CAUSE NO. 141-172582-98

SIMEON EDEN McLEAN, Individually and as Heir to the Estate of DELORES McLEAN, Deceased, and SIMEON EDEN McLEAN, as Next Friend of JAMILA IMARI McLEAN, IMANI ZAKIYA McLEAN and MAHLON McLEAN, Minors,	*	IN THE DISTRICT COURT
plaintiffs	*	
v.	*	141ST JUDICIAL DISTRICT
HARRIS METHODIST H-E-B, JEROME DOUGLAS NOVOTNY, JR., M.D., ROBERT MORROW WELCH, M.D., MARK ALAN GODFREY, M.D., HEALTH PARTNERS MEDICAL GROUP, P.A. and MID-CITIES FAMILY PRACTICE ASSOCIATION, P.A.	*	
Defendants	*	TARRANT COUNTY, TEXAS

VIDEOTAPED ORAL DEPOSITION
OF
FRANK J. BAKER 11, M.D.
TAKEN ON MARCH 15, 1999

DEPOSITION AND ANSWERS OF FRANK J. BAKER 11, M.D., taken herein by Counsel for the Plaintiff, before JANET ARGO, a Certified Shorthand Reporter in and for the

State of Texas, on March 15, 1993, at the Hyatt Regency O'Hare, 98 West Bryn Mawr, Rosemont, Illinois, in accordance with the Rules of Civil Procedure.

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

LARRY F. SMITH, M.D., J.D.
Morgan & Weisbrod
10260 North Central Expressway
Suite 100N
Dallas, Texas 75231
COUNSEL FOR PLAINTIFFS

JEFFREY W. RYAN, ESQ.
Chamblee & Ryan, P.C.
2777 Stemmons Place, Suite 1084
Dallas, Texas 75207
COUNSEL FOR DEFENDANT, MARK ALAN GODFREY, M.D.;
HEALTH PARTNERS MEDICAL GROUP, P.A.; and
MID-CITIES FAMILY PRACTICE ASSOCIATION, P.A.

JOEL J. STEED, ESQ.
Law Office of Joel J. Steed
5910 North Central Expressway
Suite 650
Dallas, Texas 75206
COUNSEL FOR DEFENDANT, JEROME DOUGLAS NOVOTNY, JR.

LARRY HAYES, ESQ.
Cantey & Hanger, L.L.P.
801 Cherry Street, Suite 2100
Fort Worth, Texas 76102
COUNSEL FOR DEFENDANT, ROBERT MORROW WELCH, M.D.

MAX E. FREEMAN, II, ESQ.
Gwinn & Roby
4100 Renaissance Tower
1201 Elm Street
Dallas, Texas 75270
COUNSEL FOR DEFENDANT, HARRIS METHODIST H-E-B

T A B L E O F C O N T E N T S

E X H I B I T S

E X H I B I T S - Continued

P R O C E E D I N G S

(Exhibit Nos. 1 through 5 marked.)

THE COURT REPORTER: Agreements?

MR. FREEMAN: Whatever. I don't care.

MR. STEED: Under the Rules.

MR. HAYES: The Rules. Thirty days okay. Objection by one inures to the benefit of all?

MR. FREEMAN: Or may be asserted by all at whatever time could be appropriate.

FRANK J. BAKER II, M.D.,

having been first duly cautioned and sworn upon his oath to tell the truth, the whole truth, and nothing but the truth, testified as follows:

E X A M I N A T I O N

(On the record at 11:25 a.m.)

BY MR. FREEMAN:

Q. What is your name?

A. Dr. Frank Baker, B-a-k-e-r.

Q. What is your address?

A. 89 Timber Court, Oakbrook, Illinois.

Q. I'm sorry. Oakbrook?

A. Oakbrook, Illinois.

Q. Is that your residence address?

A. Yes.

Q. Do you have a business address?
A. Rush Presbyterian St. Luke's Hospital, which is 1750 West Harrison in Chicago.
Q. And how long has your business address been at Rush St. Luke's Presbyterian Hospital?
A. I started at Rush in September of '98.
Q. And has your business address been continuously there since September of '98?
A. Yes.
Q. Where was it immediately prior to that, please, sir?
A. I was an attending physician in emergency medicine at MacNeal Hospital, which was -- let's see, 3249 South Oak Park Avenue in Berwyn, Illinois.
MR. FREEMAN: Objection, nonresponsive.
Q. (By Mr. Freeman) If from time to time people make objections, please take no offense. They're not in any way directed at you. You've been through the deposition process --
A. Sure.
Q. -- before, haven't you, sir?
A. Sure.

Q. I'll hand you what has been marked as Exhibit No. 5, which is the notice for your deposition with the duces tecum. Have you ever seen that before, sir?

A. I saw it this morning.

Q. Have you brought documents today with you pursuant to that?

A. Some of them I have. Some of them I don't.

Q. Would you tell me what you don't have with you today, please, sir.

A. Sure. Let's see, I don't have the billing records. Actually, I didn't have a copy of my report, but I have obtained a copy from Plaintiffs' counsel. I don't have documents concerning depositions that I've given in the past. Actually, in general, they don't exist.

Q. And we'll get to that here momentarily.

A. And I don't have documents concerning each time I've testified at trial in the past.

Q. And we'll get to that momentarily as well. Item number one on this list, sir, I believe asks for all notes that you have made with respect to this case.

A. Yes.

Q. Have you made any notes?

A. There are notes scribbled in the charts and in the depositions, mostly in the margins.

Q. Okay. Other than what is in the marginal notes in the depositions and in the charts that you have here, have you otherwise put pen to paper with respect to this case?

A. No

Q. Have you made any computer-generated notes?

A. No. The only thing that I have that was generated on a computer was the report that I sent to Mr. -- Dr. Smith on August 4th, 1998.

DR. SMITH: Objection, nonresponsive.

Q. (By Mr. Freeman) Do you have a computer file on this particular case?

A. I don't know whether this got erased or not.

Q. Do you maintain --

A. Do I have a file, no. No, there's not a computer

file, per se, on this case. There wouid only be the report that I generated.

Q. And do you have earlier drafts of the report?

A. Probably not. I probably generated a report and then went through and corrected it and saved it as the corrected copy.

Q. Do you potentially have a previous --

A. I don't --

Q. -- draft on the computer?

A. No, I don't think so. I don't generally save first drafts or second drafts.

Q. Item number two on the duces tecum asks for all correspondence with Plaintiffs' counsel in this case. Have you brought that with you, sir?

A. What I don't have with me is billing records or a

copy of a fee agreement, which I probably sent them.

Q. Is that something that you can locate?

A. Yes. Actually, I forgot those materials this morning, including my own report. But I have them, yes.

Q. If I mark on a blank piece of paper the words "Fee

Agreement and Billing Records," will we both understand what we're talking about?

A. Sure.

Q. And have I done that, sir?

A. Yes.

(Exhibit No. 6 marked.)

Q. And if I mark this as Exhibit No. 6, would it be reasonably convenient for you to get to the court reporter the fee agreement and billing records within, say, the next five days?

A. Sure. No problem.

MR. FREEMAN: And I'd ask the court reporter to please give the doctor a card or some way that that can be accomplished.

Q. (By Mr. Freeman) Is that acceptable to you, sir?

A. Sure.

Q. What correspondence do you have with Plaintiffs' Counsel?

A. These would be mostly cover letters and two items which were faxed to me at some point in the case regarding

definitions under Texas law of four terms: negligence, ordinary care, proximate cause and gross negligence.

Q. And if I mark -- may I mark this collectively as Exhibit No. 7?

(Exhibit No. 7 marked.)

A. Sure.

Q. And have I done that, sir?

A. Yes, sir.

Q. Other than your report dated August 4, 1998 and the documents in Exhibit No. 7, have you had any correspondence with Plaintiffs' counsel in this case?

A. I don't think so, no.

Q. Do you recall or can you tell from Exhibit 7 when you were first contacted in this case?

A. No,

Q. Do you recall when you were first contacted in this case?

A. No, sir

Q. Do you know about how long ago it was that you were first contacted?

A. Well, it would have been sometime prior to my August 1998 report, but I can't tell you off the top of my head when.

Q. Would your billing records indicate when you first

spent time concerning this case?

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A. Yes.

Q. Would your fee agreement indicate something about when you first did work on this case?

A. Well, it would indicate when they signed the agreement. There's a date on it. And it may be before or after I started work on the case, because I've done work for this firm before, I think on one occasion, and I don't really require a fee agreement to do work. They seem to pay their bills.

Q. With firms that you have an ongoing relationship or a past relationship, you don't necessarily make them sign a fee agreement?

A. I ask them to sign a fee agreement, but that doesn't stop me from beginning work on a case.

Q. When you had a previous case for them, did you do a report?

A. I don't recall whether I did a report. I did give a deposition in it.

Q. So you were disclosed to the other side in that case?
A. Yes.
Q. Do you recall the name of the case?
A. No
Q. Do you recall the type of case it was?
A. No.

Q. Do you recall the name of the lawyer that took your deposition?
A. It was Mr. Weisbrod.
Q. Do you recall the name of the other folks that questioned you during the deposition?
A. No.
Q. Do you have a copy of the deposition?
A. No.
Q. Do you know when that deposition was taken?
A. I'd say maybe a couple of years ago. I think the case settled, actually
Q. I see. Do you remember the medical issues that were involved in that case?
A. No.
Q. Do you recall where the health care providers

practiced in that case?

A. No.

Q. Was there an institution involved in that case?

A. Actually, I don't remember.

Q. Do you know if it was a case that health care providers were in Texas?

A. Yes. I think it was in Texas.

Q. Do you know in what part of Texas?

A. No.

Q. Was your deposition taken here in Chicago?

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A. Yes.

Q. Do you know how many people came up for your deposition at that time?

A. I think there were three or four attorneys from the other side.

Q. Do you have a copy of that deposition?

A. No.

Q. Do you have a copy of the blank file folder from that case?

A. No. I -- well, I'm not sure. As I -- off the top

of my heaci, I think the case was settled, which means that the file would have been disposed of.

Q. Okay. Typically, you would throw away files when you're done?

A. Oh, sure.

Q. And typically, you would save the file folders and keep them, the empty file folders, after throwing away the contents to keep track of what cases that you had?

A. No.

Q. Do you recall testifying in the past that that was your practice and habit?

A. I've never testified to that. I don't keep records from old cases.

Q. Are you telling the jury that you've never kept the file folders from old cases so you can keep track of the

names of the cases that you've had before?

A. That's true.

Q. Do you have billing records or some other record in your office or on your computer that would show the name

of the case or your previous contact with the Morgan & Weisbrod law firm?

A. Probably not. Probably not. I -- I keep records for tax purposes, but they are not kept -- you know, they're sort of all kept with tax records. It's a little bit dependent upon whether they send me a 1099 or don't send me a 1099.

And I would not ordinarily, like I say, keep any file at all. All of it gets thrown out except for what I need to report for income tax.

Q. So if you had a 1099 from the previous case that you did for Morgan & Weisbrod, you would have kept that?

A. Yes. And I could probably find it if I knew what year it was.

Q. And you said it was within the last couple of years?

A. Well, that's what I think, yeah.

Q. Okay. So it would be sometime between, I take it, 1996 and present?

A. Maybe. I mean it could be '95. My memory's not that good for these kinds of things.

Q. Okay. And if I write "1099s, 1995 through present, Morgan & Weisbrod" on a blank piece of paper, are we both on the same page as to what we're talking about, sir?

A. Yes.

(Exhibit No. 8 marked.)

Q. And have I marked that as Exhibit No. 8?

A. Uh-huh, yes.

Q. And can you check those records and within the next five days get back with the court reporter as to any 1095 -- 1099s -- pardon me. Let me start over.

Within the next five days, could you check and get with the court reporter as to any 1099s from the law firm of Morgan & Weisbrod, please, sir?

A. Yes. But who's going to pay for the time?

Q. Well, if you -- I'd be happy to come up and go through your tax records and --

A. No, that's not acceptable. You can't go through my tax records

Q. Okay. Then how long will it take you to go through and look at your 1099s?

A. I have no idea. I haven't done it.

Q. Well, you filed a tax return, I take it, in 1995,

1996, 1997 and --

A. '98's not due yet.

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Q. Not '98. But it wasn't in the '98 year, I take it, that you did the previous case for them?

A. That's correct.

Q. So we're talking about three years of tax returns?

A. That's correct.

Q. And how long do you anticipate it will take to look to see whether or not there's a 1099 for three years of tax returns, '95, '96 and '97?

A. Less than an hour.

Q. And how much do you charge for doing that?

A. I charge $500 an hour for work that I do in the case.

Q. The -- well, I'd request that you -- if it is going to take less than an hour as to previous correspondence in the form of a 1099 with the law firm of Morgan & Weisbrod, I'd ask you to do that, sir.

A. Okay. And you'll agree to pay the bill?

Q. Well, I'm not going to agree to anything right

now, because I can't respond. I'm not being deposed.

A. Well, I'm not going to do it unless you agree to pay the bill.

Q. If there are previous 1099s with respect to Morgan & Weisbrod and if and to the extent it is less than an hour that it takes you, I think that we can find some way to compensate you for that fractional portion of an hour

that it takes to find that,

A. Well, I've heard that story before. The question is who's going to compensate me, and who do I send the invoice to?

Q. You can send the invoice to me, sir. Or you can send it to Mr. Smith, and he'll send it to me.

A. But you still haven't agreed to pay it.

Q. Oh, I just did.

A. Okay.

Q. Yeah, I did.

A. All right.

Q. Item number three is for -- let me back up. With respect to item number two, other than the 1099 that we have

talked about and other than the materials that we have identified in Exhibit No. 7, your report, which I think has been marked as Exhibit No. 3, and the billing records which you have not but will provide us, is there any other correspondence that you have ever had with anyone at the law firm of Morgan & Weisbrod?

A. No

Q. Item number three asks €or all correspondence regarding this case. Have you corresponded with anyone else with respect to this case?

A. No.

Q. Have you talked to anyone else with respect to

this case, other than someone with the firm of Morgan & Weisbrod?

A. No.

Q. Item number four asks for all documents concerning any opinion that you will render in this case. Have you brought those with you, sir?

A. Yes.

Q. And what do we have, please, sir?

A. Well, we have the records I reviewed, which consist of the office records of Dr. Mark Reimer.

(Off-the-record discussion.)

A. The chart from Harris Methodist Hospital of Delores McLean dated 4-24-96; radiology records from Harris Methodist involving the same patient; also the records from Harris Methodist for 7-8-96; the Euless Fire Department records from 7-9-96; the Harris Methodist Hospital emergency department records from 7-10-96; a copy of the autopsy report; copy of the investigator's report; copy of the death certificate; copy of the depositions of Dr. Godfrey, Dr. Welch and Dr. Novotny; copy of the deposition of Grace Croft, R.N.; copy of the deposition of Delores McLean -- no, medical records of Delores McLean from Health Partners, which includes Dr. Terry, Dr. Godfrey and Dr. Drake; copy of the deposition of Nurse Pearson; of a respiratory therapist by the name of Regina Earzo; copy of

the deposition of Meagen Stillwagoner, who is a nurse; COPY of the deposition of Steven Deutsch, who is a paramedic;

and some reprints that I brought for you, one a copy of the oxyhemoglobin disassociation curve from Barry Shapiro's book entitled "The Clinical Application of Blood Gases," specifically Page 85; a copy out of the Rosen textbook, "Emergency Medicine Concepts and Clinical Practice," fourth edition, Page 128, also regarding the oxyhemoglobin disassociation curve; and a copy of Page 56 out of the third edition of Dr. Tintinalli's book, "Emergency Medicine: Core Content" regarding the relationship between the oxyhemoglobin saturation and plasma PO2.

Q. Have the articles that you have there, please, sir, been marked as one of the exhibits?

MR. HAYES: No.

Q. (By Mr. Freeman) Would it be acceptable to you, sir, if I marked this as an exhibit?

A. Yes, sir.

(Exhibit No. 9 marked.)

Q. And have I done that as Exhibit 9?

A. Yes, sir.

Q. Do you have any other documents that you have reviewed in this case other than what you have just identified for us?

A. No.

Q. You have identified some medical literature of which you've been kind enough to provide a copy. Have you looked at any other medical literature with respect to this case?

A. No.

Q. Have you done a MEDLINE search?

A. No.

Q. You've done a report in this case.

A. Yes, sir.

Q. Is your work complete, as we sit here today, as far as what you have been asked to do in this case?

A. Yes, sir.

Q. Is your report complete?

DR. SMITH: I'm going to make an objection as to form.

A. With -- maybe with one exception. Just let me check it.

Q. (By Mr. Freeman) Okay. Please check it and tell me the one exception, if one exists, please, sir.

A. Well, I think the item that I probably failed to put in the report, which actually came out when I read the depositions last night, was this issue of when the PO2 from

the first visit was drawn.

THE WITNESS: Who's got the medical records?

Because I need them back.

A. And that is, that, if my memory serves me correct, the PO2 of 56 was drawn on a blood gas that was, I think, drawn at 1415 hours, which was about an hour after the patient had been treated with an Albuterol treatment

Q. And that affects your --

A. Well --

Q. Pardon me. I apologize. If we both talk at the same time, the court reporter will fuss. And since I'm, I think, closer, I'll probably be the one that she kicks. I apologize, sir.

That affects your opinion in what way?

A. Well, the PO2 of 56 posttreatment is much more significant than it was pretreatment in that it obviously reflects a much severer degree of hypoxemia; in addition, further brings into question the diagnosis of asthma.

Q. With that addition being made to your report, is your report now complete?

A. Yes.

Q. Item number five on the duces tecum asks for all documents upon which you will rely for any opinions that you have in this case. Have we identified those?

A. Yes, sir.

Q. Item number seven, I believe, asks for your complete file. Do you have anything in your file other than what we have already identified?

A. No.

Q. Do you keep these in a manila file folder?

A. Yes.

Q. And where is your manila file folder, sir?

A. Sitting on the table at home.

Q. Why didn't you bring the file folder with you today?

A. Well, actually because I forgot it.

Q. Okay. Where --

A. I didn't even bring my report with me today I had to get a copy from Counsel when I got here.

A. Yes.

Q. And within the next week, can you get -- or next five days can you get the file folder and its contents to the court reporter so she can attach it to the deposition as Exhibit No. 10?

A. Yes.

Q. And will you do that, please?

A. Sure.

Q. Other than that, do we now have your complete file in this case?

A. Yes, sir.

Q. Now, with respect to the file folder, is there a file number on it?

A. No,

Q. Do you keep track of the files that you have and that you're reviewing alphabetically or by number or by lawyer?

A. By firm.

Q. By law firm?

A. Yes.

A. Actually, it's four to five times.

Q. And when you originally set the $350 an hour, you were charging $57 an hour working at McLean, or wherever the --

A. MacNeal.

Q. MacNeal. I'm sorry. I apologize, sir -- working at MacNeal?

A. Right. But it's not actually four to five times. The formula's not four to five times what you make doing something else. The rate is based on figuring the -- you can only bill out consulting time -- at least, the rest of us in the world, unlike you attorneys, can only bill out consulting time -- based on working about 25 percent -- or 20 to 25 percent of a workable year, which is 2,080 hours.

So basically, you figure out what your salary would be if you were going to do this full time, and then

you divide that by 2,080 and multiply by four to five. so that's how you come up with it.

Q. Is that the formula -- I apologize

A. That's how you come up with the consulting fee.

Q. Is that the formula that you use to go from $57 per hour in the emergency room to $350 per hour testifying when you were charging that rate?

A. Actually, I don't think I multiplied by what I was getting paid to do clinical work in the emergency department. I think it was based more on what I would be paid if I was getting my professional fees.

You understand, in emergency medicine we charge professional fees, but the hospital collects and keeps them and gives us some small fraction of them. And the hospital, at least currently, is billing out about $500 an hour for what I do.

Q. Okay.

A. I don't remember what they were billing at the time, but it was about -- actually, I think almost $400 an hour.

Q. You mentioned something about full time in response to the question before last. You're not engaged in the full-time practice of medicine, are you, sir?

A. Well, sure. What do you think I do?

Q. The -- okay. Well -- and are you telling us that

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you have been engaged in the full-time practice of medicine for the last 10 years?

A. Sure. I've been a part-time employee at the hospital, but I do full-time medicine. I mean, I don't run a gas station or do other things. I do full-time medicine. That's all I do in life.

Q. I see. Let me go at it this way: Are you currently working full time at the hospital?

A. I'm not a full-time employee, no.

Q. When was the last time you were a full-time employee at a hospital practicing medicine, please, sir? Was that at the University of Chicago?

A. That was 1987.

Q. And in May of 1987, you left the University of Chicago?

A. No. I left in the end of June in 1987.

Q. And the University of Chicago is, what, a 750-bed hospital or thereabouts?

A. Basically.

Q. Level -- I always get the numbers wrong. Is it a Level I trauma?

A. Level I.

Q. That's the last, Level I trauma --

A. Well, actually it was a Level I until after I left, and then they withdrew from the trauma system and now

they're not a level anything. They're not a participant anymore.

Q. That was the last Level I hospital of which you ever practiced; isn't that true?

A. Level I trauma center, yeah.

Q. And that is the last time that you have been engaged in the full-time -- as a full-time employee at any institution in the practice of medicine?

A. Yes, that's true.

Q. And the medicine that you have practiced since June of 1987 has either been taking care of family members, friends and the like -- which you occasionally do at your house -- on the one hand, or practicing in a hospital as a part-time emergency room physician; isn't that true?

A. Or consulting *or* teaching.

Q. I'm talking -- or doing medical-legal consulting?

A. Or teaching.

Q. Okay. And tell me what teaching --

A. I've done a -- I've done a series of overseas programs, mostly in Russia, in the former Soviet Union, mostly sponsored by the Ministry of Science of Russia, although programs have also been sponsored by the Ministry of Health of Kazakhstan and the Ministry of Health of Pakistan and the Ministry of Tajekistan.

Q. Could you spell that, sir? Because I don't have

any idea where that is.

A. That's in Central Asia.

Q. And for the benefit of the court reporter, can you spell it? She probably knows, but I don't.

A. T-a-j-e-k-i-s-t-a-n.

Q. In '91, '93, '95, '96 and 1997, you testified in each of those years that greater than 50 percent of your income was derived from medical-legal review?

A. Yes, that's probably true.

Q. And is that still true today?

A. Yes.

Q. In fact, at one point, it was 69 to 70 percent of your income was derived from medical-legal review?

A. Well, actually, I have had some health problems, as you well know, since you've obviously read my -- some previous depositions of mine. And there have been some periods of time when, basically, a hundred percent of what I've made has been from consulting or various sorts because I wasn't able to be clinically active.

