at some point in the future she'll develop tendinitis or bursitis again?
A I think it's very likely. It's a very common problem.
Q And as she gets older, are there any other complications or effects of basically using her arms to propel her body instead of her legs?
A You know the shoulders aren't set up to be weight bearing for full body weight. Your hips and your knees are. Your shoulders and your elbows are for reaching and that sort of thing, lifting things, but not your full body weight. So repetitive use and constantly bearing your full body weight through your shoulders can cause premature arthritis of the acromial clavicular joint, which is in this area, and also the gleno-humeral joint, which is the big shoulder joint that you usually think of. Both of those can get arthritis associated with the overuse and be painful, and also limit mobility down the line.
Q Is there any type of condition that may develop over time? Is there something called overuse condition or is there something like that?

A Right. Well, tendinitis is a type of -- tendinitis, bursitis, is a type of overuse syndrome. You can also have that in the elbows.

Q Do you think she's at risk for developing overuse syndrome as she gets older?

A I do.

Q And will that interfere at times with her ability to be independent?

A Yes, because she needs her arms to be able to transfer. She needs her arms, fortunately now she has an electric wheelchair. But, you know, being able to get out of bed in the morning and be able to hub transfer yourself over to the commode, you know, the toilet, the commode, that's -- you know, when you can't use your arms because you have to rest them because they have tendinitis, that would require more help. So that makes sense.

Q At any point in time after she was discharged from Fairlawn, did you recommend to Mrs. Rhodes that she begin a weight-loss prograM?

A I did discuss that with her on a number of occasions.

Q And why did you have those discussions with her?

A She -- I think that if she could lose weight, that that

would help to relieve some of the stress on her shoulders and it would just help her overall health. But it would relieve some of the stress involved with trying to transfer and problems for her mobility.

Q Dr. Roaf, do you recall what Mrs. Rhodes' weight was when she was admitted to Fairlawn?

A While she was at Fairlawn her weight was -- I know it was at one point 180, at another point 186, I think.

Q Did she gain weight after the discharge from Fairlawn?

A She did.

Q Did she gain a significant amount of weight?

A She did.

Q Mrs. Rhodes is five foot four?

A Yes, she is.

Q And what's the average body weight for a woman who's five foot four?

A The average?

Q Or if there's some other --

A Ideal body weight --

Q The ideal body weight --

A -- if that's what you're asking. Actually, according

to -- we have a nutritionist consult on our patients when they come to Fairlawn, that's part of the standard protocol, and they did a consultation and calculated that her ideal body weight, based on that height is a hundred and twenty pounds is her ideal body weight.

Q Her ideal body weight is a hundred and twenty pounds?

A Right.

Q So if she weighs 200 pounds right now, she's a significant distance from her ideal body weight?

A She is.

Q How much weight do you think would be good for her to lose in order to become more independent and place less strain on her shoulders?

A If she could lose 50 pounds, I think that would be great.

Q Do you think it is likely that she is going to lose 50 pounds?

A I think it is unlikely.

Q Unlikely?

A Unlikely.

Q So again, any weight loss would help her mobility?

A Any weight loss would help her mobility.

Q Dr. Roaf, is the weight loss or exercise regimen for a paraplegic different than that of an able-bodied person?

A It's different -- it is different.

Q How?

A It's different in that when you can't use your legs to exercise, you're limited in the amount of muscle mass that you can use in exercise in order to lose weight. So she doesn't -- she's not able to participate in an exercise program of walking or jogging or any of the things we think about for weight loss. She can do strength and aerobic exercise with her arms. She could do an arm-held bicycle. She can do some strength for her abdominal muscles and her back muscles. But doing an aerobic regular walking program, she won't be able to do.

Q Does she have the arm bicycle?

A She does.

Q And does she use it?

A She does.

Q And have you overseen a program for her to do stomach muscle exercises?

A Well, she -- we have talked about that during her

visits. We've reviewed some of the exercises, but the -- if you think about the muscle mass in your arms versus the muscle mass in your legs, the amount of energy that you're burning through using your legs for exercise versus your arms, it's very different. And even if you do trunk strengthening, you're still -- I think that it's -- there's a tremendous barrier to losing weight with paralysis. Even in people that exercise.

Q Dr. Roaf, at some point in your treatment of Mrs. Rhodes, did you learn that she had developed pressure sores?

A She has had pressure sores.

Q And do you recall monitoring her care during that period when she had pressure sores?

A Yes.

Q Doctor, could you explain, what exactly is a pressure sore?

A Skin is covering of the body. And when two much pressure is put on the skin, or a combination of pressure and shearing or pulling or a combination of pressure and wetness or dampness, it's called maceration, the skin can break down. It can -- there are different -- the skin can break down. So

you have what's called a pressure sore. And there are different names for them too.

Q And are there different categories of pressure sores?

A There are different ways that pressure sores are classified, but the most common classification of them is a four-stage classification. Would you like me to talk about that?

Q I would.

A Okay. The Stage 1 is just redness of the skin. When you push on it, the redness doesn't go away. Stage 2 is where the skin itself has been compromised, it's been opened up. There's either a blister or there is erosion in the skin. Stage 3 is when actually the sore is not only in the skin, but it's through the whole length of the skin and down to deeper than that, to the fascial layer. And then the deepest one is --

Q What's the fascia?

A Fascias the connective tissue that overlies muscle. Okay, it's lying over the muscle, covering it. And then Stage 4 is when it's down to the muscle, involving a muscle or perhaps even down involving the bone.