MR. FREEMAN: Other than "There have been some times where basically 100 percent of my income has been from reviewing cases," everything else would be nonresponsive, to which I will object.

Q. (By Mr. Freeman) Again, that's not directed at you, sir. I say that only for purposes of the record.

Over the years, you've reviewed hundreds of cases, haven't you, sir?

A. If you include cases that I do in the clinical arena not involving forensic issues, thousands of cases.

Q. My question was unclear, and that was my fault. I

apologize. Over the years, you have reviewed hundreds of medical-legal cases for Plaintiffs' lawyers, haven't you, sir?

A. And Defense lawyers.

MR. HAYES: Objection, nonresponsive.

Q. (By Mr. Freeman) Over the years, you have reviewed hundreds of cases for Plaintiffs' lawyers in the medical-legal context, haven't you, sir?

A. Yes.

Q. Now, you tell me that you also reviewed some cases for Defense lawyers.

A. Sure.

Q. And you've testified previously that you did that on a 50/50-type basis?

A. I don't keep track. Those are strictly estimates or even guesses. I mean, I just don't simply keep those statistics.

Q. That would be a guess, wouldn't it, sir?

A. Sure.

Q. And the fact of the matter is, it would be more

accurate to say that 98 and a half percent of the cases that you review, you review for Plaintiffs' lawyers in the medical-legal context; isn't that true, sir?

A. How would I ever know, and how would you ever know? I can tell you that I have some reasonably good suspicion that by the time we get to court, 80 to 90 percent of what I do, in terms of court testimony, involves Plaintiffs. But 98 and a half percent, I don't think so.

Q. You review about three cases for a Defendant for about every 130 cases for a Plaintiff. Does that statistic sound reasonably accurate to your recollection, sir?

A. No.

Q. Now, you indicated that you had some health problems. I think in 1993, you had some health problems, didn't you, sir?

A. 1993?

Q. Why don't we go at it this way: The -- I don't want to get into a detail of your health. Can you tell me in general terms how your health condition has affected your part-time work in emergency rooms since '87 --

A. Sure. In --

Q. -- without getting into detail?

A. Sure. In -- sometime in '87, sometime in the fall

of '88, I had a severe fracture of -- involving my left leg,
and, basically, was off for a year on crutches and have had

some significant intermittent problems with that leg since then

And then in the fall of '96, I was bitten by a brown recluse spider necessitating amputation of three toes. I was off from basically November of '96 through July of '97. I returned to work, had a relapse of a wound infection; was off from November of '97 until September of '98.

Q. And then in September of '98, you went back to the -- or you went to for the first time to --

A. Rush University Medical School.

Q. Is that Rush St. Luke's?

A. Right.

Q. Now, in May or, I guess, June 1987, you left the University of Chicago?

A. That's correct.

Q. You didn't start at the other hospital working on

a part-time basis until June of 1988, which is about a year later --

A. Actually, April.

Q. Do you recall testifying previously that it was June?

A. It wasn't June. It was April.

MR. FREEMAN: That would be nonresponsive

Q. (By Mr. Freeman) Do you recall ever testifying

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that it was June?

A. No.

Q. Okay. You didn't break your leg until the fall of 1988?

A. True

Q. So the -- from June until, as you say, April time period -- which is, what, some 10 months?

A. Yes.

Q. -- you were not practicing medicine because of your broken leg?

A. That's true.

Q. During that time period, I take it you founded and

became the president and CEO of Professional Medical Consultants, Limited?

A. Well, actually, I did that, I think, before I left the university. I think I did that in '87 sometime.

Q. That is the organization through which you do your medical-legal consulting?

A. Yes. Actually, it's a Subchapter S corporation. And it's not limited, it's incorporated.

Q. Did it used to be called L-t-d?

A. I don't think so.

Q. But it's now -- or whether it used to be or not, it's I-n-c, Inc.?

A. Yes.

Q. And when we look at the billing records, will they be through Professional Medical Consultants, Inc.?

A. Yes.

Q. From June of 1988 through April of 19 -- or June of '87 -- let me start over, please. I was -- I got tongue-tied.

From June of 1987 through April of 1988, I take it your sole income-producing endeavor was through your legal consulting work through Professional Medical Consultants, Inc.?

A. Yes, that's true.

Q. Otherwise, what did you do during that time period? Did you go off and go fishing?

A. That's exactly what I did.

Q. Where did you go off and go fishing for 10 months?

A. Well, wherever I could find.

Q. Could you tell me about this trip?

A. It wasn't a single trip. My wife and I traveled. In fact, we started traveling before I left the university.

Q. In any event, in either April or June of 1988, you came back to MacNeal?

A. Yes.

Q. As a part-time emergency room staff physician?

A. Yes.

Q. I take it MacNeal's licensed to be about 350 beds?

A. Actually, MacNeal is licensed at 437 beds.

Q. But they don't operate at 437 beds, take it?

A. When I left, they were operating about 145 beds.

Q. And at how many beds was the University of Chicago operating when you left there?

A. The University of Chicago, I think, is licensed for about 750, and I suspect they were operating about 550 maybe.

Q. About 600?

A. Yeah, something like that.

Q. Have you ever advertised your willingness to do medical-legal reviews?

A. No.

Q. And number nine on the duces tecum, I believe, asks for any advertising with respect to medical-legal reviews. You don't have any such documents?

A. Doesn't exist. Never been done.

Q. Have you ever gotten medical-legal cases to review for Plaintiffs' lawyers through referral agencies?

A. Yes. Actually, I once received a case from an outfit in, gosh, either New York or New Jersey or something called the -- oh. National Medical Advisory.

Q. And that was a clearinghouse that would put Plaintiffs' lawyers and folks willing to review their cases together?

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A. Actually, I'm not sure what it is, other than I believe it's either a physician or it's owned by some physicians. It does find expert witnesses. I don't know whether it does it for Plaintiffs, Defense attorneys or both, but I did review a case for them.

Q. And that case was on behalf of a Plaintiff or for a Plaintiff?

A. I think that that case was on behalf of a Plaintiff. I -- I'm sort of guessing, but I think so.

Q. And there are other agencies, similar agencies, through which you have gotten cases, aren't there, sir?

A. I have received -- yes, that's true. I have received one case from, I think, a now-defunct organization in Detroit that did almost exclusively Defense work called EPT Enterprises, and I think -- yeah, there's a group of nurses in South Florida, Palm Beach Medical Consultants, who I think primarily does Plaintiffs as well who have sent me cases.

Q. Actually, it's West Palm Beaah Medical Consultants, isn't it, sir?

A. No, I don't think so. I think it's Palm Beach Medical Consultants.

Q. Have you ever done it for West Palm Beach Medical Consultants?

A. We're probably talking about the same group of

folks, but I don't think that's their correct name.

Q. And the fact is they do it exclusively for Plaintiffs, don't they, sir?

A. I don't know. I have nothing to do with the organization officially.

Q. I see. But you're familiar with the organization, aren't you? You've said you've done a number of cases for them over the years?

A. Sure.

Q. You've done a lot of case in Florida?

A. That's true.

Q. And you're familiar with West Palm Beach Medical Consultants -- or, I guess, Palm Beach Medical Consultants, whatever their name is -- the relationship and affiliation they have with the Montgomery Searcy law firm?

A. Yes.

Q. Tell the jury what that relationship is between West Palm Beach Medical Consultants and the old Montgomery Searcy law firm.

A. Actually, I don't -- I don't really know, because I'm not privy to their corporate papers.

Q. I see. But you've done a lot of cases for Searcy, haven't you --

A. Yes.

Q. -- over the years?

A. Yes.

Q. And you know that they're a Plaintiff's firm?

A. Sure.

Q. And they're name is no longer Montgomery Searcy. That's changed some time ago?

A. That's right. Mr. Montgomery left the firm, and it's now called Searcy Denny and a half dozen other names.

Q. There are three other names?

A. I don't know.

Q. In any event, for them, you have been critical of physicians in West Palm Beach, Florida in cases that you have reviewed, haven't you, sir?

A. That's true.

Q. Been critical of physicians in Miami?

A. Wherever the cases come from. I mean --

Q. Sarasota?

A. I don't keep track of the towns or cities out of which these people practice.

Q. Do you recall Sarasota?

A. Off the top of my head, no.

Q. Do you recall Tampa?

A. No.

Q. Do you recall Tallahassee?

A. I have done cases up in Tallahassee. I've done a Defense case up in Tallahassee. I don't know about a

Plaintiff's case.

Q. Do you recall Pensacola?

A. I have reviewed a case out of Pensacola but not for the Searcy Denny firm. At least, I don't recall them.

Q. It was for another law firm, actually, in

Pensacola?

A. Yes.

Q. But it was for a Plaintiff?

A. It was for a Plaintiff.

Q. Orlando?

A. I've done cases in Orlando €or both Plaintiff and Defense.

Q. Can you give me the name of the Defense lawyer in Orlando for whom you've ever done a case?

A. Sure. There's a fellow by the name of John Black who last sent me a case maybe six months ago.

Q. Do you know what firm John Black is with in Orlando?

A. I think his own law firm.

Q. The name of the firm is John Black?

A. I think so.

Q. Jacksonville?' Ocala? Coral Gables? Do you recall cases in those?

A. Not off the top of my head, no.

Q. Are there any cities in Florida where you have

been critical of physicians other than the cities that I've

Just mentioned?

A. I don't keep track of where cases come from whether I'm either defending or critical of physicians or nurses or hospitals.

MR. FREEMAN: Objection, nonresponsive.

Q. (By Mr. Freeman) You have been critical of physicians in over half of the United States, haven't you, sir?

A. That's true. You mean state-wise?

Q. Yes, sir.

A. Sure.

Q. Do you know how many different states that you have been critical of physicians?

A. I think -- well, I have reviewed cases from just about every state except Hawaii, but I can't tell you off the top of my head whether they would have been Defense, Plaintiff or both.

Q. Obviously, you've been critical --

A. I guess the answer is no, I don't know exactly. I mean, you asked me about whether I was a Plaintiffs' expert witness in how many states. I can't tell you.

Q. Okay. Well, you have at least been a Plaintiffs' expert against physicians in Indiana?

A. Yes.

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Q. Kentucky?
A. Yes.
Q. Wisconsin?
A. Yes.
Q. Illinois?
A. Yes.
Q. Kansas?
A. Yes.
Q. Missouri?
A. Yes.
Q. Louisiana?
A. Yes.
Q. Ohio?
A. Yes.
Q. Both in Cincinnati and Columbus and also in Cleveland?
A. I don't keep track of cities.
Q. Okay. Pennsylvania?
A. Yes.
Q. New York?
A. Yes.
Q. Massachusetts?
A. Yes.
Q. North Carolina?

A. Yes.

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Q. South Carolina?

A. South Carolina. Don't know.

Q. If I gave you the name, would that refresh your recollection in South Carolina?

A. It might.

Q. Okay. I'll do that in a minute. Arkansas?

A. Don't remember any in Arkansas. That doesn't mean it doesn't exist, but I don't recall.

Q. Oklahoma?

A. Yes.

Q. Washington, D.C.?

A. Yes.

Q. Michigan?

A. Yes.

Q. Rhode Island?

A. Maybe. I don't recall off the top of my head.

Q. West Virginia?

A. Yes.

Q. Maryland?

A. Yes.

Q. Georgia?

A. Yes.

Q. Connecticut?

A. Yes.

Q. Minnesota?

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A. Yes.

Q. Have I missed any that you can recall as we sit here today where you have had cases where you have been critical in a health care provider's taking care of a patient?

A. Well, sure. You missed Texas.

Q. That's right. You had a case in Houston. You've had at least one case in Houston, haven't you, sir?

A. Well, I had a case with Mr. Weisbrod, but I don't remember where it was from.

Q. And I'll get to that one in a minute. But you had another case in Houston that didn't involve Mr. Weisbrod, didn't you?

A. I don't know.

Q. You had a case in Sherman?

A. Sherman?

Q. Uh-huh. Sherman, Texas.

A. I don't know.

Q. Do you even know where Sherman, Texas is?

A. No, not of€ the top of my head.

Q. In fact, do you recall the name of the hospital -- could I see the medical records, sir?

A. Methodist.

Q. Okay. It's Methodist, I think, H-E-B?

A. Right.

Q. What's H-E-B stand for?

A. I don't know. I asked Dr. Smith this morning, and he didn't know what H-E-B meant either.

Q. I see. Did you ask Mr. Smith to go check and find out what H-E-B meant?

A. No.

Q. Do you know where H-E-B is located?

A. No.

Q. Do you know what town --

A. Greater -- greater Dallas area, I was told.

Q. Do you know what town H-E-B is located in?

A. Specifically?

Q. Yes, sir.

A. No.

Q. Now, do you recall the Kelton versus Elliott Raja, R-a-j-a, Schiffer, S-c-h-i-f-f-e-r, and Lester, L-e-s-t-e-r, case?

A. No.

Q. Do you recall a case where you were not allowed to testify in a court of law in the State of Florida?

A. Not that I know of.

Q. Do you recall a case where you were disqualified from testifying?

A. Not that I know of.

Q. Nobody ever told you that you have been

disqualified and not allowed to testify in a court of law?

A. Well, an attorney asked me that question and pulled out a list and said that I had been disqualified from a case -- at least that's what he claimed -- but I have never been informed by either a Court or by an attorney that I was disqualified. So, you know, that's -- I'd have to take his word for it. And why would anybody take a word of

an attorney?

Q. I see. Did he tell you it was 1997?

A. I have no -- I don't remember.

Q. Did he tell you the name of the case?

A. Well, I think -- you know, as you mention it, I think Kelton was the name of the case, yeah.

Q. Did he tell you why it was that you were disqualified for testifying in that case when he gave you whatever explanation he gave you?

A. You mean why he alleges that I was disqualified.

Q. Yes, sir.

A. No, he didn't tell me. Or at least I don't remember him telling me.

Q. Did you ever go down to Florida to testify in the Kelton case?

A. Not that I recall, no.

Q. Did you ever get on the stand and have anybody cross-examine you in the Kelton case?

A. I don't remember the case at all.

Q. Do you recall giving a deposition in the Kelton

case?

A. No.

Q. Do you recall what the facts of the Kelton case were?

A. No.

Q. Have you been provided with a copy of the draft transcript of Dr. Walton in this case?

A. I don't know who Dr. Walton is.

Q. Have you been told what any of the other experts had to say in this case?

A. No.

Q. Have you discussed that with Mr. Smith or anyone else from the Morgan & Weisbrod firm?

A. No.

Q. With whom else at the Morgan & Weisbrod firm have you spoken with respect to this case besides Mr. Smith?

A. Well, let's look at the cover letters.

Q. Sure.

A. Actually, I don't remember anyone else, but this case goes back, I suppose, more than a year. Well, I don't know. Maybe not -- maybe less than a year, but I don't recall talking to anybody else.

Q. Okay. And I take it that either yesterday or

today you met with Mr. Smith to go over the deposition or to have some discussion about what we were going to do today?

A. Yes. He and I had breakfast this morning.

Q. Prior to that, have you ever met in person with Mr. Smith or anyone else with the law firm Morgan & Weisbrod with respect to this case?

A. No.

Q. Prior to that, had you met with anyone in person regarding the other case or cases that you may have reviewed for Morgan & Weisbrod?

A. Just Mr. Weisbrod when he came up here and did my deposition in whatever Case that was a couple of years ago.

Q. Okay. Dr. Walton is somebody who's provided some testimony for the Plaintiffs in this case, and I'll just tell you that. But would you disagree with him that the practice of medicine is an art as well as a science?

A. No.

Q. Would you agree that the art of practicing medicine deals in part with the exercise of clinical judgment?

A. Sure.

Q. Clinical judgment is what a physician believes and thinks is going on in a case based in part, I take it, on their training, education and experience?

A. That's true

Q. And also based on what they see, what they hear by way of history, what they feel by way of palpation and what they sense as going on with the patient by the exercise of all of their senses as they then and there interact with the patient?

A. Sure.

Q. I think you've testified before that there is no symptom for any kind *of* disease process that is -- and I'11 get this wrong because it's -- pathognomonic?

A. Pathognomonic.

Q. Pathognomonic. P-a-t-h-o-g-n-o-m-o-n-i-c, I think.

A. Yeah. I think that that's generally true. I mean, at least as we sit here, I can't think of an exception

to that.

Q. Generally true as the spelling or the --

A. No, the general -- the statement is generally true.

Q. Okay. The -- and just so it's clear -- and I think it is. But for the record, you were not ever there to interact with the patient that is involved in this case, Delores McLean, were you, sir?

A. Well, of course not.

Q. You would agree with me that physicians sometimes disagree in the exercise of their judgment?

A. Sure.

Q. That happens all the time, doesn't it, sir?

A. Sure

Q. And in the hospitals in which you practice or in which you're employed part time as an emergency room physician and in which you staff, you've had professional disagreements with colleagues there, haven't you, sir --

A. Sure.

Q. -- with respect to the exercise of your professional judgment?

A. Yes.

Q. And that, in and of itself, does not necessarily mean that you or your colleagues are negligent or wrong, does it, sir?

A. Of course not.

Q. That just kind of goes with the nature of the practice of medicine and the exercise of judgment, doesn't it, sir?

A. Yes, sir.

Q. And you would expect physicians to exercise clinical judgment when they're taking care of a patient?

A. Sure.

Q. That's an important part of the practice of medicine, isn't it?

A. Sure.

Q. You've heard the term "retrospectoscope" before, haven't you, sir?

A. Sure.

Q. In fact, you probably discussed that with Mr. Smith this morning, didn't you, sir?

A. Yes.

Q. A retrospectoscope is not a real medical

instrument, is it, sir?

A. That's correct.

Q. If it was, we'd probably all in this room like to have a patent on it. Wouldn't that be true?

A. That's true.

Q. A retrospectoscope is a medical way of saying that hindsight is 20/20, isn't it, sir?

A. Hindsight is 20/20.

Q. What we're talking about is a matter of perspective, is it not?

A. Yes.

Q. When you're taking care of a patient in the emergency room, you're generally treating a patient prospectively, aren't you?

A. Of course.

Q. When you are reviewing a case such as this, you're doing it from a different perspective, aren't you, sir?

A. Yes.

Q. You're doing it retrospectively?

A. That's correct.

Q. That means you're looking back having the benefit

of knowledge that the people then and there taking care of the patient would not have had?

A. That's true.

Q. For example, in this case, I take it, one of the things that you have reviewed has been the autopsy report?

A. True.

Q. In this case, when you were originally contacted in the case, you were told what the ultimate outcome was, weren't you, sir?

A. Probably. I don't recall, but probably.

Q. And when you reviewed the records initially, you had the benefit of the autopsy report?

A. Yes, sir.

Q. And that was something that -- that was information that none of the health care providers that had previously taken care of the patient had the benefit of, obviously, when she was alive when they were trying to take care of her?

A. Obviously.

Q. So you've not been in a position, in your review of this case, similar to the position that the health care providers were when they were taking care of the patient;

isn't that true?

A. Well, I think that that's generally true even though, obviously, I read the ER records and formed some opinions before I got to the postmortem exam, which is at the end of the pack of materials. But I think you're probably right, because I suspect that I, at least, had known from a telephone conversation what the ultimate problem was.

Q. You've testified previously that in medicine you try to do what lawyers try to do, and that is to look at the preponderance of the evidence and come up with a single explanation?

A. Yes, that's true.

Q. And I think you indicated that in the Griffin case and also in the Weber case?

A. I don't know whether -- I actually don't remember those cases. But that is indeed how we practice medicine, and that's how I have testified in the past.

Q. And you try to exercise your judgment as a physician to find what you think is going on with the

think that charting makes or doesn't make for the standard of care. It's what we do for a patient. And hopefully, most of it gets to the charts, and if it doesn't, that doesn't mean that there was a deviation of the standard of care.

Q. (By Mr. Freeman) Okay. And I think you explained it in the Parker versus Arlington case by indicating the records may not be precise because by and large you try to be precise as to what you're doing with the patient as opposed to taking care of the chart?

A. That's true.

Q. You'd agree with me, sir, wouldn't you, that a patient has an obligation as a reasonable and prudent patient to follow reasonable recommendations of the physicians and health care providers?

A. Sure.

Q. And that's what you would expect patients to do, and that's what you want patients to do when you give them advice, recommendation, orders and things of that nature?

A. Sure.

Q. But they don't always follow your recommendations as a reasonable and prudent patient, do they, sir?

A. That's true.

Q. In fact, if they don't follow your recommendation, it can make it more difficult to diagnose and treat the patient; isn't that true?

A. It can.

Q. In part, it can be more difficult to diagnose the patient, because part of your diagnosis is based on their response to what you understand their treatment to have been?

A. That's also true.

Q. And it will make it more difficult to treat, because if a patient is not following your treatment, advice and recommendations, then whatever course it is that you have recommended can't be of any benefit if they don't follow it?

A. That's true.

Q. You've had patients in the past yourself where you've asked them, Have you followed the treatment, recommendation, advice? Have you taken your medications?

I mean, you've gone through that scenario with a patient, haven't you?

A. Sure.

Q. And you've had patients that just by the way they hesitated and the way they looked at you when they told you yes that you knew that they hadn't. I mean, you've had that experience, haven't you, sir.

A. Well, as a matter of fact, there's some pretty good data out there to suggest that 80 percent of the patients, fully 80 percent of the patients, do not follow exactly instructions that they're given. In other words, they don't take all of the medicine, they don't take it all on time, or you know, there's some variation anyhow in their implementing your instructions.

Q. That's based on a study in the late '70s done at the University of Chicago in which you had some input; isn't that true, sir?

A. Well, actually, not that particular study, no Actually, the study you're referring to is one in which we looked at a very small part of that, and that was whether or not patients went for follow-up.

Q. That was the referral study?

A. Right.

Q. And you found that 60 percent of them wouldn't even follow directions with referrals?

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A. That's true.

Q. And with respect to actually taking medications, as opposed to referrals, the patients would violate what you would want them to do as a reasonable and prudent patient 80 percent of the time?

A. That's true.

MR. FREEMAN: Could we take a rest room break, please?

(Recess at 12:33.)

(On the record at 12:57.)

Q. (By Mr. Freeman) I had told you -- are you ready to go?

A. Yes.

Q. I had mentioned that I would find the name of a case to see if that refreshed your recollection on one of

the states or cities, and I can't remember which state or city we were talking about earlier. Do you remember which one --

A. No, sir.

Q. -- that was? In Texas, you've also testified in --

MR. STEED: South Carolina.

MR. FREEMAN: Was it South Carolina?

MR. STEED: I think so.

Q. (By Mr. Freeman) In any event -- let me start

over with the question. You have testified against doctors in Beaumont, Texas?

A. I don't know.

Q. Do you recall working with the Humphries law firm?

A. Not off the top of my head, no.

Q. Do you know where Beaumont is with respect to wherever the hospital's located that's involved in this case?

A. No.

Q. And in Arkansas, does the Begay, B-e-g-a-y, case

refresh your recollection as to testifying against doctors there?

A. Yeah. That name is familiar, Begay. I don't have a recollection of what the case involves, but I recognize that name.

Q. And one state I think that we forgot to mention was Montana. You've testified against health care providers in Montana as well, haven't you?

A. I think I reviewed a case for an attorney in Montana. I don't recall whether it ever came to a deposition or not.

Q. Was that in Butte, Montana? B-u-t-t-e, I think.

A. I don't remember.

Q. *And* in Rhode Island, it was the Obuchon, O-b-u-c-h-o-n, case. Does that refresh your recollection?

A. I recognize that name, but I don't relate it to Rhode Island. I recognize the name.

Q. And in Connecticut, the Giannotti, G-i-a-n-n-o-t-t-i, case? Does that refresh your

recollection there?

A. No.

Q. And in Sarasota, the Pflung, P-f-l-u-n-g, case.

Does that refresh your recollection there?

A. No.

Q. Now, on the Exhibit 9 pages from medical literature --

A. Yes, sir.

Q. -- you have the cover page from one of the books?

A. Yes.

Q. Blood gases, correct?

A. Yes, sir.

Q. And you don't have the cover page for the other book. Which one was that?

A. There were two. The one graph, the sigmoid curve, is from "Emergency Medicine Concepts and Clinical Practice" by chief editor Peter Rosen. It's the fourth edition. And the chart that relates oxygen saturation of PO2 is from Tintinalli's book, the third edition.

Q. Okay. And Tintinalli's book is the red one, the big red book --

A. Yes.

Q. -- eight and a half by 11?

A. Right. One volume.

Q. Okay. And the other book is one that in the first edition, second edition you had something to do with yourself?

A. That's correct. I wrote the chapters on cardiac arrest and also was an associate editor.

Q. But you didn't have anything to do with the third volume -- or third edition or the fourth edition, have you, sir?

A. That's correct

Q. Okay. And I understand from previous testimony that textbooks, like anything else, are pretty much out of date -- a year out of date, year and a half out of date -- by the time they hit the streets?

A. Well, some things. I mean, it's like sort of saying the encyclopedia's out of date when it gets published. That's not entirely true. The vast majority of things in it are indeed still factual. I mean, you can't change the fundamental structure of the skull. It's still a skull.

But there are sort of cutting-edge therapies or maybe even diagnostic techniques which have been deve1oped since the book went to press. So to some extent, some of

those things may be outdated.

Q. Okay. Medical thinking on handling problems, different areas, changes over time, doesn't it?

A. Sure.

Q. And the new editions tend to reflect those changes over time?

A. Yes.

Q. And that's why in addition to medical textbooks that come out in different editions over the years, medical journals come out on a whole variety of medical topics on monthly, weekly and other bases?

A. Yes, that's true, although there's a fundamental difference between journals and textbooks, because by the time something hits a textbook, it's fairly well agreed on or at least it's recognized in the textbook that it's a

controversial issue and maybe not agreed on, unlike journzls in which a substantial number of the articles may not be generally accepted.

And there's sort *of* research that is ended -- or is pointed in going in some direction, and it doesn't make it into a reference textbook until it's been confirmed by other studies.

Q. But by that, you're not vouching for all textbooks, are you?

A. Oh, no, not at all. And in fact, you know, I

don't think there has ever been a single textbook that one could say is authoritative in its entirety. I mean, you might find a chapter that's authoritative or a page or two. But to say an entire textbook is authoritative in terms of how you folks use the term, meaning -- or at least my interpretation -- that it's sort of irrefutable and the last word on a topic, I don't think you can say that about an entire textbook.

MR. FREEMAN: Objection, nonresponsive.

Q. (By Mr. Freeman) With respect to the -- and that's not directed at you, sir. I say that only for purposes of the record.

With respect to the three books that you have cited to us by bringing copies of their pages, do you believe that those three books are reasonably reliable such that I could go and look up and address issues that may be raised in this case?

A. I think they're reasonably reliable, yes.

Q. I think Dr. Walton told us about three days ago, on March 11th, in this case that on April 24th --

A. Yes.

Q. -- the first visit that the hospital €or the records, which **I** believe you have there in front of you, that there's not a single sign or symptom that was inconsistent with bronchospasm and sinusitis. Would you

agree with that?

A. Yes. Having a clear chest, I think, is inconsistent with bronchospasm. The patient was noted to have a clear chest on physical exam, and that is indeed a finding on exam. And a normal pulmonary exam is not

consistent with having bronchospasm.

MR. FREEMAN: Objection, nonresponsive.

Q. (By Mr. Freeman) Dr. Walton also said on March 11th that in May and June -- between the April and July visits, that the patient indeed did not have a pulmonary embolus. Do you agree with that?

A. No. I think actually the patient was probably having recurrent emboli during this entire period between the two ER visits.

MR. FREEMAN: Objection, nonresponsive, after the first word.

Q. (By Mr. Freeman) Do you agree that on July 8th that the patient did not have any signs or symptoms inconsistent with pneumonia?

A. Yes. I believe that the patient did have signs and symptoms which were inconsistent with pneumonia.

Q. Dr. Walton told us that he could not swear that the patient indeed, in fact, had a pulmonary embolus on April 24th. Do you disagree with that?

A. Yes.

MR. FREEMAN: I'd like to take a short -- just a short break.

Off the record.

(Recess at 1:07.)

(On the record at 1:08.)

MR. FREEMAN: Doctor, I believe I'll reserve the remainder of my questions until the time of trial. I think these other fine folks have a few questions they want to ask as well.

THE WITNESS: All right.

MR. FREEMAN: Thank you very much for your time.

THE WITNESS: Thank you.

E X A M I N A T I O N

(On the record at 1:09.)

BY MR. STEED:

Q. Doctor, my name is Joel Steed. I met you for the first time today, I believe; is that right?

A. Yes, sir.

Q. I understand -- I represent Dr. Novotny, one of the emergency room physicians. And for your sake of recollection, I think he saw Mrs. McLean on about the 8th of July prior to her coming to the hospital in arrest and being pronounced dead shortly after midnight on the 10th. Does

25 that refresh your memory?

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A. Yes.
Q. I know you've done this before. Let me go ahead and have some agreements with you, though. If I ask you something that you don't understand, will you make me repeat or rephrase my question before you answer it?
A. Yes, sir.
Q. If you answer without asking me to do any of those things, will it be fair for me to assume that you've understood my question and answered it truthfully and completely?
A. Yes, sir.
Q. Do you understand that although the judge and jury are not here today and we're in an informal setting here in Chicago, your testimony is under oath and can be read to the Court and the jury at the time of trial?
A. Sure.
Q. For that reason, I want to make sure we're on the same page, so don't hesitate to stop me. Okay?
A. Right.

Q. Is it a captive group that the hospital employs, or do they interview and screen and hire and fire doctors on a one-by-one basis?

A. Oh, no. It's -- it's not a captive group. I mean, each faculty member is hired or fired on, you know, his own by the department chairman, who is also a hospital employee.

Q. Okay. What is your current faculty position?

A. I was offered a full professorship in medicine. The hospital does not have an emergency medicine department, and it's the department of medicine that runs the emergency services division.

Q. Same thing as internal medicine?

A. Oh, yes. That's what **I** meant. Internal medicine, yes.

Q. And when did you receive that position?

A. Well, I started in September. Actually, I was offered the position in January, but because of health reasons had to put off starting until September.

Q. Offered in January of '98 and took it in September of '98 due to health problems?

A. Yes.

Q. Have you ever been a tenured professor at any medical school or university?

A. No

Q. Have you ever been up for tenure at any medica1 school or university?

A. No.

Q. Basically, then, on a day-to-day basis, how much time do you spend in the clinical practice of emergency medicine at a hospital? Is that the 24 hours last week that you referenced? Is that hands-on patient care?

A. Yes.

Q. So the range would be -- last week was 24 What's the maximum number of hours you've worked in a week since September of '98, and what's the minimum?

A. Oh, gosh. I mean, I haven't worked more than 24

hours a week since September of '98. In fact, I was off for

some more surgery between January and just, oh, early March for some more foot surgery. And at least for the foreseeable future, I don't see myself working more than three shifts a week.

Q. When you were interviewed, did you let them know about your health problems and tell them that because of the health problems, you weren't going to be able to work more than, say, a maximum of three shifts per week?

A. Oh, sure. They knew that one of the reasons why I was going back into academic medicine was because physically my injured foot could not take the stress of working as a primary physician in an emergency department in a busy community hospital. And because of my physical needs, I was coming back to academic medicine and that teaching was going to be less stressful physically than primary care was.

Q. And when you say "academic medicine," do you mean a job where you have a private practice in that hospital and you also had teaching responsibilities?

A. Well, what I mean in terms of emergency medicine specifically is that I have teaching responsibilities, and I will be at a university hospital where a major part of the

emergency department staffing is done by a resident staff, unlike the private hospital or community hospital that I was at. We only had a resident staff about half the time.

Now on any given shift, I have about four residents and maybe an intern or two and a couple of medical students. So I get to do a lot more teaching and actually have less physical stress on my foot.

Q. Okay. Let's take last week, since that's fresh on your memory, where you worked in the ER 24 hours, three shifts. In addition to that, what did you do professionally last week? Just give us an idea or sketch of what your week was like besides working in the emergency room.

A. well, let's see. I mean, actually, i don't remember, but I can tell you that I worked in the ER on Thursday from four till midnight, on Friday from four till midnight and on Saturday from noon to 8 p.m. You're going to ask me what I did Monday, Tuesday and Wednesday, and I don't remember.

Q. All right. Did you have any teaching responsibilities last week, any courses, or are all of your teachings didactic, working with residents?

A. No. All my teaching is -- or at least at this point -- I mean, you know, basically, I've just started this job. All my teaching at this point has been bedside teaching with resident staff. It's clinical teaching. It involves specific patients. And I have not done any formal didactic teaching for this group of resident staff.

Q. So you have no classroom responsibilities or

anything?

A. Yeah, that's generally true. Most clinical physicians, we don't have classes that, like, meet on a particular day of the week at a particular hour.

Q. Did you do anything else, then, professionally for income generation or to make a living last week other than the 24 hours worked at the hospital?

A. I don't remember what I did on Monday, Tuesday and Wednesday.

Q. Did you give depositions any last week, or did

you meet with lawyers any last week?

A. No, I don't think so.

Q. Didn't testify at trial last week?

A. No.

Q. Have you ever treated a patient that you diagnosed to have pulmonary embolism?

A. Sure.

Q. And how many times in your career?

A. Oh, gosh, hundreds.

Q. Can you be more specific than hundreds? Is it close to 300? Close to a hundred?

A. I have no idea. I mean, I've been practicing years, and it's not an infrequent diagnosis.

Q. How many years, then, does that hundreds of pulmonary embolism diagnoses encompass?

A. Twenty-five. Actually, I've been an intern since 1971, so it's pushing 30.

Q. Have you, on each of those hundreds of occasions, made the diagnosis of pulmonary embolism yourself? Or has it been mixed where, for instance, on occasion you, as an

emergency room physician, would consult with a specialist and the specialist would make the diagnosis of the pulmonary embolism?

A. Well, the diagnosis of pulmonary -- the answer is that it's a mixture of both. The diagnosis of pulmonary embolus is not always apparent from the first test that one does. And frequently, the definitive diagnosis isn't made until after the patient becomes an inpatient and specifically after pulmonary imagery has been done, which we don't do out of the ER.

Q. It is true, is it not, that frequently pulmonary embolism is not diagnosed by the emergency room physician but rather diagnosed at some later date following admission to the hospital by some other primary care physician, be it internal medicine physician, pulmonologist, someone else?

A. Sure.

Q. In the hundreds of pulmonary embolisms that you've been involved in diagnosing, just give us, if you can, an estimate of the percentage of those where you made the initial diagnosis versus someone else after you making that

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diagnosis.

A. Oh, gosh, I'd have no way of even putting you in the ballpark.

Q. Would 50/50 split even be in the ballpark?

A. I mean, I suppose that's unreasonable. Whether that would be 75/25 or 25/75, I mean, I don't have any -- any reasonable way to take even guesses as to how those numbers work out.

Q. Fair enough. And I don't want you guessing. so you would agree with me that in the times where you've been called upon to make a diagnosis of pulmonary embolism or have had the occasion to make it, many times you've made that on your own, but also many times it's been you assessing a patient, having a patient admitted and then someone else, some other specialist, making the diagnosis?

A. Well, what we're really talking about, so that you and I understand each other, is I'm talking about the definitive diagnosis. In other words, it's fairly unusual for an emergency room physician to not be thinking of that,

admit the patient then have someone come back the next day and say, Oh, you know, you completely missed the fact that this patient had a pulmonary embolus. That's not what we're talking about.

What we're talking about is that I admit the patient with sort of the presumptive diagnosis of a

pulmonary embolus, but it isn't confirmed until someone else does the definitive tests.

Q. Doctor, in fairness, in 25 to 30 years -- maybe a few times, maybe more -- there has at least been occasion where you, as an emergency room physician, did, in fact, either admit a patient or send a patient home to have that patient return where you were, in fact, surprised that someone had made a diagnosis of pulmonary embolism that you have not even considered?

A. Well, let me answer that by saying I don't know of any, but it wouldn't surprise me if -- if that had occurred. You have to understand that the nature of

emergency medicine practice is that if I make a mistake, I frequently never hear about it, because if I'm not on when the patient comes back or if the patient goes back to a different hospital, I mean, I just simply don't get the feedback.

Q. Sure.

A. So, you know, I don't dispute what you're saying. I just have no -- no idea.

Q. I recognize that, and that was my initial question. Do you recall, at least, an occasion in 25 to 30 years where you did see and evaluate a patient for a medical problem, failed to pick up on the fact that there was a pulmonary embolism due to lack of clinical findings or lack

of historical information or whatever, and either discharged that patient, or maybe admitted the patient to the hospital thinking it was something else and then were shocked or surprised to learn that they did, in fact, have a pulmonary embolism? That's happened at least on occasions, hasn't it?

A. Well, not that I remember. I'm not denying that it might have happened. I just don't remember it.

Q. It wouldn't surprise you if it did happen, just given the fact that this is not necessarily an easy diagnosis. Do you agree with me on that?

A. Yeah, I think that that's true. I think that there are some patients that clearly you cannot make the diagnosis of in the ER, and they get admitted with some pulmonary problem of unknown etiology or unknown cause that somebody else then defines.

Q. Let me ask it this way and just remove it from your individual experience and just say: In the time that you've been staffing emergency rooms over the 25 to 30 years, whenever you've done that over that course of time, have you learned of situations where patients were seen in emergency rooms where you worked, whether seen by you or somebody else, who had a pulmonary embolus, it was not detected or diagnosed and then they ultimately died as a result of complications from that embolism?

A. I don't know about died. I mean, I'm fairly sure

that people have been sent out with them and have come back and that, you know, one of us in the emergency department have made the diagnosis.

I don't -- I can't tell you that I know that any of those people have gone out and died.

Q. Is that a fear of yours, that any kind of serious illness such as cardiac abnormalities, strokes, pulmonary embolisms, is that a fear that you live with on a daily basis working in the emergency room that a patient might present with some history or clinical symptomatology that may not be clearly apparent to you and that they might be allowed to go home and have a complication from that i1lness?

A. Oh, sure. I mean, that's one of the -- I mean, that sort of goes with emergency medicine is that, you know, you never want to send anyone home who has a potential life threat and obviously have them deteriorate as a result of that.

Q. And you wouldn't want it suggested to a jury that's going to hear this case that because Mrs. McLean was seen in the emergency room on two occasions in April and July and was sent home and later returned in distress due to

a pulmonary embolism, you wouldn't want it stated to the jury that that, in and of itself, indicates that these doctors were negligent in how they treated her, right?

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A. That's clearly the case, that just because she came back a third time and died from a pulmonary embolus doesn't mean that, in and of itself, they should have made the diagnosis.

Q. To be a little more clear, a doctor -- getting back to this art and science that was spoken of earlier -- a doctor can apply his education, training, experience. He can get a history from a patient. He or she can make -- perform a physical examination and reach a judgment that retrospectively may appear to have been in error, but when viewed at the time under the circumstances was totally reasonable and appropriate. Do you agree with that?

A. Yes, I do agree with that. But I think we need to be careful about understanding the difference between clinical judgment and a decision, because not every decision involves judgment. You know, when you're driving a car and

Q. And the thing that makes pulmonary embolism. so, at times, difficult to diagnose or detect is that some of the symptoms you can get with pulmonary embolism are consistent with many, many other types of medical conditions or illnesses?

A. Yes, that's true.

Q. In fact, in your practice of emergency medicine, do you find it easier to evaluate cardiac-type problems, possible MIs or cardiac defects as opposed to pulmonary embolism?

A. Yes.

Q. There are so many illnesses and disease processes that I can't be specific with this question. But would you agree with me that pulmonary embolism is among the most, if not the most, difficult, medical illness to be detected or diagnosed in an emergency room setting?

A. Can be.

Q. And again, you qualify it by saying it can be. It

depends on each case and what the patient's presenting with and what history the doctor is getting and so forth, correct?

A. Yes, that's exactly true. In other words, some may be very obvious, and some may present in an entirely aberrant fashion in which you have no idea that this is a pulmonary embolism.

Q. Do you agree that day to day when you work in the emergency room -- not day to day, but let's say 24 hours last week -- you make decisions on eval -- testing to be performed on patients and so forth based upon medical necessity as you view it, given your years of training and experience?

A. Sure.

Q. And I take it you don't make it a practice to order medical tests or evaluations that you don't feel in your judgment are medically indicated in a given circumstance?

A. Sure. Of course.

Q. And what may be medically indicated to you in a given circumstance may not be medically indicated to another emergency room physician, depending upon what that circumstance is?

A. That's also true.

Q. Again, that kind of weaves us back to this art and science in terms of what amount of history, physical findings and so forth would cause you, Dr. Baker, to exercise your judgment to run a certain test versus what amount might cause Dr. Youngblood, another expert that's been designated in the case by the Plaintiffs, or Dr. Walton, one of their other experts, to run tests of a particular type on a patient, right?

A. Sure.

Q. And the fact -- again, specifically with regards to this case, the fact that some doctors might feel that certain tests are indicated and others might not, that does not, in and of itself, indicate that one group of doctors is negligent and the other group is practicing good medicine?

A. That's true.

Q. Do you agree, in fairness, that Ms. McLean had symptoms and some signs that were not only consistent with pulmonary embolus, as you've pointed out in your report, but also many other medical problems?

A. Yes.

Q. Let's just talk about some of those for just a second. From time to time, there is notation of coughing, correct?

A. Yes.

Q. Some congestion?

A. Yes.

Q. Some respiratory problems?

A. Yes.

Q. There's a dispute as to whether she had chest pain, and if so when, but let's assume hypothetically right now there was at least an episode of chest pain.

A. Yes.

Q. Those symptoms right there are consistent with just a laundry list of medical problems and potential medical complications, correct?

A. That's true.

Q. Run the -- runs the gauntlet from the common cold to the flu to a virus to pneumonia and on and on and on including pulmonary embolism?

A. Yes, sir.

Q. Do you agree that usually if a pulmonary embolus

Is causing respiratory difficulty in a given patient that that respiratory difficulty comes along acutely?

A. That's generally the case, or at least the patient notices it acutely, you know, what is reasonably well until some point in time at which they experience some problem. That's true.

Q. Once those problems or symptoms become acute enough to where the patient notices it and may complain about it, do those complaints persist until the pulmonary embolism is resolved?

A. They may or they may not. It's sort of -- it's a little bit dependent upon the patient and exactly the extent of -- of the embolus; for instance, the shortness of breath might exist until you start oxygen and in which case it goes away. A little bit depends upon the size of the embolus, and if you're having small emboli the extent, and to some extent whether or not the patient continues to throw emboli

over for a long period of time. I mean, there's so many factors in there that -- things do change.

Q. Generally speaking, as an emergency room physician, when a patient walks into the facility where you're working and they become your patient, in terms of respiratory difficulties, an acute onset of a respiratory distress or respiratory problem is somewhat more concerning to you than a patient who has had a chronic history of respiratory problems and tells you, for instance, that they've had bronchitis or asthma?

A. It depends upon what their clinical status is. In other words, if all they're complaining of is nonproductive cough, well, obviously, I'm not going to be terribly worried if it was something that has been going on for weeks or months.

If what they're talking about is being short of

breath to the point that they're cyanotic, then I'm still worried, even if it's been going on -- even if their cough

has been going on for weeks. The Fact that they've got a new symptom still is very worrisome.

Q. Fair enough. And you saw nothing in any of the records or the deposition testimony to indicate that Mrs. McLean ever became cyanotic up until she was transported to the emergency room in respiratory arrest, correct?

A. That's true. There's no evidence of cyanosis.

Q. And obviously, cyanosis is blueness around the lips or face or in the peripheral extremities that causes you to be concerned, as a physician, that they may not be pumping oxygenated blood as well as they should be?

A. That's true.

Q. And so in this case, you see no evidence of that, which you can see in severe cases of pulmonary embolism, can't you?

A. Well, you can, but I mean, when you see a patient who is cyanotic from their pulmonary embolus, we're in deep, deep trouble.

Q. Okay. Makes the -- makes the diagnosis a little easier if you see cyanosis and you have reason to suspect pulmonary embolism than otherwise. Fair enough?

A. Well, sure. But that's going to be the vast

minority of the patients, and that patient's going to be more likely to die than not.

Q. Let's go back, then, to the question I asked you earlier about patients that appear in the emergency room. And working in the emergency room is all about having a working diagnosis, an idea of what a patient's problem may be and attempting to work up that problem to your satisfaction that that patient is stable and able to be discharged or alternatively unstable and needs to be admitted, right?

A. Yeah. But you've got to be careful about how you use the term "stable" because stable doesn't necessarily mean that you have no life threat. In other words, you can be --

Q. Sure.

A. -- stable with your heart attack, meaning I have a rock-solid blood pressure and a pulse and my respiration's okay, but yet I can die from my arrhythmia five minutes from now. So, you know, that's a term that gets thrown around a

lot, but you have to really define whether you mean stable vital signs *or* whether you mean the disease is stable and not likely to either get worse or deteriorate.