Q Doctor, could you turn to Tab 24 in Exhibit 58, please. January 6, 2003, progress note. And this is one of your progress notes, Dr. Roaf?

A Yes, it is.

Q Did Mrs. Rhodes have to come to see you in an ambulance on January 6, 2003?

A Yes, she did.

Q And why was that?

A In order to assess pressure sores on the backside, on the buttocks, I needed to have her lying down so that I could look at the area.

Q And did you examine her in the ambulance or in your office?

A The ambulance drivers bring people in on a stretcher, and then we either transfer them over to a different stretcher or onto the examining table. So I examined her in the office, to look at her pressure sores, or decubitus ulcers.

Q In the treatment of pressure sores, do doctors ever look at pictures of the sores instead of actually examining sores themselves?

A Yes.

Q And why is that?

A It's a way of -- it's one way of recording the sores.

It actually is in one of the guidelines, the AHCPR guidelines of pressure sores, they actually recommend photographing them.

Q So you --

A I think that's the guidelines. It could be the ones from the Spinal Cord Consortium. One of them actually recommends taking pictures of the sores at the outset and then following then through and having sort of series of them.

Q So that you can track whether the sores are healing or --

A Correct.

Q -- how they were compared to last week?

A Right.

Q What level of pressure sores did Mrs. Rhodes have when she came to see you in January of 2002?

THE COURT: 2003? 2003?

MS. PINKHAM: Yes, excuse me.

THE COURT: We're still on Exhibit 24?

MS. PINKHAM: Still on Tab 24.

THE COURT: Okay.

A So looking at the note, on her right ischium, right buttock, there was a stage 1 to 2 that was healing. And there were several small areas that were

stage 2 that were dry and healing. And then in addition to that, in the gluteal fold, in the buttock fold, there was a large area that was shaped like a butterfly that had yellow sloth on it.

Q And what does that signify?

A You can't tell, when there's yellow sloth, you can't tell how deep it is. So yellow sloth is unhealthy tissue that is overlying it.

Q And does your progress note from January 6th of 2003, towards the bottom, indicate that Mrs. Rhodes wanted to speak to you alone that day?

A Yes, it does indicate that.

Q What did she want to talk to you about?

A Let me just review it here for a moment.

Q Sure.

A She was -- the anniversary of her accident was coming, she didn't want to be home then, she wanted to do something so that she wouldn't be thinking about it, and she asked me whether I thought it would be advisable for her to go with a friend to Foxwoods.

Q And what did you tell her?

A I told her I didn't think that was a very good idea.

Q Why not?

A She had sores on her -- on her backside. I just didn't think it would be a good idea for her to be riding around in a car, in a hotel, where she didn't have her usual support. I just -- I recommended not to go.

Q And what type of treatment did you recommend for the pressure sores?

A I recommended a specific type of wound care, some different salves.

Q And as part of the recovery from pressure sores, not putting any more pressure on the area that has the sore?

A That's part of it.

Q And so what did that mean to Mrs. Rhodes?

A She had to limit her out of bed time.

Q And this was starting in January of 2003?

A Yes.

Q Dr. Roaf, would you turn to Tab 26 in Exhibit 58, please. Is that another one of your progress notes?

A Yes.

Q Dated March 17th, 2003?

A Yes.

Q And so this was two months after the one that you had just reviewed from February -- excuse me --

January 6th?

A That would be two months afterwards.

Q Is there any indication in the first page of your note about Mrs. Rhodes' mood? Particularly turn your attention to the third paragraph.

A It says that her mood is not good because she's discouraged. She had been in bed much of the time.

Q And being in bed makes it difficult for her to be mobile and to learn how to maneuver?

A It did and apparently affected her mood at that time as well.

Q Could you turn to the next page of that tab, Dr. Roaf. If you could review it for a minute, I'm going to ask you some questions about the level of ulcers that she had in March. They got worse, didn't they?

A It does look that way, mm-hmm.

Q She now has Level -- or at least one Level 3?

A Mm-hmm. Yes.

Q And the Level 3 is the one that goes through the skin, down to on top of where the muscle is?

A Right.

Q Dr. Roaf, did you advise Mrs. Rhodes about how

long it could take to get these pressure sores to heal?

A I did advise her about that.

Q And what did you tell her?

A I told her that I had seen pressure sores last a year or longer.

Q And how did she respond when you told her that?

A She wasn't very happy about that.

Q Did she continue to be greatly restricted in her movement because of the pressure sores after March of 2003?

A It's my recollection that she did.

Q Do you recall whether she had tried to self-catheterize again in 2003, while she had pressure sores?

A Not off the top of my head.

Q Okay. Then could you turn to Exhibit -- excuse me -- Tab 27, please. Is this another one of your progress notes, Dr. Roaf?

A It is.

Q And it's from April 28th of 2003?

A Yes.

Q Does that note reflect that the wounds got worse?

A Yes.

Q And why did they get worse?
A She was doing intermittent catheterization and she was leaking urine and it was providing dampness to the area and making things worse for her.
Q So you advised her to stop the catheterization program?
A I did.
Q At some point, did Mrs. Rhodes ultimately go to a wound care clinic for the pressure sores?
A She did.
Q And do you recall what she -- what was determined when she went to the wound care clinic? Did she ever -- was she ever diagnosed as having a staph infection in some of the sores?
A Oh, I don't remember that.
Q If you could turn to Tab 43, please. Have you found Tab --
A I believe so.
Q And this is not one of your medical records?
A No.
Q This is from Sturdy Memorial Hospital?
A Yes, it is.
Q Have you ever seen a record like this?
A Have I see a record like this?