Q. Do you agree, in general, that the role of an emergency room doctor is really, basically, two-fold and obviously has many subparts, but one is to assess medical

problems that come into the emergency room, and then to the extent you're able, stabilize that patient with regards to whatever problem you've assessed and evaluated?

A. Well, sure. I mean, you know, and the short of that is define and stabilize the life threat.

Q. Okay. And once you've stabilized them, then you need to properly see that they follow up with either their family doctor or that they're admitted and seen by the appropriate specialist, and it depends on the circumstances?

A. Yes, that's true.

Q. Going back, then, when a patient comes into the emergency room and becomes your patient and your

responsibility, and that patient hypothetically is morbidly obese and tells you that they aye having some difficulty breathing, especially with exertion, and that they've been diagnosed several months before with asthma or bronchitis that's off and on, that patient, taking those factors alone, is not as concerning to you as a patient who comes in with that same degree of respiratory problem and says, This has hit me acutely and I've never had it before and I don't know what's wrong with me?

A. Well, the problem is you haven't given me enough data to really answer that question. In other words, you haven't told me the vital signs. You've just given me a little bit of history, but you haven't given me the vital

signs. You haven't given me the physical examination in terms of the cardiorespiratory exam, and we don't know anything yet about things like pulse oximetry and arterial blood gases or electrocardiograms. So --

Q. And I'm going to get into all of those specifics.

What I'm trying to understand right now Is just theoretically whether you can accept the proposition that the chronicity of a patient's problem can cause you to have some less concern about it than if it is an acute new problem that they've never experienced before.

A. Well, the answer to it is, it could be that you're correct. But one of the things that you have to do in emergency medicine and which we, at least, always try to remember to do is to say to that patient, Well, if you've had this for a while, why is it you're here today?

In other words, it's really an important question of, you know, if you've had this headache and it comes every day, why today? Why did you come today to the ER? Why not yesterday or the day behore? And you can usually tease out that the patient says, Well, something changed. Something got much worse. Or there's some new symptom that exceeded their threshold for, you know, coming into the emergency department.

That's really one of the key questions in emergency medicine is, if you've got this chronic disease,

then what are you doing here? Why didn't you go see your family doctor next week?

Q. And some patients are better at giving you that history than others?

A. Oh, sure.

Q. And in terms of the history you obtain, I bet you can't tell me today, without even identifying the patients, of the patients you saw during your 24-hour work week last week, you can't recall the specific information given by each of them to you historically, can you?

A. That's true.

Q. And you didn't make a note of each and every piece of history that they gave you. You didn't contain everything about that in the medical record, correct?

A. I'm sure that that's true. I mean, there's certainly going to be some of those patients in whom I didn't record the entire history, and there are going to be others in which I was probably extra careful to try to record everything that they told me.

Q. There's some things you ask and some information you seek as an emergency room doctor that's just second

nature that you're going to ask of every patient that you evaluate in the emergency room?

A. That's true.

Q. Have you ever reviewed any medical-legal cases

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that you recall that dealt with allegations that a pulmonary embolism was either not detected or not properly treated?

A. Well, you know, I've been doing this for 25 years. I'm sure that I have reviewed cases of missed pulmonary embolism, both in the forensic area as well as in the hospital peer-review setting. I don't remember the details of any, but I'm sure that it's come up.

Q. Can you recall ever giving deposition or trial testimony in a case where the issue of pulmonary embolism diagnosis and/or treatment was in question or at issue?

A. Not specifically, but I suspect I have.

Q. But you can't recall anything specifically for it?

A. That's true.

Q. And you won't be able to recall for the jury, if this case is tried, specific cases of pulmonary embolism

where you've been asked to evaluate or assess?

A. No. There's no reason why I would do that.

Q. If you have your report in front of you, I want to ask you some questions about it.

A. Yes, sir.

Q. I'll just take it chronologically. What does it take to become a life fellow of the American College of Forensic Examiners?

A, Well, first you have to join the organization. Then they have to offer to make you a fellow, to make you a

diplomate, and then you have to agree to pay the life fellow dues rather than the yearly dues.

Q. So you make application and then they accept you and then you pay the dues?

A. Well, it depends upon the organization. But most organizations have some sort of board examination that you have to take in order to become a fellow. Or --

Q. That's what I'm -- I'm sorry.

A. Or you have to be recognized as a specialist in

your area.

Q. Did you sit for any kind of written or oral exam to become a life fellow of the American College of Forensic Examiners?

A. No. They waived the examination.

Q. Do you know why the examination was waived?

A. Well, presumably, because I am who I am, well known and, you know, participated in writing a textbook. I was a professor of medicine and a professor of emergency medicine and department chairman at one of the top three universities in the world.

Q. Do you know for a fact that your testing, if any, or further work necessary to become a life fellow of the American College of Forensic Examiners was, in fact, based upon a waiver due to your past accomplishments or your writings or anything like that or is that just your

supposition?

A. I wouldn't remember the specifics of that.

Q. How about the -- being a diplomate of the American Board of Forensic Examiners or a diplomate of the American

Board or Forensic Medicine. Did you have to sit for any tests, written or oral, for either of those --

A. No.

Q. -- diplomacies?

A. No.

Q. Were those applications and acceptance and annual fee payments that granted that status?

A. Yes.

Q. Now, with the American College of Emergency Medicine and the American College of Internal Medicine, I would imagine there were tests associated with those?

A. There were.

Q. Written and oral for both?

A. No, actually, internal medicine, when I took it, was a two-day written test and emergency medicine was a one-day written test and an oral exam.

Q. Okay. Did you become board certified and pass those tests, both written and oral, on the first occasion for each of those specialties?

A. Yes.

Q. Have you ever had your certification revoked,

suspended *or* in any way limited since you became board certified?

A. No.

Q. Have you ever had your privileges at any hospital, clinic or other health care facility revoked, suspended or in any way limited?

A. Well, obviously, they're limited to emergency medicine. I mean, clearly, I'm not a neurosurgeon. So when I ask €or privileges, I get them --

Q. Sure.

A. -- in my specialty.

Q. And I'm talking about limited within your area of specialty, specifically, €or instance, based upon quality of care or any type of penalty *or* sanction by a hospital or health care entity.

A. No.

Q. You've never been arrested or convicted for any felony crime or crime involving moral turpitude such as theft **or** anything like that?

A. That's correct.

Q. How about the fellow with the American College of Emergency Physicians? What was required for that position of a fellow?

A. Well, originally, when American College of

25 Emergency Physicians established their fellowship, you

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1 became a fellow simply because you had passed the American
2 Board of Emergency Medicine exam.
3 Then they subsequently rethought that several
4 years later and then asked that you submit evidence that you
5 had done additional academic things or that you had
6 participated in a professional society or somehow did
7 something other than sit for an exam. So all of us have
8 subsequently submitted that sort of data to them.
9 Q. Have you had to be recertified by either of those,
10 American Board or the American College, or are grandfathered
11 in to both organizations?
12 A. Internal medicine, in the year I took the exam,
13 required no recertification, so I have not been
14 recertified. Emergency medicine, I was recertified in 1992.
15 Q. Do you remember pulmonary embolism being any part
16 of the recertification exam, whether written, oral or a case
17 hypothetical?
18 A. No.

Q. And the recertification exam, I take it, you passed that on the initial attempt?

A. No. Actually, I took the recertif exam -- recert exam twice

Q. Okay. When did you first take the recertification exam?

A. The previous year, in '91.

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Q. In emergency medicine?

A. Yes.

Q. Did you sit for that here in Chicago?

A. Oh, no. It was in Detroit.

Q. And the recert, is that totally a written exam or also oral?

A. It's a totally written exam.

Q. So you did not pass it in '91 and retook it when?

A. '92, next year.

Q. And passed it in '92?

A. Yes.

Q. Is it scored on a zero to a hundred scale?

A. I don't know what it's scored on.

Q. Do you remember how close you were to passing in

'91 or how your scores compared in '91 and '92?

A. No.

Q. Do you remember which part of the -- or parts of the exam you failed in '91?

A. No.

Q. To your knowledge, did any parts of the exam that you failed have anything to do with diagnosing, evaluating or treating pulmonary embolism?

A. No.

Q. Have you ever been sued before?

A. Yes.

Q. How many times?

A. Twice that I know of.

Q. Approximately what years?

A. 19 -- 19 maybe 82 or 83 in a case called -- the Plaintiff was a fellow by the name of Benjamin Wilson.

Q. The patient Plaintiff?

A. Right. He was an 18-year-old who was shot at a basketball game and taken to another hospital.

Q. Just in general, what was the claim against you in

that case?

A. That I had failed to -- as the director of the paramedic program for the South Side of Chicago and as the chairman of the department failed to establish a trauma system in the city of Chicago in 1982.

Q. What was the result of that case?

A. It was dismissed by the Court.

Q. I take it you felt you had done nothing wrong and weren't responsible in that case?

A. That's true.

Q. Did that progress enough to where they designated any medical expert against you?

A. Oh, sure. There were two experts identified, one an ex-resident or former resident of mine, a fellow by the name of John Turns, and a fellow by the name of O'Reardon from L.A.

Q. Were these emergency room experts or --

A. Yeah, uh-huh.

Q. Okay. And it got thrown out without going to trial?

A. That's true. It got thrown out after I gave a deposition.

Q. Okay. And did the other experts give depositions also or --

A. Yes.

Q. -- or reports?

A. No. They gave depositions.

Q. Where was that case filed?

A. Chicago.

Q. And when was it resolved or dismissed?

A. I'm going to say about '87 or '88.

Q. All right. When was the next case that you can recall?

A. And **I** had a case filed claiming I was a Defendant in maybe '95, '96, something like that.

Q. Do you remember the patient's name?

A. No. But she was a patient that I saw at MacNeal who was subsequently transferred to another hospital. As I recall, she died a couple of days later. She was transferred because her HMO wanted her transferred, and actually, she wanted to be transferred too. And the case

was dismissed by the Court €or failure to identify an expert.

Q. Okay. Was that here in Chicago?

A. Yes.

Q. Are the courts here in Chicago referenced as county courts, district courts --

A. Circuit courts.

Q. Circuit courts? Do you remember the circuit court that either of the cases was pending in?

A. Well, it would be Cook County. The circuit court of Cook County.

Q. Any other lawsuits that you can recall?

A. No. You have to understand I was the department chairman at a university hospital for ten years, so I might have been, you know, named as the chairman of the department for actions that involved my department but I might not even know about them --

Q. Let me ask you --

A. -- if I wasn't a principal.

Q. Let me ask it broadly, then. Whether it was you or a resident or an intern or someone within your department that you may have been felt to be responsible €or or somehow

attack?. to from a liability standpoint, have any of those cases ever involved a death or injury from a pulmonary embolus that was allegedly not timely or properly diagnosed

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or treated?

A. No indeed. I don't even know of any cases at zero case, that were filed. But I'm just saying that they may exist and I might not have been notified about them unless I was a primary care giver.

Q. Are you on notice of any lawsuits currently? Has anyone sent you a letter saying they might sue you but they haven't actually filed it?

A. No.

Q. Have you ever had a grievance filed against you by any state authority or any medical entity?

A. No, not that I know of. I presume if I had, somebody would have notified me.

Q. Are you still licensed in both Illinois and Indiana?

A. Yes.

Q. You've never been licensed in the State of Texas, nave you?

A. No

Q. Have you received any training in medicine from the State of Texas?

A. What do you mean? In or from?

Q. In the State of Texas?

A. Well, I've gone to, you know, medical meetings down there. I mean, I can't remember the last time I was

down there, but, you know, the American College of Emergency Physicians has their home office down in Dallas.

Q. Right. Have you attended any continuing medical seminars or anything like that through the American College in Dallas?

A. I -- boy, it's been a long time since they've had a meeting in Dallas. They generally don't meet there.

Q. Have you ever given lectures to lawyers about medical malpractice cases?

A. No. Actually, the only thing I've done at a

A. Well, basically, I said yes, that, you know, I thought that she had pulmonary emboli on her first visit on 4-24. And I thought she had pulmonary emboli on 7-8-96, and I thought that she had recurrent emboli in between.

MR. HAYES: Objection, nonresponsive.

MR. SMITH: What's the basis of your objection?

MR. HAYES: I just don't think he responded to the question.

Q. (By Mr. Steed) Did you ask about whether there were autopsy slides, or did that come up in discussing some of the testimony of Mr. -- Dr. Walton?

A. No. That came up as a response to my answer to Dr. Smith's question. In other words, I answered that I thought that there were probably continuing pulmonary emboli in between the two visits to the emergency department. And he, said, Well, that's really interesting because, in fact, I've had some additional slides made, and a pathologist has looked at them and said, Yes, indeed, there is evidence of chronic embolization.

Q. Who is'the pathologist that has looked at them?

A. I don't know.

Q. Where is he from or she from?

A. I have no idea.

Q. Did you see a report or did he read a report to

you about what that pathologist's findings were?

A. No.

Q. Prior to this morning, then, having reviewed the autopsy report, you were not aware nor did you believe that there were pathology slides of the lung tissue; is that correct?

A. Well, I presumed that there were pathology slides of lung tissue, not that -- just that they hadn't been recut or looked at specifically regarding this issue of chronic embolization.

Q. Did you look at the autopsy report?

A. Sure.

Q. Do you see any kind of microscopic findings on the autopsy report showing what the medical examiner looked at or saw with regards to --

A. No, actually --

Q. -- embolization?

A. I don't recall. We'd have to look. But I don't recall without looking --

Q. Why don't you look real quick?

A. -- the microscopics. But it would be unusual for a pathologist not to do microscopics.

Q. Well, see if you can find one in there.

A. There is not a report in here. It's just that -- there is the notation that they have saved samples of the

viscera in fixative. It doesn't say what the -- that they were eventually sectioned or what they did with them.

Q. In fairness, it's unusual -- if there was tissue taken and preserved and evaluated microscopically, it's unusual that it wouldn't be contained in the report, isn't it?

A. Oh, there'll be an addendum to this report, just -- I can tell you from experience. Sometimes it takes

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it is really important whether this was continued embolization or whether, in fact, this was emboli that were present on April and then may be present -- or some suggestion that they might have been present during specific periods of acute illness in between and then present again in July and whether there were periods in between where there were none. You know, I don't see that that makes any difference in terms of the standard of care.

Q. would it be significant to you at all that if on July the 9th of '96 after all of these Defendants had seen Mrs. McLean she threw a massive clot to her pulmonary tree and that that's what led to her death and that she had no embolization at all before that?

A. I don't think that that's the case.

Q. Well, would that be significant to you if that was the case?

A. Well, I suppose if somebody could say, yes. I mean, you know, if somebody came along and says, Well, I can

tell you that there is no way that she could have had an embolus back in April based on the pathology, I'd say, Well, okay. That's very interesting. Now tell me how, since you don't have the slides from April, because those tissue sections were taken in April, how you could reach that conclusion. I mean, I would be hard-pressed to believe that because I -- you'd have to explain it to me in detail how

you can make that statement.

Q. But in terms of dating the clot that was found during the autopsy, you certainly can't date when that clot was thrown or how long it had been pressing, correct?

A. Well, I'm the wrong guy to do that.

Q. Right.

A. A pathologist might be able to do that on the basis of microscopic sections.

Q. But you can't?

A. But I can't. He could tell you maybe whether there was some organization of the clot and fibrosis and those type of things.

Q. Obviously, if Mrs. McLean threw a massive clot on

July the 9th that caused her to go into distress and arrest and ultimately took her life, that would not be the fault of any of the doctors, would it?

A. Well, you know, no. I mean, if that was a single isolated event, no. But even if that was present, it doesn't mean that she wasn't having emboli back in April or two days earlier and that had those emboli been discovered and the patient been placed on heparin and eventually Coumadin, you know, that -- had those things been done, we probably wouldn't be here today.

MR. HAYES: Object as nonresponsive, everything after the word "no."

Q. (By Mr. Steed) Doctor, you don't believe that putting a patient on heparin or Coumadin precludes that patient from having a pulmonary embolus and dying with it, do you?

A. Not a hundred percent. There are exceptions. But mostly that's why we do it, and it does indeed prevent, you

know, future pulmonary emboli in most patients.

Q. Well: does heparin or Coumadin *or* any type of thinning medication serve to absolve or dissolve clots that are already in existence?

A. That's a different issue.

Q. In other words --

A. It is -- the idea of putting a patient on heparin and Coumadin is to prevent future clots, although there's some evidence, not great evidence, that maybe Heparin -- putting a patient acutely on Heparin does something to accelerate the dissolution of existing clots. But certainly not to the level of thrombolytics and streptokinase and those kinds of things.

Q. And streptokinase and thrombolytic medications can only be used in certain circumstances. There's a strict criteria --

A. Absolutely.

Q. -- isn't there?

A. Absolutely strict criteria, and she didn't meet

any of those criteria, at least on the first two visits.

Q. That being --

A. April,

Q. And July the 8th?

A. Yes.

Q. And in terms of heparin and Coumadin, from a scientific standpoint, there is no science that indicates more likely than not that heparin or Coumadin actually dissolves or absolves existing clots, but rather those drugs simply thin the blood to avoid further growth or accumulation of a clot, correct, or reformation of new clots?

A. Yes.

Q. And there are patients who are detected to have clots -- and let's say deep-vein clots in their legs -- and they're given Coumadin or heparin, and they still throw clots to their lungs and die while on Coumadin and heparin?

A. Yes, that's true.

Q. You're not here today, nor will you be at the courthouse at trial, to render opinions about exactly where the clot came from that took Mrs. McLean's life, correct?

A. That's true. And I by and large think it's irrelevant.

Q. And you're not here and you won't be at trial to testify in terms of how long the clot that took her life

existed, because that's more of a pathophysiological-type opinion, correct?

A. That's also true.

Q. I take it that based on your training and experience if at any time someone would have been suspicious of a possible pulmonary emboli with regards to Mrs. McLean, then the only treatment that would have been available for her would have been admission and giving blood thinners in hopes that the clots would be reabsorbed over time and no new clots would be formed?

DR. SMITH: Objection, form.

A. Yeah, ultimate treatment, that's true. But there would be other things that, obviously, one would do, at least regarding the first episode in April. I mean, you would have put her on oxygen; she had a -- you know, a PO2 that was seriously depressed. And obviously, that wouldn't have made a difference in the long run. You know, you're not going to put a patient on oxygen for long term like this. But for the short term, it should have been done.

Q. And my point *is,* with regards to dealing with what in your opinion ultimately caused her death, and that being the clot that was thrown to her lungs or that existed in her lungs, there was -- to your knowledge, there was no source of treatment for that clot, if, in fact, it existed, other than admitting her and placing her on blood-thinning-type

medications, correct?

A. We don't have enough information to really answer the question scientifically, because had she been admitted, at some point in time someone -- and I'm not necessarily saying it would have been done -- but someone may have done, for instance, a venography of her lower extremities to try to identify the source.

If then she turns out to have some complication from Coumadin or thinning of her blood, there are other therapies available to preventing propagation of clots from the lower extremity, primarily the placing of physical

Q. -- as best you can tell?

A. Yes, sir

Q. Just in your own words and without reading definitions and so forth, if you render opinions in this case that a physician is negligent or violates a standard of care, what do you mean by that?

A. That he has failed to exercise the judgment that a prudent physician would use in a similar case.

Q. How about proximate cause when you use that term in your report?

A. Well, to me, proximate cause means that, you know, without the negligence that we wouldn't have reached the outcome or damages that we did.

Q. What type of birth control pill was Mrs. McLean on at any time from April of '96 up until her death?

A. Apparently, she was on a birth control pill by the name of Demulen, which is a comparatively low-estrogen pill.

Q. Do you know what the estrogen makeup of Demulen is --

A. No.

Q. -- that she was on?

A. No.

Q. Do you know if it's Less than 50 micrograms of estrogen?

A. No. Do I know? No. Do I think it's relevant? No.

Q. And that's because you don't see the birth control pill as being any type of significant risk --

A. No, actually --

Q. -- for pulmonary embolus?

A. No, actually, I do. And in fact, you know, that's what we teach emergency physicians, that birth control pills are indeed a significant, you know, risk for pulmonary embolus.

But I'm a practicing emergency physician, and I also train other physicians. And I can tell you that in almost 30 years when I see a patient who might have a pulmonary embolus because of both symptoms and signs and then either I or someone else has written on the chart "birth control pills," that's enough of a connection for me to make.

I have never, literally, in 25-plus years of practice, then gone to the PDR and found out whether this is a high-estrogen or low-estrogen pill, because don't forget

25 people have pulmonary embolus and die of them who aren't on

1 birth control pills. People have pulmonary embolus and die
2 of them who have actually no predisposing factors
3 whatsoever.
4 So you cannot simply dispose of this as a
5 diagnostic possibility because it's a low-estrogen pill. so
6 I just look at it and say, Well, okay. You know, she's at
7 little bit of increased risk because she's obese and she's
8 got -- she's on birth control pills, and proceed with the
9 workup that would be indicated anyhow in her sort of case.
10 MR. HAYES: Object to that as being
11 nonresponsive, everything after the words, "that's what we."
12 *Q.* (By Mr. Steed) Let me ask you, Doctor: Are you
13 saying that regardless of the estrogen component that the
14 risk is the same for pulmonary embolus to a lady who's on
15 birth control? In other words, whether it's a hundred
16 micrograms or 30 or 50 or a 150?

A. I actually don't know.

Q. Well, have you seen any literature to that effect?

A. Well, I know that that literature came out, gosh, a long time ago. That's why they supposedly developed the low-estrogen pill. But I don't know whether that's held up over the last 10 or 15 years. I mean, I just simply haven't followed that literature.

Q. Are you a member of the American Academy of Family Physicians?

A. No.

Q. Have you ever been a member of that group?

A. No.

Q. Do you subscribe to any of their literature or their information, be it audio, visual, written?

A. No.

Q. Do you agree with this statement: That recent studies suggest that at less than 50 mcg -- and mcg stands for what?

A. Micrograms.

Q. Do you agree that recent studies suggest that at less than 50 micrograms of estrogen the risk of thromboembolic effects are minimal or no greater than in nonusers of oral contraceptives?

A. I don't know. I'd have to -- you know, I'd have to look at the studies that they're quoting. I mean, I have no reason specifically to disagree with it, but I'd want to look at what the references are.

I guess the real question is, is that a -- is that something that the company puts out, or is that a piece of -- or is that a statement that was published in some referee journal. I would tend --

Q. It was in a journal.

A. I would tend to believe it if it was referee journal.

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MR. FREEMAN: Pardon me.

Starting with "I guess" would be nonresponsive.

Q. (By Mr. Steed) Do you look to organizations such as AAFP to provide you with continuing educational

information?

A. I don't look at AAFP. I mean, I look at the American College of Emergency Physicians and the American College of Physicians because those are the two groups that I'm in. I'm not a family practitioner.

Q. Do you have any particular ax to grind with the AAFP? Do you think it's an inferior organization or a --

A. Oh, no, not --

Q. -- subpar organization?

A. Not at all.

Q. When you go to continuing education seminars and you get information, do you factor that into your gestalt, I guess, of information to hopefully improve your ability to diagnose and treat medical problems?

A. Sure.

Q. Are you telling me, then, and will you tell the ladies and gentlemen on the jury that whether the birth control pill that Mrs. McLean was on was 150 micrograms of estrogen or 35 micrograms of estrogen, it's irrelevant to you either way?

A. Well, it --

DR. SMITH: Objection, form

Excuse me, Doctor.

A. It's irrelevant to the emergency physician in terms of evaluating this patient for what she has, because she has some other predisposing factors for a pulmonary embolus and, in fact, even if she didn't, you can have a pulmonary embolus with no predisposing factors.

Q. (By Mr. Steed) What were her predisposing factors to P.E.?

A. Well, she is 250-something pounds and 5 feet 4 inches tall. So she's obese. She's probably sedentary, you know. And I haven't looked at, actually, in much detail what else she might have for predisposing factors, because this whole business of predisposing factors you can look at from a statistical point of view, but they're meaningless in an individual patient, because if you gave me a dollar for everybody who died of a heart attack who didn't have any predisposing factors or died of a pulmonary embolus who had no predisposing factors, you know, I can take a lot of money to the bank.

So, you know, you can't allow the lack of high

A. Yes. That's -- actually, that's the only thing I can think of that I've been told is associated -- that it is associated with, namely pulmonary embolism.

Q. Have you taken the films yourself to confirm that you agree or disagree with Dr. Novotny's description on Page 87 and 88 of his deposition?

A. No. I don't think I've seen the films, and I don't believe that they were sent to me.

Q. Okay. When you send films to a radiologist, do you tend *to* rely upon what the radiologist tells you in terms of what that film shows?

A. Yes and no, in that **I** and emergency physicians, in general, look at all of our films, because, number one, we're in the unique position to know exactly what we're looking for because we're seeing the patient. And number two, about two-thirds of the time in most emergency departments, there is no radiologist. So we have to read our own -- our films ourselves.

So -- and I guess number three is that about once

or twice a month, sometimes more often, sometimes a little less, I find something on a film which is significant that the radiologist has missed, not because I'm better at reading x-rays but because I've seen the patient and I really know what I'm looking for, and he maybe only thinks he knows what I'm looking for.

Q. Well, let me ask you bluntly. You expect your radiologists who are trained to read films to inform you if they see some infiltrate that is classic for a pulmonary embolus, don't you?

A. Yes.

Q. And in this case, if, in fact, the chest film on Mrs. McLean from July the 8th of *1996* showed a wedge-shaped infiltrate, then I take it by your testimony you would expect Dr. Novotny to think that might be associated with a P.E.; is that right?

A. Yes.

Q. Well, certainly, likewise, you would expect the specialist who read that film to have that same degree of concern and point that out *to* Dr. Novotny?

A. Also true, yes.

Q. And although you may have your own interpretation of a film, is it not true that from a radiologic standpoint,

if you and the radiologist disagree on what you think the radiograph shows, that you generally defer to the

radiologist?

A. Generally, yes.

Q. Are you aware that the radiologist advised Dr. Novotny, at least in his report, that he thought the right upper lobe infiltrate was consistent with pneumonia?

A. Yes.

Q. And are you aware that the report is silent as to any concerns or thoughts about pulmonary embolus being the origin of that infiltrate?

A. Yes.

Q. In terms of radiographic evidence, are you aware of any other description of the chest film or the lungs or the surrounding pleural space that is indicative or even consistent with pulmonary embolus besides the wedge-shaped infiltrate that you just mentioned?

A. Well, actually, most chest x-rays are completely normal in patients with pulmonary emboli.

Q. Are you telling me -- I want to make sure I understand this -- that a pneumonia of the right upper lobe would not normally appear as an infiltrate that's wedge-shaped?

A. Yes.

Q. Do you agree that a wedge -- wedge-shaped infiltrate is a nonspecific finding of a pulmonary embolus?

A. Just the fact that it's an x-ray finding

suggestive of pulmonary embolus tells me that it's relatively specific. I mean, I guess I don't know how you're using the term "nonspecific."

Q. Well, let's go with nondiagnostic. It's certainly --

A. Right --

Q. -- nondiagnostic --

A. -- it certainly is nondiagnostic. You know, you need -- you would do other things to confirm the diagnosis. It's highly suspicious, and then you would move to do a VQ scan.

Q. But if nonspecific is meant to mean, as I think it

does, that it might be associated with pulmonary embolus but it's not specific for pulmonary embolus, it could mean other things. I take it by your earlier testimony you would disagree with that?

A. It's -- I think it's strongly suggestive of pulmonary embolus, and I can't think of anything else offhand that it is frequently seen with.

Q. Okay. Going back, then, to some of the symptoms that can be consistent with pneumonia --

A. I suppose you could be -- I suppose you could see it in a mucous plug in one of the tertiary bronchials might cause a wedge-shape infiltrate

Q. Okay. Have you, to your knowledge, ever seen

pleural effusion or atelectasis with a pulmonary. embolus?

A. Yes. You can see atelectasis and pleural effusion. But, again, most often the chest x-ray is normal.

Q. Going back to symptoms of pneumonia, chest tightness, chest tightness without chest pain, either/or can be associated with pneumonia, right?

A. Sure.

Q. Also, you can have an oxygen saturation level that's in the 90 to 95 percentile with problems related to pneumonia --

A. Sure.

Q. -- can't you? How about a PO2 abnormality --

A. Sure.

Q. -- can you see that with --

A. Yeah, sure you could be hypoxemic.

Q. In terms of the arterial blood gas that was done in April on Mrs. McLean, you have cited in your report what the PO2 value was, and you testified earlier, I think, it was 56?

A. Yes, sir.

Q. Do you remember the corresponding 02 saturation reading on the arterial --

A. 90.

Q. -- blood gas? Assume with me it was 88.88 on the blood gas at the time the PO2 was 56. Would you -- are

the -- is the PO2 and the oxygen saturation linear? In

other words, as one goes up, do you have a corresponding increase in the other? And as one goes down, do you have a corresponding decrease in the other one?

A. They do change directly, but they are nonlinear, which is why I brought you a copy of the sigmoid curve that I'm sure that you have seen before.

Q. That's been marked as an exhibit already, hasn't it?

MR. FREEMAN: It has.

MR. STEED: Do you remember which number?

THE WITNESS: You marked it as a group exhibit.

Q. (By Mr. Steed) That's okay. Let me just ask you on this curve.

MR. FREEMAN: I thought it was 9, but I could be wrong.

Q. (By Mr. Steed) I think No. 9 is a multipage document, and the curve is one of those pages; is that right?

A. Yes.

Q. On this document, the longitudinal axis represents the 02 saturation?

A. Yes.

A. Well, it is always the relationship that is -- the relationship is always defined by a sigmoid curve. The sigmoid curve is going to move depending upon other factors, and that's one of the other handouts I gave you. And that is that, as you can see, this --

Q. For the record, we're looking at Page 85 of the

arterial oxygenation text?

A. Yes. And what this shows is what happens when you move the curve either to the right, called shift to the right or shift to the left, and how that affects the difference in various saturations and how they reflect the P02.

What's important is that you can cause a shift to the left as a result of the alkaline pH or a decreased PCO2, which means that you increase the affinity of oxygen to hemoglobin and which explains why you could have, for instance, an 02 sat which is, say, at a higher level but reflects a lower P02.

Q. You understand in this case if you took the

relationship that's depicted on Page 128 and used those numbers for the O2 saturations, then this curve would show the PO2 to be somewhat higher than 56, wouldn't it?

A. Yes. But that's because that curve is drawn assuming a PC02 of 40, and if you adjust this curve by the explanation that's on Page 85, you'll see why the PO2 was actually 56 instead of something higher.

Q. Okay. So Page 85 of what's been marked as Exhibit 9 gives the explanation for why you would see that difference?

A. Yes.

Q. Do you know what the 02 saturation level was on

January the 8th -- I'm sorry -- July the 8th of '96 when my client, Dr. Novotny, saw Mrs. McLean?

A. 93 percent.

Q. Do you agree that that 02 saturation was improved from what it had been in April?

A. Yes. It's higher than it was in April.

Q. Do you agree that patients can have a chronically

a low PO2 that's not related to pulmonary embolus?

9 A. Sure, if they have underlying pulmonary disease.

10 Q. Well, other than underlying pulmonary disease can

11 morbidly obese patients who are deconditioned, can they have

12 a baseline PO2 that is substantially lower than what a

13 normal nonobese conditioned patient might have?

14 A. They might, but in that setting, they would have a

15 normal respiratory rate. And if you have a elevated

16 respiratory rate, what that is telling you is that you are

17 having to breathe faster -- and generally speaking,

18 deeper -- in order to maintain the same level *of*

19 oxygenation, and when the oxygenation is below normal, what

20 you're saying is that you're having to breathe faster just

21 to maintain a subnormal oxygen level and that you can't even

22 get up to normal with the elevated respiratory rate, which

23 is what she had on actually both of those visits.

24 *Q.* Well, you would expect her baseline respiratory

25 rate to be above normal, wouldn't you, given her size and

her deconditioning?

A. No.

Q. You wouldn't?

A. No. As a matter of fact, one of the problems with obese people is that their baseline rate sometimes is less than normal. But obesity, basically, does not affect your respiratory rate.

Q. So in terms of breaths per minute or chest excursions associated with breathing or the labor of breathing, is it your testimony that obesity has no impact on those factors?

A. Oh, no, no. The labor of breathing is increased by obesity, but the respiratory rate doesn't go up as a result of your being obese.

Q. How about chest excursions? That's how the chest moves when you breathe, right?

A. Chest excursion is actually breathing at rest and is related to excursion of the diaphragm, not excursion of the chest.

Q. Would you expect the chest excursion to be at all abnormal for -- or different for the morbidly obese patient versus the nonmorbidly obese?

A, I think it's really more of a function of body

habitus. In ocher words, you have to include height as well as weight, and you have to include girth of the chest. And

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basically, I don't think it's very predictable at all. I mean, I don't think there's a lot of science involved here in terms of being able to predict exactly what you're talking about. But what you can say is that the respiratory rate at rest is not going to be elevated.

Q. Can you say, Doctor, that their chest excursion would be abnormal, generally speaking, if they're morbidly obese?

A. No.

Q. When you talk about a respiration rate being normal, what is the rate range that you're using?

A. I use 20 as the upper limit. Actually, the upper limit is really 18. Twelve to 18 is the real range of normal. But, you know, we would sort of push it up to 20 because -- mostly because of the way nurses count respirations.

Q. And just so I'm clear, you don't see the normal range for a morbidly obese patient in terms of respirations per minute or respiration rate to be any different?

A. That's correct.

Q. Do you agree that you can have pneumonias that are nonresponsive to antibiotics?

A. Sure.

Q. You've seen that, haven't you?

A. Sure.

Q. And have you frequently been called upon in treating a patient for pneumonia to change their antibiotics if their initial antibiotic was not effective?

A. Yes.

Q. Can you be afebrile, or without fever, and have pneumonia?

A. Well, if you're the very young or the very old and you're unable to have a normal immune response, you may have a clinically significant pneumonia, no fever. Most patients who have a pulmonary infiltrate, which is then called a

pneumonia, who have no *fever* are clinically better. And it's just that the radiologic picture of pneumonia resolves much slower than the clinical picture.

And, in fact, what you will see is that a patient comes in with pneumonia, has rales on examination with a stethoscope. He's clinically ill, has a fever and a cough with yellow sputum and the chest x-ray is normal. Tomorrow, as they progress, the pneumonia infiltrate shows up on their chest x-ray. A week from now they're completely better, but they still have the infiltrate on their chest x-ray, and it doesn't go away for another three or four days.

MR. STEED: Object as nonresponsive.

Q. (By Mr. Steed) Let me ask you this: Do you agree with me that you can have a pneumonia and have a patient on antibiotics and have that patient afebrile, or without

fever?

A. Not a normal host. it would have to be an abnormal host.

Q. When you say "host," you mean the organism for the pneumonia?

A. No, I mean the patient. The patient would have to be the very young, the very old, debilitated, leukemic.

Q. Are you testifying --

A. On steroids.

Q. Are you testifying that it would be absolutely impossible for Mrs. McLean to have had a pneumonia and be without fever?

A. Absolutely impossible, no. There's no such -- there's almost no such thing in medicine, but it would be highly unusual.

Q. Does your assessment ever differ from a nurse that sees the same patient you do in the emergency room?

A. Sure.

Q. And if there's a difference in your assessment, do you usually rely upon your training and experience in terms of making your diagnosis and instituting your treatment plan as opposed to that of the nurse?

A. In most circumstances. I mean, there's a couple of circumstances in which everyone recognizes things are really subjective, like, for instance, looking at the whites

of the eyes of somebody who is marginally jaundiced. And if a nurse says to me, Gee, you know, I think their eyes are just a little yellow, and I say, Well, I think they're normal, I do the bilirubin anyhow.

But, you know, when there's a way of objectively resolving the issue, then I move to objectively resolve the issue. If not, you know, I consider what people say and then put stock into what I say as well.

Q. Generally speaking, -- well, strike that.

What would you classify as the normal heart rate for a 30-year-old female?

A. Sixty to 100.

Q. Is the normal heart rate affected at all by morbid obesity, in your experience?

A. Well, actually, the normal heart rate -- I mean, you know, we call it a normal rate between 60 and 100. But, you know, the real honest answer is that -- that individual, 90 percent of those people are going to have heart rates between, say, 60 and 80.

We won't get concerned unless it's over a hundred,

but the vast majority of the people aren't going to be anywhere near a hundred. Obese patients, it sort of depends. At rest, they should have a normal pulse rate. Under, you know, stress, exercise, you know, walking a block, obviously, they're going to get tachycardiac.

Q. Do you agree that stress and exertion can even be as minimal as having a patient who's morbidly obese stand up from a seated position and actually step up on an examining table?

A. Yes.

Q. And to make sure I understand your answer earlier, is the range of 60 to 100 inclusive of what you would think to be the normal range for either the morbidly obese patient, or does it need to expand beyond that minimum and maximum?

A. No. I think that's the normal range. When you see it above a hundred, you have to come up with an explanation. Your explanation may be that they're morbidly obese and you just exercise them a little. But anytime

anyone has a pulse over a hundred, you need to have some sort of explanation for it.

Q. Do you think the 02 saturation rate is equally useful whether it comes from an arterial blood gas or from a pulse oximeter?

A. I think it's more accurate when it comes from an arterial blood gas.

Q. My question was: Are they both equally usable by you, or useful to you?

A. Oh, well, yeah, they're equally usable, but they're not as usable as the actual PO2 from the arterial

blood gas. In other words, because of that business that we showed you with the sigmoid curve and the fact that it moves to the right or to the left, that affects how usable the data is. And it's generally usable data, but it's not precise. If you want the precise answer, you do the P02, which is the arterial blood gas.

Q. Is 02 saturation on the arterial blood gas a calculated number, or is it a deferred or inferred number?

A. Actually, I don't know the answer. I think it's somewhat dependent upon the machine. Machines may measure it.

Q. Do you know what Mrs. McLean's arterial blood gas measured her saturation by --

A. No.

Q. -- whether it was a number that was deducted from the PO2 or some other source or whether it was an actual calculated number?

A. Don't know.

Q. How much time have you spent reviewing this case before today?

A. I don't know.

Q. Pardon?

A. I don't know.

Q. More than five hours?

A. Oh, yeah, sure.

Q. More than 10 hours? Can you give me a range?

A. Well, I spent a good 10 hours yesterday reading this stuff.

Q. How about before yesterday?

A. I suspect that I had spent probably at least that amount of time between reading the materials in the depositions and writing the expert report.

Q. Do you feel that your training and board certification in internal medicine gives you a little more specialized knowledge or ability than what you would generally see in an emergency room physician?

A. No, actually, I don't. I mean, don't forget I ran a training program in emergency medicine for ten years at the University of Chicago. So I have some level of sophistication of those people. And €or at least what we're talking about -- we're not talking about resuscitation. We're talking about, you know, the approach to the patient with shortness of breath and cough and all the things that she had.

And I think that pretty much internists, family practice people and emergency physicians are equally sophisticated in this particular area.

Q. So you would -- you would feel that an emergency room doctor and an internist would have equal training, education and skill in assessing, diagnosing and treating

pulmonary embolus?

A. Yes.

Q. Did you see any evidence of deep-vein thrombosis in Mrs. McLean?

A. Well, no. I mean, there's no evidence on postmortem exam. I don't know that anybody really looked very carefully and, in general, we wouldn't spend much time looking for it, anyhow. And I certainly didn't see any of the physical exams that were done in April or July.

Q. Didn't note any swelling or edema, that type of thing?

A. No. But in ai250 pound, 5 foot 4 individual, you could probably miss a truck in her lower extremities.

MR. STEED: Objection, nonresponsive after "no."

Q. (By Mr. Steed) Do you know how to calculate a body mass index?

A. I'd have to go to the book and look up the formula.

Q. Can you do it today?

A. No. I don't have any books here.

Q. So you can't answer that question today?
A. No.
Q. Do you agree with me that based upon Mrs. McLean's morbid obesity she had decreased life expectancy?

A. Oh, I think that that's probably true, sure.
Q. Do you agree with me that that decrease could have been anywhere from 10 to 20 years?
A. I don't know about the 20. Ten wouldn't surprise me at all.
Q. Do you agree that once a patient, even if successfully treated, has been diagnosed with pulmonary embolism they are more likely than not going to experience a shortened life expectancy from the normal person?
DR. SMITH: Objection, form.
A. If you separate out that group of survivors into those who have recurrent pulmonary emboli versus those who don't?
Q. It's more than 50 percent, isn't it?
A. I mean, I don't know the answer. Obviously, the

people who have a recurrent pulmonary emboli are going to have a shortened life expectancy. Whether the ocher group has -- you know, whether the people who never get another pulmonary embolus have a shortened life expectancy because of something happening with the original embolus or not, I don't know.

Q. Well, let's in fairness take Mrs. McLean. Let's assume hypothetically that she had a pulmonary embolus on the 8th of July and that my client, Dr. Novotny, diagnosed it and that-she did not die. Do you agree that she was at

risk for having recurring pulmonary emboli for the rest of her life given her morbid obesity and the fact that she would have already had a diagnosed episode of pulmonary emboli?

A. Yes, I think that's true.

Q. And certainly, those two factors, the morbid obesity and the fact that she had a pulmonary embolism, would put her at a statistical risk for premature death?

A. Yes, I think that's true. I just don't know how much. And I'm kind of the wrong guy to ask.

Q. Okay. You know, when Mr. Smith told you this morning that it was interesting that you thought that there was chronic embolization here because that's what his pathologist had indicated to him, did he indicate whether his pathologist told him that there was evidence of overlying asthma or bronchitis or other type of lung problems going on with Ms. McLean?

A. Yes, I did, because we had talked about it's very difficult to make the diagnosis of asthma in people who don't wheeze. I mean, how can you make the diagnosis of asthma in people who don't wheeze. There's only one circumstance, and that is when they're short of breath. When they're well intercurrently, they can have no wheezing

But when they're short of breath, if they have no wheezing, they are almost dead. And so then you intubate

them. And as they get better when they start to move enough air, they'll start to wheeze. But there's no such thing as

a patient with symptomatic asthma complaining of shortness of breath who has no wheezing. They said, Well, that's, you know, sort of interesting you say that too, because indeed -- and I had said to him that only one person of all these visits had ever heard any wheezing.

He said, Well, you know, that's interesting too, because the pathologist says there's no evidence that she ever had any asthma, which -- which is what I thought all along.

Q. Do you know where the tissue samples were taken that this pathologist has reviewed for Mr. Smith?

A. No.

Q. From what area of the lungs or --

A. No. I presume that there would be some tissue samples from both the upper lobe that had the wedge-shaped infiltrate as well as some other part of the lung that was not apparently affected with the infiltrate.

Q. Besides what you anticipate, do you know for a fact where any or all of the lung samplings were taken for the microscopic pathology?

A. No, sir.

Q. Do you agree that Ms. McLean's 02 saturation 1eve1 had improved by time she saw Dr. Novotny?

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A. Well, let me just double check here for a minute.

Q. Assume with me it was 93 percent on room air and had never -- or Let's assume it was at 93 percent on room air. And let's assume that on the arterial blood gas it was 88.8 percent, and on room air it was 90 percent during part of the visit in April.

A. Well, but also in April there was one measurement that was 94 percent. So the answer is, well, it was a little improved over the lower one and a little less than the best one she had.

Q. How many 02 saturations were obtained in April?

A. Looks like three.

Q. Including the arterial blood gas?

A. Four.

Q. And his reading in July was better than three Of those four?

A. Yes.

Q. You never saw any evidence that any doctor or

nurse actually observed any productive red phlegm or sputum from Mrs. McLean, did you?

A. No.

MR. STEED: I'm going to go ahead and pass the witness so Larry can have a chance to ask as many questions as he needs to. I might have some follow-up for you later on.

(Recess at 3:25.)

E X A M I N A T I O N

(On the record at 3:40.)

BY MR. HAYES:

Q. Dr. Baker, my name is Larry Hayes, and I represent Dr. Welch in this lawsuit. You said you had determined that the blood gas was taken about an hour after the treatment --

A. Yes.

Q. -- that was administered? How did you make that determination?

A. Actually, there's reference to it made in the depositions as well as the medical record. Once I had read

it in the deposition here, I went back and --

Q. Well, what specifically did you look to --

A. -- looked at the timing.

Q. -- that told you that the one thing you left out of your report was that the blood work appeared to have been taken about an hour after treatment?

A. Because I had not noticed on the blood gas analysis that it says the time that it was done was 1400 hours here. It's written on the blood gas slip as well as on the emergency department nursing record where it says 1415 ABGs obtained. Actually, you couldn't read that number originally, and I managed to come over -- across it again

last night.

Q. Well, when did you determine the treatment was given?

A. Well, the treatment, let's see, is -- that's actually referred to in, I think, one of the R.T.'s depositions, and then there is someplace else here. Oh, here. It says here 1:20 Ventolin, and then there's -- it's initialed by one of the respiratory therapists here.