Q Yes. Not this particular one, but these types of --
A Yes.
Q -- results?
A Yes, I have.
Q And what does this record mean to you?
A This is a wound culture. It says that she has methicillin resistent staph aureus bacteria and diphtheroid bacteria growing. I don't like wound cultures in general unless I think that the wound is infected because people always have bacteria in the wound. We have bacteria on our skin. So --
Q Is this the same type of bacteria that she had when she was at Fairlawn? The metha --
A It is resistant -- like -- yes, it's the methicillin resistant staph aureus, like she had at Fairlawn.
Q And it requires special antibiotics?
A If it's an infection and not a colonization, it requires special antibiotics.
Q Okay. In any event, Dr. Roaf, did Mrs. Rhodes continue to essentially be on bed rest for several months after May of 2003?
A I believe she did.
Q In addition to suffering from the pressure sores in 2003, at some point did you become aware that

Mrs. Rhodes actually had bone fractures?
A Yes.
Q What's your memory of how the bone fractures were diagnosed?
A I believe the orthopedic surgeon diagnosed them when she was sent over to see him.
Q Do you recall that she was first being treated for what was thought to be an infection?
A Yes.
Q And at some point an x-ray was taken when the infection didn't respond to antibiotics?
A Yes.
Q And what did the x-rays show?
A She had a broken tibia bone, I believe it was on the right side.
Q Which one's the tibia bone?
A One of the bones down in the lower leg. I think it was sort of down more toward the ankle, not involving the ankle, but in the lower part of the tibia bone.
Q Dr. Roaf, could you turn to Tab 35 please. Are you at Tab 35?
A Is that the one labeled 3/27/03?
Q 3/27, yes.

A Okay.
Q And again, this is not one of your medical records, Dr. Roaf.
A No, it isn't.
Q It's from Milford Orthopedic Association?
A It is.
Q Do you know who Mrs. Rhodes' orthopedic surgeon is who's treating her leg fracture?
A It's Dr. Mastriani.
Q So is this one of the records from Dr. Mastriani's office?
A It appears to be, yes.
Q Drawing your attention to the second page of this exhibit, Dr. Roaf, could you basically interpret the x-ray results so we can understand what exactly is fractured?
A This is talking about the left knee, not the other -- this is the left knee, which is a different area. Okay. So the left knee, tibial x-rays show a small or suggest rather -- suggest a small minimally displaced fracture of the medial tibial lip and a fracture of the fibula neck.
Q What's the fibula neck?
A There are two bones in the lower leg. One of them

is the tibia, the other one is the fibula. The tibia is the big bone that runs right from the base of the knee down the front of the leg, you can feel it on the front of your leg. The fibula is the smaller bone that's off to the side, it doesn't involve the knee joint, and it goes down and the fibula is the outside of the ankle. That bone on the outside of your ankle is part of the fibula.

Q And so Dr. Mastriani treated her for those?

A So we talked actually about the broken -- other broken --

Q Right.

A -- area. But she --

Q She actually -- she actually had more than one broken bone.

A Yes, because it's the -- I just -- it seems a little confusing. She had the broken bone down at the bottom of one side, and then she had some little chips up in this area on the other side.

Q So she had problems with bone fractures on both legs?

A Right.

Q And the bottom paragraph of Dr. Mastriani's notes makes reference to an issue with her great toe.

And I wanted to ask you a question about the -- the osteomyelitis.

A Osteomyelitis is an infection of bone.

Q And do you have an understanding of -- based on this medical record, of what Dr. Mastriani's concern was?

A He stated that he was concerned that because she had some ulcerations on her foot, that it might develop into an infection of the bone and then possibly have to lead to an amputation.

Q Is that a common or an uncommon thing for paralyzed patients?

A Specifically what are you asking about?

Q The bone infection.

A When people have pressure sores that go -- that can become deep, there's always a risk that the bone can become infected. That's one of the reasons why it's so concerning when someone has a pressure sore. It's not just that the skin is broken, it's that you're concerned that then you'll have a deep infection or that it will involve the bone. They're difficult to get rid of. Is it a common thing? It's a common thing when you have these wounds. It's a common thing that you have to be

concerned about.

Q And has Mrs. Rhodes had recurring pressure sores on her toes?

A She has had episodes where -- multiple episodes of pressure breakdown on her feet, yes.

Q Dr. Roaf, the bone fractures that Mrs. Rhodes suffered after she was released from Fairlawn, are the bone fractures common or an uncommon thing for paralyzed patients?

A They're actually fairly common.

Q Why is that?

A Bone is a dynamic organ. It's constantly being turned over. It -- the bone cells are constantly laying down new bone and breaking down old bone and responding to the stresses in the environment. So when -- so weight-bearing exercise is important for maintenance of bone mass. And so in paralyzed individuals who are not walking, the normal stresses and strains on the bone from the muscles pulling on the bone, moving the legs around, are not present, and so they frequently will develop osteoporosis or thinning of the bone, and consequently may develop fractures associated with that.