Q. Well, how does that tell you when the treatment was done?

A. It says 1:20.

Q. 1:20 is when you interpreted the treatment was done?

A. Yes.

Q. Based on your review of the records?

A. Right. It says 1320, and it's 1400 or 1415 that the blood gas was drawn.

Q. Where do you see 1320?

A. 1:20 is 1320 in military time.

Q. And you can make out a 1:20 written where, next to where it's noted?

A. Next to where it says Ventolin.

Q. All right. Did you see anything that raised any questions in your mind in reviewing the records as to when the treatment was given?

A. The Ventolin treatment?

Q. Right.

A. That's it right there.

Q. All right. That wasn't my question. My question is: Did you see anything in the records which raised any question in your mind as to when the Ventolin treatment was given?

A. I don't understand your question, then.

Q. Well, if you did, tell me; if you didn't, tell me no.

DR. SMITH: Objection, form.

A. I don't understand what you're asking me.

Q. (By Mr. Hayes) I said in your review of the records, did you see anything that raised any question in your mind as to when the Ventolin treatment was given?

A. No.

Q. Okay. You looked up some stuff on blood gases. Why did you do that and give us copies here before your deposition started?

A. Well, because I see my job as having to educate you as well as the jury.

Q. Well, why did you look up articles on blood gases?

A. Because I didn't think that you folks, not being a physician, would understand the oxyhemoglobin disassociation curve and the effective changes of PC02 on the alkalinity on

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the movement of that curve from right to left.

Q. It wasn't because you weren't all that familiar with the oxygen disassociation curve?

A. I'm intimately familiar with it. I teach it every day.

Q. You just looked that up to help us out?

A. I even gave you handouts

Q. In order to help us out, right?

A. That's absolutely right.

Q. Now, this -- what is your understanding *of* what a normal Pa02 would be?

A. Well, the majority of adults are going to have a normal that's in the 90 to a hundred range, although there are going to be some adults who go down to as low as 80 and maybe even 75 as normal.

Q. All right. So between 75 to a hundred would be a normal PaO2?

A. No, because you should consider any patients you see with a Pa02 of less than 80 as having an abnormal PaO2.

Q. All right.

A. Even though for them below 80 might be normal If you're seeing it on a one-time basis and you don't have a track record to prove that, you know, their Pa02 between 75 and 80 is normal for them, you need to assume that it's

abnormal

Q. Okay. Is the normal or abnormal Pa02 affected by the PCO2?

A. No, oxygen saturation is.

Q. I was asking specifically --

A. Right, right.

Q. -- about --

A. Pa02 is not affected by PaCO2.

MR. FREEMAN: I apologize. I didn't get that, and it was probably just my error in hearing. Can you say what you just said again, please, sir?

A. Sure. PC02 affects oxygen saturation, but it does not affect PaO2.

MR. FREEMAN: Thank you.

I apologize, Larry, for the interruption.

Q. (By Mr. Hayes) What is the knee of the curve?
A. What is the what?
Q. Knee of the curve.
A. The knee of the curve is the part of the curve where it's becoming vertical. It's changing from horizontal to vertical.
Q. Can you tell by looking at the oxygen saturation whether or not the Pa02 has increased?
A. Not precisely, because it's affected also by PCO2 and by alkalinity.

Q. Well, can you take a reading of -- a pulse oximeter reading of the 02 saturation and estimate what the Pa02 might be in a patient?
A. You can estimate as long as you understand that it's an estimation. And if you really want to know the real answer, you have to do an arterial blood gas and measure the Pa02.
Q. Well, let me ask it a different way. Can you correlate 02 saturation with what the arterial pressure of

oxygen might be in the bloodstream?

A. Only roughly.

Q. Can people's oxygen saturation remain the same or very close on a pulse oximeter reading but yet their Pa02 increase?

A. Yes, if the PC02 is changing.

Q. what if the PC02 remains the same? Can the Pa02 increase?

A. No, not without changing either PCO2 or alkalinity or temperature.

Q. What's the PVO?

A. The venous oxygen.

Q. All right. And a normal -- what's a normal venous oxygen?

A. Between, say, 38 to 42.

Q. Now, you told us that the -- if the PC02 changes,

it could cause a shift in this oxygen disassociation curve?

A. PCO2, yes.

Q. If the PC02 remains in the normal range, would

that cause a shift to the left of the oxygen disassociation curve?

A. Well, if the PC02 remains fixed, the curve doesn't move right or left.

Q. All right. What if it stays in the normal range? Will it --

A. Well, it's not a matter of whether it's in normal range. It's a matter of whether it's up or down. In other words, if you measure it at one point and then the PC02 changes, it's going to move the curve. It doesn't make any difference whether it's in the normal range or not, the curve's going to move.

Q. How readily can the Pa02 change?

A. Pa02 can change from minute to minute -- I mean, literally, minute to minute -- and so can the PCO2.

Q. Is there any way to correlate or estimate how fast the Pa02 can change? I mean, like, so many millimeters in one minute, or can it make --

A. It can make huge changes in a matter of a minute.

Q. In the area of pulmonary embolism, what is the most common symptom that patients have complained of in those patients you've seen that have pulmonary embolism?

A. Shortness of breath, dyspnea.
Q. What's the next most frequent symptom they complain of?
A. Chest pain.
Q. What type of chest pain?
A. I think you'd have to say sort of nondescript, because not -- the majority of them don't have pleuritic chest pain. Pleuritic chest --
Q. The majority of the ones that you've seen didn't have pleuritic chest pain?
A. Well, pleuritic chest pain implies pulmonary infarct, and there's a lot of patients with pulmonary embolus who don't have pulmonary infarct.
MR. HAYES: Objection, nonresponsive.
Q. (By Mr. Hayes) Are you saying the vast majority of the patients you've seen with pulmonary embolism did not have pleuritic chest pain?
A. The vast majority, no, I can't say that. I'd actually probably say that half or more of them did have pleuritic chest pain.
Q. All right. And how would you describe to the jury what pleuritic chest pain was?

A. Chest pain that either comes on or is worsened by deep breathing, taking a deep breath. In other words, you get it when you inhale

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Q. Is the -- where is pleuritic chest pain located, typically?

A. Anterior, lateral or posterior chest.

Q. Anterior lateral means on the side?

A. Anterior or lateral or posterior. Yes, lateral meaning on the side.

Q. The shortness of breath, do you -- can you -- I think you used somewhere "severe shortness of breath." What is severe shortness of breath to you?

A. I don't use the term mild, moderate or severe, because it varies from observer to observer. I mean, what you really need to talk about is objective criteria. So you look at things like respiratory rate, oxygen --

Q. What's a severe shortness of breath as far as respiratory rate is concerned?

A. Well, you know, severe is -- like I say, what's

severe to you may not be severe to me --

Q. I'm talking to you --

A. -- following hypoxia.

Q. -- as a doctor in the emergency room --

MR. FREEMAN: Pardon me. I apologize. With y'all talking at the same time, I can't keep track of what's being said. And it's my fault, but could y'all one or the other talk at a time, please, sir?

Q. (By Mr. Hayes) You said you looked at the

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respiratory rate, right?

A. Yes.

Q. What do you consider to be severe shortness of breath as seen by the severe respiratory rate?

A. 24 to 28 or more.

Q. And what would you describe as moderate shortness of breath?

A. 22.

Q. To 24?

A. Yeah, 22 to 24.

Q. And mild?

A. Actually, mild shortness of breath may not have an increased respiratory rate at all. It's just a subjective feeling.

Q. Is much of what -- as far as shortness of breath, is that a sensation that the patient may have?

A. Yes.

Q. It's a subjective feeling they have that you may not necessarily always be able to detect objectively, right?

A. Yes, I agree.

Q. In other words, people tell you, I feel short -- have you had people tell you, I feel short of breath, and you could not tell by looking at them that they had that feeling?

A. Yes.

Q. Is that more commonly the case?

A. I wouldn't say it's more commonly. I'd say mostly when people say they feel short of breath that, in fact, they have an increased respiratory rate. And what you described is actually the minority, but it does indeed

occur.

Q. All right. After shortness of breath and chest pain, what's the next most frequent symptom you have seen in patients with pulmonary embolism?

A. Well, the next most frequent thing that you're going to see, of course, is tachypnea, that is objective increase in a respiratory rate, say, greater than 16.

Q. Well, now, that's a sign, isn't it?

A. Yeah. That's a sign.

Q. I'm talking about symptoms.

A. Symptoms, after that, you know, it's a toss-up. I mean, there's no -- there's no other -- those are the two major symptoms and everything else is sort of about equal. And they range from cough to hemoptysis to palpitations, which is the -- you know, their feeling of a tachycardia in the chest.

Gosh, it could include everything from sore calves to lower abdominal pain to a feeling of impending doom. I mean, there's just -- there's a lot of symptoms.

Q. But other than --

A. But they're ail less than 50 percent.

Q. All right. But so that -- other than the most frequent symptom of shortness of breath and the second most frequent of chest pain, you can't determine a third most frequent, is that right, what you're telling us?

A. Yeah, that's all true. I don't think there's anything else that one sees in more than half the patients.

Q. All right. Tachypnea, though, is a sign. Is that the most common sign that you --

A. Yes.

Q. And tachypnea means rapid respiratory rate?

A. Yes

Q. And here again, are you using the same kind of criteria as you did with the shortness of breath and looking at the respiratory rate that severe tachypnea would be 24 to 28?

A. Yes. And I actually think when you look at the statistics on tachypnea that the threshold that they generally use is either 16 or 18.

Q. Well, 16 --

A. They're not talking about a lot of tachypnea. They're just talking about small amounts of tachypnea.

Q. Well, 16 to 18 would be in the normal range, you told us

25 A. Yes, absolutely.

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1 **Q.** So is it normal to be that tachypneic?
2 A. Well, what they're talking about is breathing
3 that's in what we might call the high normal range. In
4 other words, none of us here at this table are breathing 16
5 times a minutes or even 18 times a minute. We're probably
6 all breathing 12. Except for the guy at the end of the
7 table -- he smokes.
8 MR. FREEMAN: Objection, nonresponsive.
9 Don't talk about Larry that way. It's just
10 not nice.
11 Q. (By Mr. Hayes) You made the statement that you
12 pushed it up to 20 because of the way nurses count
13 respirations. How do nurses count respirations differently
14 than doctors?
15 A. Nurses generally count respirations by counting
16 the number of breaths for 15 seconds and multiplying by
17 four
18 Q. And how do doctors do it?
19 A. They count for a minute.

MR. FREEMAN: Move to strike my own sidebar to the extent that ever made it close to the record.

Q. (By Mr. Hayes) So if you count by 15-second intervals and multiply, then you can be off in what normal is, right?

A. Well, yes, that's right, because, you know, the

difference between four or five breaths in that 15 seconds makes a difference between 16 or 20. So, you know, if you're looking at a nursing rate, okay, we'll accept 20 as being, you know, the upper limit of normal.

Q. And six breaths in 15 seconds, it would be 24, wouldn't it?

A. Yes, that's right.

Q. Throw them up into severe tachypneic and short of breath?

A. Well, but 24 is clearly abnormal. 20 is just sort of borderline.

Q. In the emergency room you've worked in, have you instructed the nurses to count for a minute instead of 15

seconds and multiplying by four?

A. No. They don't do it.

Q. Have you reviewed -- other than these articles you brought in, have you reviewed anything else in preparation for your deposition?

A. No, sir.

Q. For example, did you review anything in the -- in the emergency medicine text that you were involved in relating to pulmonary embolism?

A. Well, that's where that came from.

Q. Well, one of these pages did, but did you review anything on pulmonary embolism in the textbook that at one

point in time you had connection with?

A. I reviewed the -- you know, the pages that this stuff came from. Well, let's see. Actually, the chart on Page 128 didn't come from the chapter on pulmonary embolism from Rosen's book. It came from a chapter on oxygen transport, so I just looked at that page.

The Page 56 with the Table 9.5, which relates to oxygen hemoglobin saturation and plasma PO2, that came from -- I think that came from Bob Wilson's chapter on resuscitative problems and techniques out of Tintinalli's book. It's either that or Dr. Hockberger's chapter on pulmonary embolus, and I don't recall which.

But I was specifically looking for a table that related those two because of reference in the doctor's depositions and the nurses as well that they had a difficult time relating PO2 to oxygen saturation.

MR. HAYES: Objection, nonresponsive.

Q. (By Mr. Hayes) My question was, simply: Did you review the portion of the emergency medicine textbook you were involved in on pulmonary embolism?

A. No.

Q. Did you review anything, for example, in Tintinalli from pulmonary embolism?

A. No, just this page.

Q. Do you know that both of those books do have

chapters on pulmonary embolism?

A. Oh, sure. You made reference to one in -- or someone made reference to one In Tintinalli's book written by Dr. Hockberger. I know him because I trained him. And I know for a fact that there is a chapter on pulmonary embolism in Rosen's textbook, because in the first two editions I edited it.

Q. All right.

MR. FREEMAN: Objection, nonresponsive.

Q. (By Mr. Hayes) Would you agree with the statement a pulmonary embolism has been known to mimic many serious and benign medical disorders?

A. Yes.

Q. Would you agree that chest pain is the most common symptom, occurring in approximately 90 percent of the patients?

A. Yes.

Q. Would you agree that while pain --

A. Well, no. I think I actually said shortness Of breath. But they're close.

Q. So you would say the chest pain -- you would not disagree with a doctor if he made the statement it is the most common symptom occurring in approximately 90 percent of the patients?

A. Yeah. I wouldn't disagree with that.

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Q. Would you likewise agree that while the pain is usually pleuritic in nature, it may mimic the pressure-like pain of myocardial ischemic, as well as the vague discomfort of nonspecific chest wall pain?

A. That's clear. Yes.

Q. Did you see -- in connection with the visit of April 24th of 1995, did you see anywhere in the record that Ms. McLean made any complaints to any nurse or to Dr. Welch of chest pain of any type?

A. No.

Q. All right. There's nothing in there, is there?

A. No.

Q. And I assume you looked to see whether or not she did make a complaint of the most common symptom of pulmonary embolism?

A. Well, I noted that chest pain wasn't in there, yes.

Q. In fact, Dr. Welch's examination indicates that she denied any chest tightness, correct?

A. Well, she denied any chest symptomatoiogy at all, including wheezing.

MR. HAYES: Object to the last part as nonresponsive.

Q. (By Mr. Hayes) She did complain of cough, did she not?

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A. I have to look here €or a minute. I'm sorry. She did complain of, actually, dyspnea as well, yes.

MR. HAYES: Objection, nonresponsive.

Q. (By Mr. Hayes) My question is: She did comp1ain of cough, did she not?

A. Yes.

Q. Dyspnea means shortness *of* breath?

A. Yes.

Q. Or trouble breathing?

A. It specifically means difficulty breathing, yes.

Q. All right. Do you use these schematic -- or have you ever used these schematic forms with respect to symptomatology in the emergency room?

A. No.

Q. You know they're commonly used, do you not?

DR. SMITH: Objection as to form.

A. You mean these pro forma forms regarding history and physical examinations?

Q. (By Mr. Hayes) Right.

A. Actually, no, they're not very commonly used.

Q. Do you know that for a fact?

A. Yes. After reviewing charts from hundreds of hospitals, I can tell you that I've seen these -- you can count them on one hand the number of times I've come across these kinds of charts.

Q. In your legal cases, you can count them on one hand. Have you made any survey as to how frequently they're used in hospitals?

A. No.

DR. SMITH: Objection as to form.

Q. (By Mr. Hayes) At least from the records, it indicates that she described her trouble with breathing as mild, does it not?

A. Yes.

Q. She did not describe severe -- or feeling a severe shortness of breath, did she?

A. That's true. Well, at least that's not -- that's what's recorded here.

Q. Well, do you have any reason to think that people were putting down things other than what she said?

A. Well, she's breathing at 28 times a minute, and she has a PO2 of 56. That's all pretty severe, from my point of view.

MR. HAYES: Objection, nonresponsive.

Q. (By Mr. Hayes) Do you have any basis for drawing any conclusion that people were putting things down in the chart that she didn't say?

A. I just answered you. You know, she's breathing at 28 times a minute with a PO2 of 56. That doesn't sound like mild shortness of breath to me. No sound P -- along with a

PO2 of 56. People die with PO2's of 56.

MR. HAYES: Objection, nonresponsive.

Would you read my question back, please?

(Requested portion read back.)

A. I answered it.

DR. SMITH: I'll object as to form.

Q. (By Mr. Hayes) So you can't answer that, Doctor?

A. I did answer it.

Q. Other than the way you just answered it.

A. I did answer it.

DR. SMITH: Objection to sidebar and objection as to form.

Q. (By Mr. Hayes) Well, did you correlate the history that's recorded in the chart that the -- with her history that can be gleaned from other sources?

A. Well, I don't know of any other sources.

Q. Did you do that?

A. Well, she hasn't been deposed because she's dead, so we can't ask her. So I don't know what other sources you'd be referring to.

Q. Did you look at any other medical records?

MR. FREEMAN: Pardon me. Objection, nonresponsive.

A. Did I do what?

Q. (By Mr. Hayes) Did you look -- did you look at

Dr. Godfrey's medical records?

A. I don't think Dr. Godfrey saw her on the 24th

Q. That wasn't my question, Doctor, and I think you know it wasn't.

DR. SMITH: Objection to the sidebar.

Q. (By Mr. Hayes) Did you look at any other medical records with respect to Ms. McLean?

A. Sure.

Q. Did you look at Dr. Godfrey's records?

A. Sure.

Q. Did you look at the records from the obstetrician and gynecologist that she saw?

A. Sure.

Q. All right. Now, do those records indicate that she had hypertension with her prior pregnancies?

A. Actually, I don't recall.

Q. Did they indicate that she'd had a problem with irregular periods?

A. Yes.

Q. All right. That information is contained in the history that was taken by Dr. Welch, isn't it?

A. Actually, I don't recall.

Q. All right. Well, take a look, Doctor.

A. Yes.

career nor in any *of* your studies nor in any of your readings have you seen any reports of patients experiencing bronchospasm where they were not wheezing?

A. Only patients who are in need of being intubated and put on a ventilator.

Q. Well, is that different than dying?

A. No. It's premorbid. What it means is that you're not -- if you have bronchospasm and you're not wheezing, it means that you're not moving enough air to cause turbulent

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airflow, which means that you're very close to having your cardiac arrest. And if you manage to get those patients before they arrest, treat them with Albuterol and reverse them, as they get better they will start to wheeze.

Q. How many patients do you think you've seen with bronchospasms in your career?

A. Thousands and thousands. Almost not a day that goes by in the emergency department that you don't treat at least two or three.

Q. Do you use Ventolin treatments for patients with bronchospasms?

A. Sure.

Q. Do patients with bronchospasms who undergo Ventolin and -- what's the other one -- Adovent, do you use that too?

A. Ativan, no. Atrovent, you mean.

Q. Yeah.

A. Atrovent, yes, sure.

Q. Do you use that in combination --

A. Sure.

Q. -- with Ventolin as ordered by Dr. Welch?

A. Sure.

Q. And would you expect to see improvement in a patient with bronchospasm who undergoes Ventolin with Atrovent -- how do you say that again?

A. Atrovent.

Q. -- Atrovent updraft therapy?

A. Oh, sure.

Q. And the reason being is because the drugs will help open up the airways, right?

A. Absolutely.

Q. Do the records indicate that Ms. McLean improved while in the emergency room?

A. Well, I think the answer to that is the records would suggest that subjectively Dr. Welch thought that she improved, although there's no objective evidence that she really did. As a matter of fact, the last three sets of vital signs were not accompanied by either a higher respiratory rate, and the last two sets of vital signs were accompanied by a decrease in her oxygen saturation.

Q. Were vital signs normal at 1725?

A. 1725, yes, for all intent and purpose. She's just a tad hypertensive but nothing that anyone would pay any attention to.

Q. Do the nursing records indicate that she was improved upon discharge?

A. Yes.

Q. Did the records indicate that she was walking when discharged?

A. Yes.

Q. Do you have any reason to think that if she had an abnormal respiratory rate at discharge when the nurse took her blood pressure and pulse rate that the nurse wouldn't have noted that, that it was abnormal?

DR. SMITH: I'm going to object as to form.

A. I think if the nurse had done it, it would be written down, period, whether it was normal or abnormal because it's a particularly critical vital sign in someone who complains of being short of breath when she came in and, in fact, who had an elevated respiratory rate that was significantly hypoxic, as demonstrated by both an oxygen saturation and a measured P02. So whether it's normal or abnormal it clearly should have been recorded and is a key vital sign in this patient.

Q. Well, is the important thing --

MR. FREEMAN: Pardon me. I apologize. Objection, nonresponsive.

Q. (By Mr. Hayes) Is the important thing as to whether or not the respiratory rate was normal or whether it was written down?

A. Well, obviously, it's important as to whether it was normal or not.

Q. Do you -- in your hospital, do nurses always write

down every normal finding that they make?

A. No, obviously not. But when they do discharge

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vital signs, they write down all the vital signs that they measure.

MR. FREEMAN: Objection, nonresponsive starting with "but." Starting with the word, quote, but, end quote.

Pardon for the interruption, Doctor.

Q. (By Mr. Hayes) Can you have sinusitis and not have an abnormal x-ray?

A. Well, you can have nasal congestion, but you really can't have sinusitis, per se, with a normal x-ray.

Q. So you've never seen a patient who had a sinusitis that when you ordered an x-ray of the sinuses didn't have a normal chest x-ray?

A. Well, you know it -- it's sort of splitting hairs. Do they really have that disease, or do they just have nasal congestion? And the answer is when we tag them with the diagnosis of sinusitis but they don't really have it, what

you're treating is nasal congestion. And that's okay. It doesn't make any difference clinically, because you treat them the same way. But I think you're hard-pressed to make the diagnosis of sinusitis without an x-ray.

Q. So what --

A. At least when the x-ray is negative, no.

Q. Is what you're saying is you may suspicion

sinusitis, a patient may think they have sinusitis and it may just really be nasal congestion that doesn't show up on x-ray?

A. Yes.

Q. All right. Roentgenograms are x-rays, aren't they?

A. Yes.

Q. Would you agree with the statement that roentgenograms of the chest are, however, most often abnormal in pulmonary embolism?

A. Are most often abnormal? Well, no, actually I disagree with that.

Q. And that's based on your experience?

A. That's based on my experience.

Q. Do you know --

A. Actually, the rule-of-thumb teaching is if you have a clear chest x-ray and the patient is hypoxic, think pulmonary embolus.

MR. FREEMAN: Objection, nonresponsive.

THE COURT REPORTER: Would you repeat your answer, please?

THE WITNESS: Sure

A. The general teaching to resident staff is that if you have a clear chest x-ray and you're hypoxic, think pulmonary embolus.

MR. FREEMAN: Madam reporter, did you get the objection to the responsiveness?

THE COURT REPORTER: Yes, sir.

MR. FREEMAN: Thank you.

Q. (By Mr. Hayes) Do you know whether Dr. Hockberger's experience would be different than yours?

A. I can't imagine, because I taught Dr Hockberger, both as a student and as a resident. And as a matter of

fact, he was one of my junior faculty members.

Q. So if he said --

MR. FREEMAN: Pardon me. After "I can't imagine" would be nonresponsive to the question actually asked.

I apologize for the interruption.

Q. (By Mr. Hayes) Would you agree with this statement: A chest x-ray in nearly half of all patients with acute P.E. would show an elevated dome of one hemidiagram -- diaphragm.

A. I'd be really surprised if that's true. Are we talking about massive P.E.s, or are we talking about all P.E.s?

Q. Acute P.E.

A. Well, but if he's quoting a study, you have to decide whether this is patients with massive P.E.s or all patients with P.E.s, because there's a big difference.

MR. FREEMAN: Objection, nonresponsive.

DR. SMITH: I'll interpose an objection as to form. And it's vague and ambiguous

MR. FREEMAN: Oh, no, that's too much

objection. I think you're getting entirely -- way too carried away with these objections.

Q. (By Mr. Hayes) Did you make the statement -- sidebar.

MR. FREEMAN: Move to strike my own I apologize for interrupting.

Q. (By Mr. Hayes) Did you make the statement earlier that asthma was one of the diagnoses of Dr. Wells?

A. Welch, you mean. Yeah, it was.

Q. And where did you get that idea?

A. Because he was treating the patient with asthma medicine, particularly updraft treatments with Ventolin and Atrovent. That's what those things are for.

Q. Only for the treatment of asthma?

A. And for the -- actually, they're the treatment for bronchospasm, and I can't think of any other disease that you would use them for.

Q. So as far as you know, the only type of bronchospasm seen is in patients who have asthma?

A. No. Actually, you can see bronchospasm in, quote, reactive airway disease, which is a little bit different than asthma, but the differentiation is not going to be made

on the basis of a single exam in the emergency department.

Q. Well, did you see anything in the records where Dr. Welch concluded or it was his impression that the patient had asthma on that visit?

A. Well, actually, it turns out that's not even on the differential diagnosis here under "Clinical Impression." I mean, asthma doesn't appear even as one of his options. So I guess you're right. There is no actual diagnosis here on the -- on his discharge the patient has asthma.

Q. Well, his clinical impression was acute dyspnea, right, one of them?

A. And sinusitis, and bronchospasm and hypoxemia.

Q. You've got -- do you have those copies of the depositions there?

A. Yeah.

Q. You've got a comment of "rubbish" next to certain things. On Page 56, Line 15, there's a discussion there about sinus drainage coming down the superior pharynx where the adenoids are in the back of the sinus. Do you see that?

A. Right.

Q. What's rubbish about that?

A. Because he says, "Your diagnosis *of* sinusitis was based on what, facial pain?"

"That was one aspect of it," answer.

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"Anything else?"

"The physical examination, seeing purulent drainage out of the back of her paranasal sinuses." You can't see the back of your paranasal sinuses. So then he goes on to say, "Well, some drainage in the back of the throat, that's correct." But you can't tell whether that's coming out of the sinuses or not.

He says, question, "Can you make a determination that that came out of her sinuses?" Answer, "Yes, sir." That's rubbish.

Q. Okay.

A. I mean, you can tell that there's exudate in the back of the throat, but he can't tell that it came out of the sinuses because he can't see the back of the sinuses

Q. But you can certainly draw that conclusion just by seeing the exudate, can't you?

A. No. How can you do that? I mean, well, how do you know that it's just simply not a pharyngitis? How do you know it's sinusitis?

Q. Sinusitis and pharyngitis, can they sometime go together?

A. Sure. But that's not what he's saying. He's saying he knows it's from the sinuses. You know, you can't say that.

Q. Can infection cause interstitial lung disease?

A. Certain kinds of environmental infections can cause interstitial lung disease. Bacterial pneumonia doesn't

Q. What type of environmental infections?

A. What kind of what?

Q. Viral infections can cause interstitial lung disease?

A. Oh, I guess respiratory syncytial virus, RSV.

Q. All right. Any others?

A. Not that I can think of

Q. This group of lawyers you taught to do CPR, what

group of lawyers was that?

A. American College of Legal Medicine

Q. And when did you do that?

A. Oh, gosh, back in the late 1970s.

Q. And you put on a demonstration of CPR?

A. No. We -- I hold a bunch of faculty from the University of Chicago. And a group of nurses and about io of us went down there and taught maybe a hundred attorneys, put them through a CPR course.

Q. In conjunction with their meeting --

A. Yeah.

Q. -- so they could get --

A. Yeah.

Q. -- certificates?

A. Right. Right. They actually got their certificates.

Q. These slides that Mr. Smith told you about, did he tell you when these slides were made?

A. No.

Q. Did he tell you anything about why -- I gathered from what you said, he at least gave you this impression,

tnat he was the stimulus for these slides being made from the tissue, right?

A. I think that's true, yes.

Q. All right. And did he give you any indication as to why he, the lawyer, was the stimulus in getting these slides done of the tissue from the autopsy?

DR. SMITH: Objection as to form.

A. No.

Q. (By Mr. Hayes) Did you ask him?

A. No.

Q. Weren't interested?

A. I presume --

DR. SMITH: Objection, form.

A. I presume that it was really for two things, one -- and I think both of them we talked about, one being whether there was any evidence of pulmonary embolus elsewhere and whether there was evidence of chronicity of a pulmonary emboli.

Q. You would agree that Mrs. McLean was what is called in medical terms morbidly obese?

A. Yes.

Q. And just kind of transfer into lay terms what morbidly obese means when that term is used?

A. Well, it means that her obesity is such that it's going to have some effect on her life expectancy.

Q. And I think you agreed that -- did you see in her history that she had an 80-pound weight gain over a period of about four years?

A. I didn't notice that, no.

Q. You would agree that would be a rapid gain of weight, wouldn't it?

A. 80 pounds over four years? Not particularly. I mean, the lady is morbidly obese. You know, if she had gained 80 pounds in, I guess, six months I would agree with you. But 20 pounds a year I don't see as any great problem in terms of the rapidity. What she ended up with, obviously, was a difficult problem to deal with.

Q. Did you see where at one point in time she weighed as much as 275 pounds?

A. No

Q. Okay. Would you agree that someone who -- that heavy and that height and working in a sedentary job would probably be deconditioned?

A. Oh, sure.

Q. Meaning they would probably experience shortness of breath, particularly on exertion, right?

A. That wouldn't surprise me at all.

Q. All right. And the exertion that may produce shortness of breath can vary, can't it?

A. That's true.

Q. Depending on how deconditioned you are, even a slight amount of exertion may cause that person to become short of breath?

A. Yes.

Q. Their respiratory rate increase?

A. Yes.

Q. Them having that sensation of being short of breath, right?

A. Yes

Q. The -- how often is shortness of breath a complaint in an emergency room setting?

A. Well, it's not rare, by any stretch of the imagination. It isn't sort of one of the top three, but, you know, it's frequent. I mean, there's not a day that goes by that I don't see people who are short of breath, in fact, more than one.

Q. So in that 24 hours you maybe worked last week,
you probably saw at least six or so people who complained of

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shortness of breath?
A. Oh, sure.
Q. Did you do a blood gas on every one of them?
A. No. I would start out with doing an oxygen saturation on all of them, and not necessarily go to a blood gas.
Q. All right. What's the lowest 02 saturation you saw last week by pulse oximeter?
A. I don't remember.
Q. Did you have any in the low 90s?
A. Oh, probably did, sure, because most patients with pneumonia who complain of shortness of breath are going to have an 02 sat that's 95 or less.
Q. Going back to this reactive airway disease, are you going to see that -- evidence of that on autopsy?
A. Well, the classic -- classic reactive airway disease is something that you're really talking about in

kids. This is the kid who gets a cold and he starts to wheeze when he has a cold, but he doesn't really nave asthma. And when you check in -- in between -- when he has no cold, he has normal spirometry and he has normal lung function and only has wheezing when he gets bronchitis.

Q. Can adults get reactive airway disease?

A. Unusual unless they have some particularly unusual exposure to something.

Q. But you do see it from time to time?

A. Yeah, I suppose you could see it. But it would be decidedly unusual to see -- well, in those people with reactive airway disease, when they're symptomatic they're wheezing.

Q. Always?

A. Always. It's how you make the diagnosis. They're wheezing.

Q. What's the difference -- what is labored breathing? You used that term.

A. Labored breathing really means that subjectively you're having difficulty. That term is dyspnea, meaning I

subjectively am having a difficult time breathing. But if you observe most of these people, the objective criteria is that they are breathing faster and deeper, and they're having some -- a difficult time. It's more effort for them to breathe.

Q. So they will get an increase in respiratory rate if they're feeling short of breath?

A. Most people -- sure. Most people who say, I'm short of breath, indeed are breathing faster than normal. It's only the minority who are not.

Q. Did you see any evidence that Ms. McLean was hypoxic?

A. In counter distinction to hypoxemic.

Q. They're two different things, aren't they?

A. Well, hypoxemic means that your blood oxygen 1eve1 is low. Hypoxic means that your tissue oxygen level is low. We generally equate the two. And on a minute-to-minute basis you can do that. Tissue hypoxia implies that you're not getting enough oxygen to the tissue.

When you truly get not enough oxygen to the tissue, then you get acidotic, which she wasn't.

Q. All right. So is the answer --

A. I better check that. Wait a minute. I better check that. I can look at the blood gas and tell you in a minute.

She has some marginal tissue hypoxia based on the blood gas analysis.

Q. Well, the PC02 is within normal range, is it not?

A. Well, the PC02 is really marginally low. I mean, I know that they show a normal range of 39 plus or minus 7, but that's not really correct. The normal range, really, is 40 plus or minus 5. So 32 is a bit low. And when you do your calculation, you start out with a PCO2 of 40. And for every change in PC02 of 10, you should have a change in .08.

Now, her PC02 dropped seven-tenths, from 40 down to 33, and so her change in pH should be seven-tenths of .08. So let's say her pH should be .06, more alkalotic than the midline, which is 7.4. So her calculated pH, based on

her PCO2, should be 7.46 and is actually 7.42. So she actually has just a little bit of metabolic acidosis, which is because of her tissue hypoxemia.

MR. HAYES: Objection, nonresponsive.

Q. (By Mr. Hayes) At least -- I know -- I understand from your answer you don't agree with these normals that the hospital has there. But at least her PC02 is within the normal range as set out by the hospital?

A. As set out by this hospital, yes.

Q. Does the hospital you work at have normal ranges?

A. Yes.

Q. Do you know what their normal range for a PC02 is?

A. It's going to be 7. -- I mean, a PCO2, yes, it's going to be 35 to 45.

Q. Do you know whether -- why -- did they have the same normal range when you worked at MacNeal Hospital?

A. Yes. I've never seen anything other than that.

Q. How about all these charts you've viewed over the years? Have you ever seen any different normal PCO2s than 35 to 45?

adults and children.

MR. FREEMAN: Objection, nonresponsive.

A. Well, actually, that's for adults and children. But, you see, we -- at 92, we had an adult ICU, so we could put them in a adult ICU. We didn't have a pediatric ICU so that pediatricians wanted them transferred out.

Q. (By Mr. Hayes) Now, was that at MacNeal?

A. That was at MacNeal.

Q. So anybody -- if they were a kid and they had a 92 percent oxygen saturation, they got sent to a children's hospital or --

A. Yes.

Q. And if they're an adult at MacNeal, they got put in the intensive care unit?

A. Yes.

Q. Is that just blood oxygen samples or pulse oximetry?

A. That's just -- that's pulse oximetry even with -- even off of a finger, you know, monitor.

Q. So if they got 92, they got sent to the intensive care unit?

A. Yes, sir.

Q. On a pulse oximeter in the emergency room?

A. Yes, sir.

Q. Just one?

developed within two days to probabiy a couple of weeks, they -- that's not enough time €or the body to accommodate?

A. Correct.

Q. So that type of person would €it into the category of what you described here who could walk five or 10 steps, then would have to sit down and rest €or a minute or two, and then maybe could walk another five or 10 steps and then sit down and rest for a minute or two?

A. Yes.

Q. Or is the -- the rest period going to take longer the further they walk?

A. Well, that's true too. I mean, you know, the longer they walk the more hypoxic they get, the longer it's going to take them to recover. But -- but not significantly, and we're not talking the difference between a minute and 20 minutes. We're talking about the difference between maybe a minute and two minutes.

Q. All right. In your report that you wrote, you claim that the standard of care required Dr. Welch to do further evaluation consenting of a -- consisting of a ventilation perfusion scan.

A. Yes, sir.

Q. Are you saying that if a ventilation perfusion scan had been done it would have demonstrated what you call

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a high probability €or pulmonary embolus?
A. Yes, sir.
Q. What would you -- what would depend on -- ventilation perfusion scan show in a patient who had a pulmonary embolus?
A. It would show multiple bilateral ventilation perfusion mismatch.
Q. Do you interpret ventilation perfusion scans?
A. Yes. I see them. I mean, I don't do the official interpretation. That's done by either a radiologist or pulmonologist, but we do see the results back in the ER.
Q. Then a CBC -- based on a blood work consisting of a of a CBC, electrolytes, BUN, creatine and prothrombin time and a PTT and an ECG, what would the CBC have shown?
A. Well, the CBC would -- I think, would have been normal. I mean, it would have established a baseline, because the reason you need a baseline is you're going to anticoagulate the patient. And then if they have a bleed, you want to know where they started out from as a

measurement of how much they've bled if, in fact, they have a bleed from being heparinized.

Q. So this baseline blood work, are you saying that doesn't give you the diagnosis, that just tells you whether or not you use heparin to treat?

A. It doesn't do either one of those things. What it

does, it's baseline blood work. It doesn't either make the diagnosis, or it doesn't tell me who to treat or how to treat. What it does is tell me at some later date where I am -- you know where I started from and where **I** am.

And if at some later date -- well, for instance, we need to get a prothrombin time and a partial thromboplastin time because we're going to give heparin, well, we need to know where we started from after the first dose of heparin, and it changes your values.

If you have a bleed, you will find out what your blood count is today, but we need to know where you started from. So these are all sort of baseline values that you

need to adequately proceed with treatment.

Q. Are there any other lung conditions that affect a ventilation perfusion scan?

A. Well, sure. A pneumonia affects a ventilation perfusion scan, except that you have ventilation perfusion matching; that is, when you have an infiltrate on the lung, the infiltrate is a nonperfused segment that gets nonventilated. Is there any other disease that causes ventilation perfusion mismatch? No.

Q. What about bronchospasm?

A. Doesn't.

Q. It doesn't affect --

A. Does not cause ventilation perfusion mismatch. It

would cause diffuse hypoventilation in it with no change in perfusion.

Q. So if the patient has bronchospasm, it can affect or cause the ventilation perfusion scan to be abnormal?

A. Right, but in a different way than does pulmonary embolus, and you'd be able to tell that on the scan.

Q. Is there any information that has come up recently questioning the value of ventilation perfusion scans in the diagnosis of pulmonary embolus?

A. Well, there always has been, which is why we talk about you don't make the diagnosis, you can only talk about the probability of it. And so there's low probability, medium probability and high probability scans. And the reason they are is that they're not foolproof. They're not a hundred percent diagnostic.

And indeed, there are people with pulmonary embolus who have low probability scans, and those people need to have angiography done. There are people with significant pulmonary embolus who have moderate probability scans, and those people need to have pulmonary angiography. And it's only the people with high-probability scans that you don't need to do angiography on, you just treat them with heparin.

Q. So is what you're saying the value of ventilation perfusion scans in the diagnosis of pulmonary embolus has

always been controversial, to a degree?

A. Well, it's not controversial. It's just this, that it is -- when it's really abnormal, it's good information. But it can be almost normal and not reflect what's going on in the lung.

Q. All right. So a ventilation perfusion scan could have been run on Mrs. McLean and not shown anything?

A. Well, the reason why **I** didn't --

Q. Is that true?

A. No, I don't believe, in her case. And the reason **I** don't believe that is because she was significantly hypoxic. She isn't one of these patients who is walking around with a pulmonary emboli and a PO2 of 90 or a PO2 Of 80 or a PO2 of 70. They don't get much lower than 56 and still walk around. I mean, there are not many people alive who have no emphysema who have PO2s of 56 and survive

Q. All right. So your conclusion that the ventilation perfusion scan would have been highly probable is based on her PO2, PaO2?

A. And the fact that **I** thought that the explanation of the Pa02 was pulmonary embolus and not asthma.

Q. Is there any other basis for that conclusion other than the PaO2?

A. No.

Q. Do you consider the ventilation perfusion scan as

being sensitive or specific enough to rule in or exclude the diagnosis of P.E.?

A. No.

Q. I didn't hear you.

A. No, no. I mean, that's what we just talked about. It is not -- it is not real sensitive, and it can miss a lot of patients with P.E. who do not have a large number of pulmonary embolus or do not have significant pulmonary emboli.

Q. So other -- would you agree that other pulmonary disorders that can cause abnormal perfusion scans would include asthma?

A. Yes.

Q. Emphysema?

A. Yes.

Q. Bronchitis?

A. I'd have a hard time figuring out how bronchitis could, but I suppose it could if it's bad enough. There's a

disease called chronic bronchitis, which is what the Brits tend to call emphysema. That clearly is -- can affect the perfusion scan.

Q. Let me just ask you if you agree with this statement: Abnormal perfusion scans are not only caused by P.E. but also by a large number of pulmonary disorders including asthma, emphysema, bronchitis, bronchiectasis,

pneumonia, pleural effusions, atelectasis, congestive heart failure, pulmonary carcinoma and congenital cysts?

A. Yes, that's all true,

Q. Does -- have you been asked to testify at the trial of this case?

A. Yes.

Q. And is it your intention to do so, to come down to Tarrant County and appear before a Tarrant County-Fort Worth jury?

A. Yes.

MR. HAYES: I'll pass the witness

(Recess at 5:00.)

E X A M I N A T I O N

(On the record at 5:08.)

BY MR. RYAN:

Q. Doctor, my name is Jeff Ryan. I represent Dr. Godfrey in this lawsuit. I've got a few questions, and I apologize ahead of time for jumping around. I'm going to try to fill in a few gaps and questions that I need to ask. But if you don't understand where I'm going, please let me know, and I'll be happy to rephrase my question. Okay?

A. Yes, sir.

Q. In reviewing your CV, which has been marked as Deposition Exhibit No. 2, generally speaking, it appears that the majority of your time practicing medicine has been

in the area of emergency medicine and specifically a hospital-based practice; is that correct?

A. Yes, sir.

Q. Was there ever a time when you operated as a family practice physician, for lack of a better term; in other words, a physician that had an office practice and you saw patients on a day-to-day basis?

A. The closest I ever came to that was when I was at the University of Chicago, and I had a co-appointment in internal medicine. All University of Chicago physicians were sort of owned and operated by the university, which means there were no private practices. There were only university practices.

So I had a university practice. I had a group of patients that I followed. I had mostly a half a day a week that I had set aside to see all these patients so I had to have a clinic a half a day a week with my private patients.

Q. Okay. And when was that?

A. That was sort of, like, 1970 -- actually, when I started my internship was 1971 through about 1980, oh, '6. And then things got a little too busy for me, and I actually dropped my private practice outpatient clinic.

Q. Since that time, it's been exclusively --

A. Emergency medicine.

Q. All right. Seeing patients that, generally

speaking, are of a more emergent basis than the typical

patient that would walk into a family practice physician's office?

A. Yes, sir.

Q. A couple of questions from your report, if you don't mind, Doctor. On Page 1 of your report, the very last sentence, you make a comment about Dr. Godfrey filled a prescription by telephone for erythromycin?

A. Yes.

Q. I guess I have a question -- my question on that statement is, is that significant for any particular reason, or is that just simply an observation as to what Mrs. McLean was treated with on February 14, 1996?

A. Wait a minute, and I'll tell you. No, that was just to recap a history of what was going on with her prior to when all of it started.

Q. Okay. Fair enough. At the bottom of Page 2 on your report, I need to ask you a question about a couple of the statements you make there. It is my understanding that the basis for evaluating a patient for pulmonary embolism on April 24th is due to the setting of documented hypoxemia, a clear chest x-ray and no evidence of wheezing; is that correct?

A. Yes.

25 Q. You indicate in your report that the most common

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1 cause of dyspnea, with that setting -- specifically, a
2 setting of documented hypoxemia, clear chest x-ray, and no
3 evidence of wheezing -- is pulmonary embolism, correct?
4 A. Yes.
5 Q. What is the most common cause of dyspnea when
6 there is no documentation of hypoxemia?
7 A. With or without the wheezing or chest x-ray?
8 Q. Without any of them.
9 A. Oh, well, gosh. The most common cause of dyspnea,
10 it's probably going to be a toss-up between congestive heart
11 failure with varying amounts of pulmonary edema and asthma.
12 And it's going to vary a little by age group. In other
13 words, in the older age group, it's going to be congestive
14 heart failure and pulmonary edema. In middle-aged folks,
15 it's -- the most common cause can be asthma.
16 Q. In somebody such as Mrs. McLean -- I'm sorry. In
17 somebody such as Ms. McLean, a 30-year-old individual,

the -- would you agree that the most common cause of dyspnea in the absence of documented hypoxemia or a clear chest x-ray and no evidence of wheezing would be asthma?

A. You said no evidence of wheezing? No, it's not going to be asthma, because you don't make the diagnosis of asthma without wheezing. If you have dyspnea and you don't have wheezing, you haven't got asthma. You've got something else.

Q. Okay. What do you have?

A. Well, you're going to be thinking about -- if you have an absolutely clear chest, that means no rales. Rales -- no rales means no pneumonia, and no rales means no pulmonary edema, no wheezing means no asthma, you're going to have a P.E.

Q. What percentage of the time? All the time?

A. Pretty high percentage.

Q. Greater than 90 percent?

A. There's going to be some other things that -- that

can cause shortness of breath such as severe anemia There are going to be people who will not be documented as hypoxemic if you did the tests, but they feel weak and short of breath. Primarily, those are going to be anemic -- patients who are anemic. Or it could be patients who have some infectious disease such as influenza.

Q. When we talk about dyspnea, we've already explained that that means trouble breathing, correct?

A. Difficulty is the term.

Q. I apologize. We did. Difficulty breathing. If a patient comes in with the symptom of difficulty breathing, that, in and of itself, what are the top five things that would point you to as a physician as possible diseases or possible problems?