Q And has Mrs. Rhodes developed osteoporosis?
A She -- by -- by definition she has, yes. She has.
Q Because of the paralysis?
A Right. Now, she is -- she's around the age where women may start to develop osteoporosis, but it's a different type of osteoporosis. Given her paralysis, it's a different type of osteoporosis.
Q How is it different from the normal aging?
A It's different in a couple of different ways. It's different in that the bone that's involved is different, in it's not only involving the middle part of the bone, the trabeculas of the bone, it also involves the cortico bone, the shell around the bone. Bone is made up of a central core area, that's like a sponge that's mineralized with calcium all over it. And then around the outside of it is like a -- like a shell. It's all part of one thing, but there's a cortex, and then the trabecular bone. Usually in osteoporosis, it's the trabecular bone that's eroded away. But in people who have had a spinal cord injury who are paralyzed, the bone that's eroded away is not only the trabecular bone but it's also the cortico bone, so it's different in that way. And as a result of that, the fractures

that are suffered are different. They tend to be in different areas. They involve the long bones, the femur. Not the head as much, but down near the knee, or the tibia more so. So the osteoporosis, when you think of women fracturing bones, you think of hip fractures and wrist fractures and fractures of the spine, you know, with osteoporosis, but these are different areas where the fractures occur.

Q And does the fact that the bone is getting weaker make it more -- in this case, longer for it to heal?

A It does. And in her case, where she had that one on the right side, and then subsequently another lower on the left side, as well as the chip fractures up near the knee, she had a lot of difficulty. It takes longer to heal because you're not having the weight bearing through the bones. And that doesn't allow the proper mechanics to occur. And there may be other factors with it frankly that we just don't understand yet about spinal cord injury.

Q Had she -- as a result of the fractures, has she been wearing protective devices?

A She -- initially it was casted and then subsequently has worn immobilization boots of some sort.

They're called -- Cam walkers is one way that they're described. They're these big boots that immobilize the region. They're heavy.

Q Has the fact there were bone fractures delayed any of the therapy or activities involving movement that you would like to see her doing?

A Well, it has. Sure she had the very heavy cast on them -- the right leg that went up over the knee. And then subsequently she had the other ankle fracture involved that wasn't the ankle joint itself, it was just above that. And she had to wear heavy immobilization on that side. After she had the cast removed on the right, she's had to have a heavy immobilization on that side too. So basically, and this is just to allow the bones to be immobilized because since she doesn't have the feeling to tell whether it's being reinjured or refractured, it has to be immobilized in order to not cause reinjury. So the heaviness of the equipment that she's had to have in order to allow adequate healing has caused problems for her in terms of her independence. There's also -- we wanted to start her in a pool program. We couldn't do that. It affected -- she wanted to start actually working on the standing

frame, we had the standing frame we had wanted her to do, to actually strengthen her bones, and then she got the fracture, so she couldn't do that. Ultimately, we've used it a little bit to help the fractures to heal when it had been appropriate, but --

Q The water therapy that you have just referenced, did you recommended that any special -- did she get any type of special devices before she went into the pool?

A I did not, but Dr. Mastriani did.

Q Are you familiar with his recommendation?

A Yes. I spoke with him on the phone about it actually, to make sure that we were both on the same page because I was so concerned about it.

Q And so what was your concern about Mrs. Rhodes going into the pool?

A I just was concerned that she have adequate immobilization of the -- of those areas, of the lower legs, so that she wouldn't injure herself in the pool because she doesn't have the feeling of where her feet are in space. So she can't tell whether -- it's not just that she doesn't have the feeling to have somebody touch her, she can't tell where the foot

is in space, so I was concerned that if we didn't immobilize it properly, that it might make her at increased risk for reinjuring herself with the pool therapy.

Q And she had had some instances of reinjury to her ankle.

A She did.

Q Dr. Roaf, would you turn to Tab 40 for me, please.

A The date on the first page is hard to read, so I'll ask you to go to the second page, which is dated 1/28/04. This is another record of Dr. Mastriani.

A Yes, it is.

Q Towards the bottom part of the page, this appears to be a discussion of the pool therapy, and what I'd like you to do is -- if you could go to the last sentence of the last paragraph and read that into the record, and then continue on to the next page, please.

A Sure. "Just talking the issue over, Marcia may be a little unrealistic in terms of her ability to move her legs in the water. I have explained to her that by moving her trunk she can essentially drag her legs along to have them move, but that I do not think she's going to have the capacity to actively move

her legs in the water any more than she does sitting in a wheelchair."

Q In her discussions with you, Dr. Roaf, was Mrs. Rhodes very anxious to begin the water therapy?

A She was.

Q Did she have any discussions with you about either moving her legs or at least having her legs move again?

A She -- she felt -- I know she had told me at one point that she felt that the water, the elimination of the gravity would help her.

Q Dr. Roaf, given the number of what I've referred to as complications, but what you refer to as secondary conditions --

A Right.

Q What's a secondary condition to you?

A One of the things that's been -- that's talked about in disability these days is a primary disabling condition, like a spinal cord injury or a stroke or a brain injury, and that's the primary disabling condition that somebody has. And then on top of that, because of having that disability, people may be more prone to having secondary disabling conditions. Secondary, things that happened to

them that would not have happened to them without the underlying disability. So they're talked about in terms of -- they're not complications, they're talked about in terms of a secondary, now you've got a secondary disability because you can't use your arms on top of not being able to use your legs, or what have you, whatever the secondary disabling condition is.

Q So, for example, the pressure sores are a secondary condition?

A Yes.

Q The leg fractures, the lower leg fractures?

A Yes.

Q Are a secondary condition?

A Yes.

Q Pressure sores are a secondary condition?

A Yes.

Q What about urinary tract infections?

A They're certainly more frequent in people with bladder emptying problems that require instrumentation of their bladder, require something to empty their bladder.

Q Dr. Roaf, you've treated Mrs. Rhodes since the accident. Do you have any opinion as to whether

Mrs. Rhodes will be able to transfer independently without the assistance of another person at some point in the future?

A I hope that she'll be able to do that. I don't know whether she's going to be able to do that consistently.

Q Could you place any type of probability on your hope that she'll be able to transfer independently?

A You're asking whether she will be able to transfer independently at some point in time, and then thereafter permanently be able to do it for herself, or whether she would be able to do it for periods of time?

Q Let's start with the for periods of time first.

A Okay. I think -- I think that it's -- I think that her chances of being able to transfer herself independently with the use of a slide board, and perhaps with -- I think it's -- you know, you can -- independently can mean somebody's there, making sure she doesn't fall down, or independently can mean that she's -- nobody's there. She's never transferred with nobody there. She's always had somebody there. So I don't know. I think it's -- I don't -- I think for periods of time, she may be able

to do that. I hope she'll -- yeah, I think that she -- fifty-fifty, maybe. If I'm being positive about it, that she'll be able to do that for periods of time without anybody there.

Q Without anybody there.

A I'm being very positive about this. That's very -- I think that's -- I'm not sure about that.

Q That's the highest probability?

A That would be -- yes, that would be the highest probability, yes.

Q And what about the other periods of time?

A Well, she's had episodes now of tendinitis in her shoulders. I think it's likely that she will have further episodes of tendinitis in her shoulders, and will require more than the usual amount of assistance to transfer herself. It may require perhaps somebody to do half the work for her if she isn't able to use her arms.

Q Do you think -- in your opinion, are there any special challenges that Mrs. Rhodes is likely to face as she grows older, living as a paraplegic?

A Well, we talked about secondary disabling conditions. There are -- folks who have a spinal cord injury are more likely to develop diabetes than

those in the community. They're more likely to have heart -- early heart disease and high cholesterol because of the immobility associated with paralysis. There's the increased risk of bladder cancer that we talked about, and those bladder cancers are more aggressive than other bladder -- they're more likely to be a more aggressive form of bladder cancer. There's just -- there's a whole host of them.

Q Let me ask you this, Dr. Roaf. In your opinion, is Mr. Rhodes going to continue to require significant medical attention over the rest of her life?

A Yes.

Q In your opinion, is Mrs. Rhodes likely to be hospitalized because of any of these secondary disabling conditions over the rest of her life?

A I think that's likely.

Q Do you have any opinion as to what Mrs. Rhodes life span or life expectancy is likely to be?

A You're asking me what I --

Q If you have an opinion.

A About what her life span might be.

Q Yes.

A I don't know how long she will live.

Q Are you familiar with any data on the life expectancy of paraplegics?

MR. POLLOCK: I'm going to object on foundation.

THE COURT: The objection is overruled. Foundation question.

A There is data on the life span. It comes out of the national model system database, which is a database across the country. It's -- you know, the national model systems takes into account -- it looks at all the people that are injured with traumatic spinal cord injury and actually more than 80 percent of those are young -- more than 80 percent of those are male, so you're looking -- the data -- you're looking at mortality data that is primarily based on men, and actually most of the people that are injured are between the age of 18 to 30. She was, you know, in her 40s when this happened. So it's -- you know, the data is -- it's based on a lot of -- a large group that are predominantly men. So she's in a little bit of a different category. So the mortality data is that people have been living longer than they were -- than when they used to when they were paralyzed.

People used to die because of, you know, terrible infections in their urinary system and that sort of thing. And that still happens, but people do live longer now. Some estimates are that the life span is almost normal life span. But it depends on the individual, so how can you predict what a person is -- what somebody's life span is going to be.

MS. PINKHAM: May I have a moment, your Honor?

THE COURT: You may.

(Pause)

MS. PINKHAM: I have nothing further, your Honor.

THE COURT: Thank you. Cross-examination.

MR. POLLOCK: Thank you, Judge.

CROSS-EXAMINATION BY MR. POLLOCK:

Q Dr. Roaf, I'm Russ Pollock, I'm one of the attorneys for GAF, the defendant in this case. You might recall me briefly when the plaintiffs took your deposition.

A I do recall that.

Q You're a physiatrist with the Fairlawn Rehabilitation Hospital?

A I'm a physiatrist, and I practice at Fairlawn Rehab. Hospital.

Q And a physiatrist is a doctor that specializes in physical medicine and rehabilitation issues.

A That's correct.

Q And physiatrists treat a whole range of problems, from sore shoulders to people that have been injured and are paraplegics, such as Mrs. Rhodes, to people that are even more significantly injured with quadriplegia and higher levels of spinal injuries, true? Physiatrists treat that whole range of injuries.

A Physiatrists treat people with a variety of different types of disabilities.

Q And the physiatrist's job in a medical team is to focus on restoring function to people and helping them to go on with their lives.

A That's one of the roles, yes.

Q And after Mrs. Rhodes was released from the University of Massachusetts Medical Center and after the doctors there did their job, she came under your care at Fairlawn Rehabilitation hospital.

A Yes.

Q And she was under your care from early February

to about mid April while at the hospital?

A Yes.

Q And she continued under your care after she was discharged?

A Yes.

Q And while she was at the hospital, you worked with Ms. Rhodes to teach her how to care for herself in a new and different way because of her injuries.

A That's true.

Q And you worked with Mrs. Rhodes to get her stronger, to help her reduce her weight, and to develop a program which would allow her to maximize her potential recovery from this trauma.

A That's true.

Q And during your medical training and your experience, you've treated numerous -- I know you couldn't give us a number on direct, but you've treated numerous patients with spinal injuries.

A That's true.

Q And a good number of them had spinal injuries at the T12 level because that's a very common level to be injured in a spinal -- when you severe your spinal cord in some type of accident?

A T12 is a common level of injury.

Q Now, can we agree that even under the best of circumstances, rehabilitation is a very tough row to hoe for a patient.

A Okay.

Q I mean, is that true? It's a tough thing to have to rehabilitate from an accident like this.

A It's a tough thing to have to go through.

Q And you'd also agree that rehabilitation is a two-way street. You the physiatrist can develop the best program in the world to help a patient rehabilitate, but the patient has to want to improve, they've got to follow your program, and they have to do their level best to try to get better if they're going to be successful in their rehabilitation. Is that true?

A That's true in any type of medical care.

Q And part of that is physical exercise to strengthen the muscles, the ones that work, a dietary program to get weight under control, and frankly just meeting the challenge of the rehabilitation program you prescribe.

A Okay.

Q Is that correct?

A Yes.

Q And part of your job as a physiatrist is to work with the injured person and the family of the injured person to prepare them for the road ahead when they leave your hospital and they leave your care; is that true?

A For when they leave the hospital. They don't necessarily leave my care.

Q Sure. When they leave the hospital, they go back to their homes, part of your job is to prepare them for that transition.

A That's part of the job, mm-hmm.

Q And you worked with Mrs. Rhodes to do that?

A Yes.

Q You worked with her husband Harold to prepare him for that as well? Is that true?

A Yes.

Q Did you work with their daughter Rebecca, as well?

A No, I didn't.

Q And I think you told us even after she was discharged from Fairlawn, you did treat her over three or four months or so?

A That's about right.

Q I mean on average.

A That's about right.

Q Now, we said a little while ago that the focus of a physiatrist is restoring function to people and helping them to go on with their lives, true?
A Yes.
Q With regard to Mrs. Rhodes, you talked about her physical status. She has no movement from just approximately the waist down?
A That's right.
Q And she's got no sensation at all from approximately the waist down.
A That's right.
Q So she cannot feel what's happening to her lower extremities.
A That's right.
Q And that's permanent, as you told us, as far as you know?
A That's right.
Q But she does have movement from the waist up?
A That's right.
Q And he's got sensation from the waist up as well?
A Yes.
Q And we've heard a lot about the many complications she's had on the road to recovery and independence, but would you agree that, to

some extent, she's turned the corner on a lot of those complications?

A She's turned the corner. She had some secondary disabling conditions, which she has -- she's recovered from some of them.

Q Fair enough. She had rib fractures that now are at least healed.

A Yes.

Q She is healing from those leg fractures you spoke of?

A She is healing.

Q There was an issue -- I don't know if it was brought up in your exam, but she her gallbladder removed, that's behind her.

A She did.

Q There's been no other gangrenous tissue that had to be removed?

A Not that I'm aware of.

Q Her upper body strength is improving and continuing to do so?

A Yes, it is.

Q And she's on a weight-loss program at the present time?

A She is.

Q And the last time you saw her, she had lost about thirteen pounds?
A I believe that's correct.
Q And she looked thinner to you?
A She did.
Q And you had prescribed the water therapy for her?
A I don't think that's correct.
Q She was undergoing physical therapy?
A She had burned her feet, and so she couldn't -- she hadn't been -- her feet had been burned, and so she couldn't do the water therapy because of the burns on her feet. In August.
A And August is the last time you saw her?
A Right.
Q Do you remember when in August that was?
A I don't remember the specific date.
Q You're positive it was August?
A Yes.
Q She was using the EasyStand?
A No, she couldn't use the EasyStand because of the burns on her feet.
Q Before the burns on her feet, she was using the EasyStand at home?
A We had started to use it a little bit, to help with the

fracture healing. It was part of the treatment for the fracture healing. Ultimately, I hope she can stand in it, but she -- we were doing it a little bit for the fracture healing. You need to bear weight for that.

Q What is an EasyStand?

A It's a standing frame of sorts. Excuse me. It's a piece of equipment, it's a type of standing frame, and I think it has some arm capabilities too. You can do a little arm exercise with it too.

Q And what's the purpose of it?

A To allow her to stand up and bear weight through her bones.

Q Did you see Ms. Rhodes in July?

A You know what, I don't think so, but I don't remember off the top of my head.

Q I'm going to show you a document, just to see if this refreshes your recollection.

MR. POLLOCK: May I approach, your Honor?

THE COURT: You may.

Q Dr. Roaf, do you recognize this document?

MR. PRITZKER: Is there a date on that?

Q Would you read the date to us please?
A July 1, 2004.
Q I'd asked if you recognize the document.
A Oh, okay. I do recognize it.
Q This is your July 1st of 2004 treatment note of Mrs. Rhodes?
A It is.
Q And at this time there was talk about water therapy?
A There was.
Q And she had lost the thirteen pounds, she was looking thinner to you.
A I don't remember if on that date it was loss of thirteen pounds. She weighed 205 that date. Oh, yes.
Q It does say she lost thirteen pounds.
A Thank you, yes, it does.
Q All right. And she was going to physical therapy as I mentioned?
A She was going to the Wellness Center for exercise.
Q And are you familiar with the Wellness Center?
A I've never been there.
Q Is it your understanding that it's exercise center where people go to exercise?

A It is an exercise center.
Q And she was going there with her health care assistant?
A Truth be told, I don't know who she was going there with.
Q Your record reflects that she was using this EasyStand five or six times per day?
A No, I think it reflects that she was using it 30 minutes at a time, three days per week.
Q Oh, I'm sorry. Your plan was for her to -- you're absolutely right. Your plan was for her to increase the frequency of the use of the EasyStand to five to six times per week, three days at twenty minutes and three days at forty minutes?
A Let me just review it there. Yes.
Q Why don't you read that plan -- paragraph in.
A "Water" -- "Plan. Water therapy. Continue PT. Increase frequency of use of EasyStand to five to six times per week, three days at 20 minutes and three days at 40 minutes for trunk strengthening, balance and bone stimulation for healing."
Q Thank you.
A Mm-hmm.
Q And just for the record, this should be part of

Exhibit 50, and the numbers on the side 006326, 006327 down there at the bottom. Now, the overall goal of your treatment is to make -- help Ms. Rhodes make her life more independent, have a more normal life after this severe injury. True?

A That's one of the goals.

Q And one of the goals you had for Ms. Rhodes, part and parcel of that would be to get her on that intermittent catheter -- I'm not going to -- I'm never going to be able to say this word --catheterization program; is that correct?

A Yes.

Q And she had a lot of difficulty doing that because of her size, true?

A Yes.

Q And while at the hospital, she was unable to intermittently self-catheterize; is that your recollection?

A I can't recall if we had her do that in the hospital. I just can't recall.

Q But at some point -- strike the question. And you wanted to get her to do that because the Foley catheter was more prone -- makes a patient more prone to urinary tract infection?

A Yes.
Q And the self-catheterization would allow her to condition or train her bladder so she could go to the bathroom more regularly?
A It doesn't -- it doesn't train the bladder to work properly. It allows the bladder to fill up with a little bit more urine, and then it's catheterized out. It doesn't retrain it so that it works properly.
Q But it catheterizes out when you insert the catheter.
A You drain the bladder with the catheter.
Q And you also wanted her to do that to prevent the buildup of stones and reduce the chance of cancer?
A Right.
Q As well as to reduce the frequency of urinary tract infections.
A If possible, yes.
Q And after she left the hospital, I think you told us she was able to do self-catheterization.
A I don't think I told you that.
Q She had to stop it because it was causing her irritation.
A Okay. I didn't tell you that she was able to do it.

Q Maybe I misunderstood you. Can we agree that it would be an appropriate goal for her, a goal that you would have for her, if she could lose that weight, to get on an intermittent catheterization program?

A I think she failed the multiple attempts, and I don't think it's a goal for her.

Q So you've given up on that goal?

A I have.

Q Are you familiar with what's called a Vocare Bladder System?

A A what?

Q A Vocare Bladder System? Have you heard that --

A I'm not familiar with that particular name.

Q Now, Mrs. Rhodes testified that one of her goals is driving a van, a van that she already owns that's been modified with hand controls. And you'd agree with us that getting her license and allowing her to use that van is an appropriate goal for her.

A It is.

Q And you have not given up on that goal for her?

A I have not.

Q And you're familiar with wheelchair accessible minivans in your line of work?

A Minivans?
Q Well, the vans that you use -- that people with wheelchairs are able to use.
A Yes.
Q They're not minivans?
A No. You can't fit an electric wheelchair in a minivan. You need a full-size van. You have to have an electric lift on it, too, in order to bring the chair up.
Q Are you familiar with the van that Mrs. Rhodes actually has?
A I've never seen her car.
Q Okay.
A Her van.
Q And that would allow her to get the wheelchair into the van by herself and drive herself places? True, with hand controls?
A She needs -- in order to get into the -- she'd need an electric lift to lift the electric wheelchair into the van so she could go into the van and drive the van.
Q Right. And that's -- getting her license and learning how to do that would allow her to do that herself.
A Well, she's working on that.
Q Right. And that's a goal that's realistic for her that

you have?

A It is.

Q And you anticipate she'll achieve that.

A Yes.

Q Now, Mrs. Rhodes also told her that one of her goals is transferring --

THE COURT: You need to move closer --

Q Now, Mrs. Rhodes testified that one of her goals is transferring from bed to wheelchair and wheelchair to chair and those other types of transfers. Would you agree that that is a good, appropriate, and important goal for her?

A I think that -- I think that it's important that she have goals and that she not lose hope. So I encourage her to work on this.

Q And, in fact, one of her Visiting Nurse Association occupational therapists indicated that she was able to perform independent transfers at some point after the accident?

A Can I see that? Can I see that note?

Q You may.

MR. POLLOCK: May I approach?

THE COURT: Sure.

Q I don't know the exhibit number of the VNA records, but it's -- the numbers at the bottom are 002904, 002905, and what I'm referring to is the portion -- you can read the whole thing. It says transfers. After you've reviewed it -- would you read that first, please.

A Sure. I've reviewed the note.

Q Would you read the paragraph about transfers?

A Okay. There are actually two areas that talk about transfers in this note. There's one on the back that says something different than the one that is on the front, in terms of her functional mobility. They say different things.

Q Could you read them both, please?

A Sure. The one on the front says, "Functional Mobility Treatment Note. Patient transferring from commode to wheelchair with standby. Patient transferring from wheelchair to shower bench with standby. Patient has private PCA who is very educated in patient needs and treatment goals to keep working toward independence."

Now, there's another paragraph on the back about transfers. "Patient transfers from bed to wheelchair with no assistance. Patient

transfers from wheelchair to chair with no assistance. Patient transfers from chair to wheelchair with assistance. Patient transfers from wheelchair to commode with standby supervision."

Q And those are the type of transfers you're talking about as far as the goal for her to try to achieve. Is that correct?

A Well, you were just asking about independent transfers, and now we're talking about standby supervision and assistance.

Q Well, I'm talking about without a human assisting her and her actually doing it by herself.

A But that's not what this says.

Q But those are the type of transfers, without having an assistant or other person helping her go from the bed to the chair or the chair to chair. That's what would be the goal for her, to make her more independent, true?

A So this is confusing though because it talks about -- in one sentence it says she's independent, but then in part of it, you're having someone stand by, that's not -- that's someone standing there. Or someone supervising her. So that's not really independent if someone's standing there. She's

not really independent.

Q Well, you'd agree at least that this occupational therapist that was there at the home, at least recorded that she was able to make a transfer without another person helping, some types of transfers, on this date?

A It does say that.

Q But even putting that aside, after the setbacks are behind her and her condition improves, the goal is that she will be able to do these types of things without another person having to stand by and position a board to help her. That is what we want for her.

A You can want something and not have it happen.

Q Would you agree that one of the goals of Mrs. Rhodes is to reduce the amount of medical people to have to care for her on a daily basis?

A I think that would be everyone's goal, not to have to see a lot of different doctors and caregivers.

Q Instead of having a caregiver with her for eight hours a day, to cut that down to a less amount of hours per day? Would that an appropriate goal for her?

A Well, it wouldn't be appropriate if she then had to

spend the rest of the time in bed.

Q That's not something you believe is appropriate for her.

A It depends on how she does.

Q At least her goal?

A You have to have goals. But the question is, you know, what will happen to people along the way and how realistic they are, given the various things that occur.

Q Included in that goal would even be reducing the amount of time she'd have to visit with you?

A You know what, I think that would be great.

Q So instead of four times a year, a goal would be maybe once, or even twice a year?

A Oh, I don't think once a year would be appropriate. That's sort of -- an able-bodied person is once a year.

Q Did you tell us that in your deposition in May?

A I don't -- you know what, I don't remember.

Q For the sake of getting out of here, let me quickly roll through this. Is it true that she has gotten some amount of independence over time, she has improved since she was discharged from Fairlawn Hospital?

A Yes.
Q She's -- at one time she did not have an electric chair. She now has an electric wheelchair?
A Yes.
Q She's working towards, as we spoke of, her driver's license, and that is something she'll have soon? Relatively soon?
A I don't know. She's working toward her driver's license.
Q Okay. Do you know what's holding her back from that --
A Holding her back?
Q From getting her license?
A I -- there's a whole series of things that have to occur. She needs the appropriate vehicle, she needs the appropriate modification. She needs someone to teacher her how to use the modifications with a learner's permit. So you have to go through the whole learner's permit process with the new vehicle modifications. You're using hand controls to brake and steer and it's not just some easy thing where you can use your legs. So holding her back, I don't know. She's in the process of it. I don't know that she's being held

back by anything in particular.

Q She's, in fact, doing all these things, isn't she?

A Doing what things?

Q She's got her van, she's got the hand controls, she learning to use them, she's got her learner's permit, she's actually out on the road practicing.

A I know she has her learner's permit.

Q Okay. Ms. Rhodes shared a little bit of her life with us yesterday, and told us about the things she enjoys doing. And I'm going to ask you about a couple of those things. One of the things she mentioned is using her computer. She told us she's drafted a treatment for a story that's she's submitting. Anything about her physical condition that would prevent her from doing those things?

A Using a computer?

Q Using a computer, drafting a story, submitting it to agents and getting it published.

A Oh, no.

Q Mrs. Rhodes discussed that she enjoyed playing the piano before the accident. Is there anything about her condition that would hamper her from playing the piano?

A Not at this time, no.

Q She discussed needlepoint, crossword puzzles and mah-jongg. Is there anything about her physical condition that would prevent her from doing those?

A Not currently.

Q Or in the future?

A Well, if she's bedbound with pressure sores or something, you know, something, I can't anticipate what specific secondary condition she'll have, but some of those require being up and about in order to participate.

Q Mrs. Rhodes discussed going out to restaurants, as people like to do, with her family. Anything preventing her from doing that with her present condition?

A Presently, she's not -- it's not a problem for her, but there are architectural barriers getting into restaurants and that sort of thing.

Q They'd have to be wheelchair accessible, no doubt. But aside from that, she can go out to dinner with her family?

A Yes.

THE COURT: All right, we're going to suspend at this point.

MR. POLLOCK: -- your Honor.

THE COURT: Let me see counsel at side bar.

(CONFERENCE AT THE BENCH, AS FOLLOWS:)

MR. POLLOCK: Your Honor, I literally have three questions, and I'd love to get her out of here.

THE COURT: Well, I know. Everyone would, but is there any other counsel that are going to inquire of her?

MR. KNIGHT: I have some, yes.

THE COURT: Yes, see. And then redirect. So, all right, folks.

MR. POLLOCK: All right, I'm sorry.

THE COURT: I suggest that if anything occurs over the weekend, at least be in touch with her.

(END OF BENCH CONFERENCE)

THE COURT: All right. We'll suspend at this point. Members of the jury, would you kindly fold up your notebooks and put them on the chair. You can step down.

(HEARING ADJOURNED)

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CERTIFICATE

COMMONWEALTH OF MASSACHUSETTS

NORFOLK, ss.

I, Dawna M. Chapin, an Official Court Reporter in and for the Commonwealth of Massachusetts, do hereby certify that the foregoing transcript represents a complete, accurate and true copy of my notes taken in the above-entitled matter, to the best of my knowledge, skill, and ability.

Dawna M Chap

Dawna M. Chapin

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