A. In this age group?

Q. Yes, sir.

A. Independent of everything else, independent of any other symptoms, any other answers to any other questions,

dyspnea in this age group is going to be a pneumonia; it's going to be asthma; it's going to be to some degree, probably, of anemia; it's going to be pulmonary embolus; probably some degree of -- some sort of underlying cardiac disease.

Q. We can agree that the identification of dyspnea, in and of itself, should not lead a physician to the performance of tests to rule in or out pulmonary embolism, can't we?

A. That's true, not automatically. That's -- that is not a starting point.

Q. Okay. And that would, obviously, be just as true if the finding were occasional dyspnea on exertion Would you agree with that?

A. That's absolutely true. I mean, the starting points are chest x-ray and some objective measurement of are you hypoxemic or not, whether it be in a -- well, these days, really, an oxygen saturation, because it's a nonevasive test.

Q. Are you -- well, let me ask you that, then. Are you suggesting in the office setting that it is necessary every time a person comes in with an indication of

difficulty breathing that blood gases be done?

A. Oh, no. That is not necessary and not indicated.

Q. Is it necessary and indicated every time a patient comes in with occasional difficulty breathing that pulse oximetry be done in a --

A. No. No, not even that. I mean, the starting point, quite frankly, is a good history to find out what it is that brings on the dyspnea followed by a physical examination particularly aimed at examining the lungs **I** mean, that's -- that's the minimum. That's the starting point.

Q. Okay. Is the existence of headaches consistent or inconsistent with pulmonary embolus?

A. Sort of independent of. I mean, you can have your headaches; you don't have to have your headaches. Hypoxemia can cause headaches. But there are people who die of hypoxemia that don't have headaches. So, you know, it's a -- you might have it; you might not. There's no strong linkage

Q. What we sometimes call as nonspecific?

A. Yes, that's true.

Q. Vomiting, is that a nonspecific finding with respect to pulmonary embolisms as well?

A. Yes.

Q. And cough, I think we've talked about, can be a

symptom of pulmonary embolism, correct?

A. Yes.

Q. But it can also be a symptom of a number of other problems including asthma and reactive airway disease, correct?

A. Yes.

Q. In your report, you make a comment that -- you say that it is well known that there is a ten-fold increase in the incidence of pulmonary embolus in patients taking birth control pills. We've talked a lot about that issue today already in your deposition. And I'm just wondering if you know off the top of your head what -- what the basis is for your comment that it is well known that there is a ten-fold increase. Are you referring to a particular study?

A. Oh, no, no. I'm just -- I think that's -- that's sort of general out there. If you went to sort of a general medical textbook, it would tell you that there's a -- YOU know, a many-fold increase in the incidence of pulmonary embolus in patients on birth control pills, independent Of this issue of whether they're high or low or medium estrogen pills.

Q. But there's no specific study that you're thinking of or referring to to make that comment?

A. No

Q. You also make the comment that it is well known

that the vast majority of patients with a pulmonary embolus will have either tachycardia, being pulse greater than 100 per minute, or tachypnea, respirations greater than 20 per minute or both. Again, is there a specific study that you're thinking or --

A. No.

Q. That's just your experience?

A. Well, it's only my experience. But if you looked this -- if you looked that data up in standard textbooks of emergency medicine or internal medicine, you'll find that there will be a discussion on tachycardias and tachypneas.

Q. And while --

A. Tachypnea being the major of the two.

Q. Okay. And while those may be symptoms, would you -- well, actually, signs, correct?

A. Yes.

Q. While those may be signs, you would agree that pulses greater than 100 a minute or respirations greater than 120 a minute are not diagnostic of pulmonary embolism, correct?

A. That's true.

Q. If a patient comes in with those findings, they do not allow you to determine that the patient does, in fact, have a pulmonary embolism, correct?

A. True.

Q. You talk in your report about Mrs. McLean's visit

to Dr. Godfrey's office on April 29th of 1996. I need to ask you a question about that. The very first place that you say Dr. Godfrey deviated from the standard of care is when you point out that he failed to review his entire emergency department chart from -- her entire emergency department chart from April 24th of '96; is that correct?

A. Yes.

Q. What is the basis, in your opinion, that Dr. Godfrey was required to review the emergency room department chart of April 24th?

A. That's a very standard -- that's a very standardly taught approach to emergency visits, to patient -- to practitioners of office medicine. When I was at MacNeal, actually, I was a member of the department of family practice. And when this didn't happen and when we failed to send a copy of an ER chart to a family practitioner within 24 hours, it became a major issue.

And virtually everyone in office medicine -- be it pediatrics or obstetrics and gynecology or internal medicine or family medicine -- all know that if you've sent the patient to the ER, you've got to get a hard copy of the report. It wasn't such a big issue 20 years ago, but now everybody's got fax machines, and you know, you've got to

25 have the data to review

1 *Q.* Do you teach the emergency room personnel to send
2 the charts to the family practitioner or the family
3 practitioner to get emergency room records?
4 A. Well, we teach our folks to be proactive; that is,
5 we have a system set up whereby these charts do get sent to
6 the family practice people. And, in fact, depending upon
7 the size of the family practice, they actually -- some of
8 them have people stop by every morning to pick up the charts
9 from the previous, you know, day. So both groups do this.
lo *Q.* These teachings that you refer to, are they -- can
11 they be found in any books or textbooks that describe the
12 need to obtain prior emergency room records when a family
13 practice physician is examining a patient?
14 A. I've never actually looked for any. And I would
15 be surprised if you looked in a family practice textbook or

family medicine textbook and it talked about something about how to run your, you know, family medicine clinic or office that it didn't say something about this issue.

Q. As we sit here today, I take it there are no documents, textbooks, journals or the like that you intend to rely on to support your opinion that it was incumbent upon Dr. Godfrey to review the ER records from April 24th of '96; is that correct?

A. That's correct. I think I'd know enough about that practice of what happens to be able to state that

is the standard of care.

MR. FREEMAN: Nonresponsive objection after "that's correct."

Q. (By Mr. Ryan) You're not suggesting, are you, Doctor, that the standard of care requires a physician treating a patient to obtain the medical records from other physicians that the patient has seen in recent proximity to that particular visit, are you?

A. No. I'm talking about emergency room visits

specifically.

Q. And that's what I want to clear up. Your testimony is not that if a patient comes in to see a Dr. Smith in mid April that Dr. Smith, it is incumbent upon him to obtain the medical records from other doctors that may have seen this patient for similar or related symptoms in the previous month. You're not saying that, are you?

A. In a non-ER setting?

Q Pardon?

A. In a non-ER setting?

Q. Yes, sir, in a non-ER setting.

A. That's correct, I am not saying that.

Q. And, Doctor, you're not telling the ladies and gentlemen of the jury that the standard of care in Fort Worth, Texas requires that every time a family practice physician sees a patient in his office that it is incumbent

upon him to obtain all of the emergency room records from a patient's visit within recent proximity to that visit, are you?

A. Well, no, just the ones that are of clinical

significance. I mean, all of them would include the discharge instruction, the registration sheets. I mean, that's not the stuff that counts. The stuff that counts is the physician and nursing records.

Q. Okay. So are you saying that it is incumbent upon a physician, a family practice physician, to obtain all physician records and nursing records and labs, et cetera, from emergency room visits that their patients have made in close proximity to the time that they're actually examining them?

A. Yes.

Q. Again, do you have any other documents or basis for that opinion other than your own experience practicing here in Chicago?

A. No.

Q. If Dr. Walton were to testify, a physician in the Dallas-Fort Worth area, that it is not incumbent upon a family practice physician to obtain all emergency room records under such a situation, I take it you would disagree with him, then?

A. I would disagree and be very surprised.

Q. So your testimony is, is that the basis for obtaining emergency room records on April 29th is nothing more than the fact that the doctor was aware she went to the emergency room?

A. Yes.

Q. So regardless of what --

A. Well, and she -- and she's here now with a -- you know, an acute problem.

Q. Okay. And so regardless of what the patient told the doctor, regardless of whether the patient brings the doctor a discharge sheet showing what the emergency room diagnosis was, regardless of what was discussed between the patient and the doctor as to what happened in that emergency room, your testimony is that in all situations where a person has gone to the emergency room it is incumbent upon them to get those records?

A. No. Let me correct that. **I** think I see where you're going. Obviously not. I mean, if this patient was there a week ago with a laceration that the doctor looked at and said, Gee, I'm going to clean it, and it doesn't require

any sutures, no, he doesn't -- and she goes back to see her primary care physician for some other problem a week later, obviously, he doesn't need to get copies of that record. I'm talking about patients who have a continued illness and in something that is, obviously, more than a cut

or a scrape or some simple self-limited disease.

Q. Earlier in your deposition, you made a comment about there's usually a reason that causes a patient to go to the emergency room as opposed to simply going back to their family practice doctor.

A. Sure.

Q. And I think the implication in that was -- and correct me if I'm wrong -- that just the fact that the patient chose to go to the emergency room suggests a seriousness that should be considered by a family practice physician who is knowledgeable of the decision to go to the emergency room.

A. That's true.

Q. Is that accurate?

A. Yes.

Q. And is that -- is that the reason or the basis €or a family practice physician needing to get those emergency room records; i.e., the knowledge that, hey, this patient was so sick, however sick she was, that she chose to go to the emergency room?

A. Well, no, because, obviously, like I say, with the laceration, you know, that's not a complex disease that requires much in the way of thought regarding follow-up and, in fact, may not even require any follow-up. The reason for that statement was that -- really two-fold

One is that patients with chronic disease are usually already plugged in to the medical system, the medical care system, and they usually go back and see a primary care physician on a regular, repeated basis. And when those people show up in the emergency department, you have to say to yourself and to them, Why would this rash that you've had for three years are you here tonight or on

Saturday or Sunday or, you know, even Tuesday or Wednesday afternoon -- I mean, why is it you're here?

The answer maybe innocuous. It may be, My doctor is on vacation. My doctor is not available. I've got to wait three weeks €or an appointment, I'm impatient, or whatever. But the answer also may be, Well, I'm here because not only do I have the rash, but I also have the chest pain today. So, you know, there's something that brought them in.

And the other thing is that you put that aside €or a minute, take all of those patients that you and I believe have trivial complaints, truly trivial -- I've got a sore throat -- you have to ask yourself why would someone come to the average ER, the average ER being either hot or cold, but uncomfortable, a place with crying kids, a place that there's no comfortable place to sit, all the magazines are old, there's no good television, and you're going to sit and wait for anywhere from 30 minutes to three or four or six or

10 hours to be seen by somebody you don't know and, you know, in a gown that doesn't fit -- I mean, it's a terrible place to want to be. Nobody wants to be in the ER.

So if you see somebody with a trivial illness, you have to say to yourself, You know, to that person, this sore throat must be really important, because they were willing to do all this to come to this uncomfortable situation to be cared for, you know, €or that sore throat. So you have to say to yourself, Well, why is that, you know. And the answer might be, Well, because I also had a temperature of 106 -- in which case, that's a really good reason -- or the answer might be, I don't have a primary physician, in which case -- well, that's a reasonable reason to come too.

But you're always looking for reasons why people do things that are not the equivalent of going out and playing golf on Saturday. And sometimes getting the answer to that question may be really important in saving their lives.

Q. Sometimes the answer might be that they didn't originally intend to go to the ER. They intended to go to their family practice physician, right?

A. That's also true. But you'll never find the answer unless you look for it.

Q. Even in a situation if you find out that the reason they came to the ER, as opposed to their family

practice physician, was that their family practice physician told them to go there, that would give you some indication, would it not, as to how serious they thought their problem was?

A. Well, that's also true, in which case, obviously, if that's what happened, the family physician, obviously, is going to want to find out, you know, what happened when I sent you to the ER.

Q. Precisely. And that's why if you get information back from that ER physician that documents what they thought the patient had, there are certainly circumstances where you can see that that would be the only records a family practice physician would want to see. You could certainly see that scenario, could you not?

A. Aren't you and I saying the same thing?
Q. I think so.
A. That you need to get those records.
Q. All the records?
A. Well, what wouldn't you get? I mean, I don't understand what you're driving at. I'm talking about the relevant nursing and physician records. I don't care about registration and all that sort of stuff. But the patient that Dr. Godfrey sent to the ER, Dr. Godfrey should want to see the relevant nursing and physician records from the ER regarding that visit.

Q. I understand. We've already gone through --
A. So --
Q. -- we've already gone through that. You believe that in all situations, then -- and tell me if this is true. You believe that in all situations absent the patient getting treated for a broken leg and coming back for something else later on, that in all situations that a patient comes to see a family practice physician, if they

have been to an emergency room within a previous month, it is incumbent upon the doctor to obtain all emergency room records related to physician records, nursing records, labs, et cetera?

A. Well, no, only if it's a continuing problem. If it's a self-limited problem that went away, completely resolved and now you're here for something different and that self-limited problem was felt by you to be trivial to begin with, no. In other words -- well, let's say that she went there with an earache, and the doctors gave her medicine for her earache. Her earache completely goes away.

You sent her there because you were closed, or whatever, on Saturday or Sunday or whatever. And then you see her a month later, and now she's complaining of cough and shortness of breath. I don't think the earache is relevant. It was a self-limited illness. It went away. It completely resolved. It was appropriately treated. It's

obviously not a continuing problem.

MR. RYAN: Objection, nonresponsive.

Q. (By Mr. Ryan) I probably haven't been very clear with my questions, Doctor. I apologize. The question I was getting at originally goes to the basis of your opinion that it is necessary to get the emergency room records. And my question is this: Is it the simple fact that the patient went to the emergency room €or a condition that they perceive to be more serious than the conditions that would typically take them to their family practice physician that should indicate to a family practice physician they need to see those records?

A. You mean that the patient thought was more serious, or that the doctor thought was more serious?

Q. Start with the patient.

A. Well, I would think under both circumstances if both -- either the doctor or the patient thought that whatever was going on was serious enough to justify a emergency department visit, because it was more serious than something that the doctor could handle in his office, that the doctor should, in fact, get the documentation and find out what's going on.

Q. Regardless of whether or not he receives

24 documentation from that emergency room physician saying this

25 is what I've diagnosed the patient with?

1 A. Well, no. Obviously, he's got that documentation,

2 then why would he need to see other -- I mean, why would he

3 need to see the records if -- oh. Okay. So let's say that

4 the ER doc writes him a letter and says, Okay. I saw your

5 Patient XYZ in the emergency department, she had this. Does

6 he need to see documentation, no.

7 Q. Thank you. One of the comments that you make in

8 your report is that the doctor failed to meet standard of

9 care when he diagnosed reactive airway disease, failed to

10 suspect pulmonary embolism and failed to admit the patient

11 to the hospital. You know the paragraph I'm talking about,

12 with respect to Dr. Godfrey?

13 A. Generally, yes.

14 Q. It's my understanding that -- I'm going to work

15 backwards here. Your position is, is that either on

April 29th or subsequent visits Dr. Godfrey should have done more to rule out or rule in pulmonary embolism. Is that fair to say?

A. Yes.

Q. Okay. And would it be true that standard of care -- it would have been acceptable and he would have met the standard of care on either of those dates if he had simply referred Mrs. McLean to the emergency room for further tests or follow-up?

A. Yeah, I think so.

Q. And is it fair to say -- let me back up again. When you talk about the things that you think Dr. Godfrey should have done with respect to his referral, does that assume -- strike that. Bad question.

We've already talked about your belief that Dr. Godfrey should have reviewed the emergency room records. We discussed that at length, correct?

A. Yes.

Q. Is the review of the emergency room records, including the blood gas results, necessary and something that you assume in order to place Dr. Godfrey in the

additional responsibility of them looking at that information and referring the patient back to the hospital or additional tests? Do you understand what I'm asking?

A. No.

Q. Okay. It was, again, a bad question, end of the day. Well, let's look at it. In the middle of the third paragraph on Page 2, where you're talking about the April 29th visit, it talks about Dr. Godfrey and him failing to review the entire emergency department chart. Do you see that? I'm sorry, on Page 3, third paragraph down.

A. Right. Okay.

Q. And it says, In addition, he failed to meet the standard when he diagnosed reactive airway disease, failed to suspect pulmonary embolus and failed to either admit

Ms. McLean to the hospital or refer her to the emergency department.

My question is this: Is it your belief that the review of the emergency room records is what would have put

the burden upon Dr. Godfrey to refer this patient for additional testing or admit her to the hospital?

A. Oh, not singly and solely, no, because he should have been able to reach the conclusion that something wasn't quite kosher vis-a-vis the fact that she was now carrying this diagnosis of reactive airway disease, using Albuterol. He was going to add Azmacort because he clearly thought she had asthma, but she had lungs that he describes as fairly clear, which he says in his deposition meant no wheezes.

So, you know, that whole thing doesn't mesh into a single diagnosis or a plan to treat that diagnosis. And therefore, he needs to have been thinking, Gee, you know, something doesn't -- two and two doesn't add up to four here, you know.

Q. Tell me, then, what it is that Dr. Godfrey saw or knew about as of the April 29th, 1996 visit that you believe imposed a burden upon him to admit this patient to the hospital or send her to the emergency room for further testing.

A. That she was getting exertional dyspnea with no wheezes on her chest x-ray at a time when he was making the

diagnosis of reactive airway disease and treating her with Albuterol and Azmacort.

Q. The treating of the patient with Albuterol and Azmacort --

A. Well, basically, he was diagnosing asthma and treating asthma when she had no evidence *of* bronchospasm. And he hadn't done spirometry to document the in-between episodes of acute bronchospasm that she was having any abnormalities in her spirometry.

Q. You're not saying do any spirometry. You're not suggesting the standard of care of a family practice physician was that spirometry was necessary at that particular time, are you?

A. Well, actually, I think he should have suspected that she had a pulmonary embolus at that time and sent her back to the emergency department for additional testing.

Q. Okay. And again, that is based upon nothing other than her coming in with evidence of exertional dyspnea without wheezes and what else?

A. And the fact that she was being treated with Ventolin and in his reaching the conclusion that this

middle-aged person who never had asthma now has asthma

Q. Okay. Anything else --

A. No.

Q. -- that you -- okay. With respect to your comment

about this middle-age person, you've seen middle-age people develop asthma, have you not?

A. Uh-huh.

Q. I'm sorry.

A. Yes.

Q. Is that a common, uncommon scenario?

A. It's relatively uncommon. Most people develop asthma before they're middle aged.

Q. Some certainly do develop it in their middle ages, correct?

A. Sure.

Q. Is it ever associated with any other health condition such as morbid obesity?

A. Well, it can be associated with a lot things.

Q. Okay.

A. But morbid obesity is not a risk factor for developing asthma.

Q. Not a predisposing factor?

A. No.

Q. What are some of the predisposing factors of a person developing asthma in their middle ages?

A. An allergic history. That's about it.

Q. Any others?

A. Not that I can think of.

Q. You're not suggesting it's against the standard of

care to treat -- to have treated Ms. McLean with the drugs that she was treated with, are you, on April 29th?

A. I think in the absence of a diagnosis, it was.

Q. Isn't the evidence that an individual is improving after treatment has been instituted, isn't that some evidence that the original diagnosis may have been accurate and that the treatment regimen is appropriate?

A. It could be. But she is still symptomatic with exertional dyspnea, and yet she has a clear chest. And those two don't make any sense. Why should this individual who hasn't suddenly gained another 50 pounds or something -- I mean, she's been cruising along at 250 pounds for a little

while -- suddenly develop exertional dyspnea that brings her to an ER and now brings her to the office when, in fact, nobody's ever heard her wheeze. I mean, you can't blame it on asthma. You've got to be thinking of something else. She has acute symptomatology and a clear chest.

MR. RYAN: Objection, nonresponsive.

Q. (By Mr. Ryan) One of the other attorneys was asking you a question about the differences between chronic pulmonary embolism and acute pulmonary embolism. I think this is where this question is going is -- first of all, you would agree that the diagnosis of acute pulmonary embolism is oftentimes a very difficult diagnosis to make?

A. Yes.

Q. Is it your opinion that the diagnosis of chronic pulmonary embolism can be even more difficult?

A. Yes.

Q. How prevalent is chronic pulmonary embolism as opposed to acute pulmonary embolism? Do you know?

A. A lot of people die of pulmonary embolism every

year, I mean hundreds of thousands. I don't think anyone knows the true incidence of chronic pulmonary embolism And the reason for that is that on postmortem examination if you look carefully, there's a lot of people who have thromboembolism, pulmonary thromboembolism.

And the problem that is difficult to determine is whether that was a morbid problem or an immediately premorbid problem; that is, was it associated with sort of the terminal two or three days of life or was it, in fact, present for some time prior to that. I mean, it's a difficult problem to determine, because most of the people that we're talking about are people who are elderly anyhow.

So, you know, it becomes a difficult question to answer in terms of would they have had these if they didn't have some other terminal illness. And if so, or in spite of that, are these somehow associated with the death. And I don't think anybody has a really good finger on that.

Q. Fair enough. Do you have an opinion as to whether Ms. McLean had a pulmonary embolus on April 29th?

A. April 29th, yes.
Q. And what evidence would you point to to suggest that she, in fact, did have a pulmonary embolism on that date?
A. I think she did. She had been in to the emergency department with all of these complaints, and she was having exertional dyspnea.
Q. Is there anything about the visit on the 29th, though, that would make you believe she had a pulmonary embolism, absent the knowledge of the findings on April 24?
A. Yes, because she was having exertional dyspnea with a clear chest.
Q. So you're saying every time a patient comes into your office with evidence of exertional dyspnea with a clear chest, pulmonary embolism?
A. No. I'm saying you do a history and physical, and you find out whether you think that they're anemic. You find out if they've been staying up all night and drinking. I mean, there's all sorts of things that can make people tired and fatigued. You only get there by doing a history and physical.

But when you come to the end of this, we don't find any other cause for her to have exertional dyspnea. And Dr. Godfrey clearly is indicating bronchospasm, and she clearly doesn't have bronchospasm. I mean, if you have

reactive airway disease but you're not having bronchospasm, you're not dyspneic. If you're not having wheezing and you're not having bronch -- if you're not having wheezing, you're not having bronchospasm, basically. If you're not having bronchospasm in the presence of reactive airway disease, you're asymptomatic. You feel well.

MR. RYAN: Objection, nonresponsive.

Q. (By Mr. Ryan) We've already established that a VQ lung scan is not going to definitively diagnose a patient with pulmonary embolism, correct?

A. That's true.

Q. Okay. It will give a physician probability of pulmonary embolism?

A. That's true.

Q. In order to make that definitive diagnosis, it would actually take additional tests?

A. That's true.

Q. Tests that are performed in a hospital, correct?

A. Yes.

Q. Prior to making the decision to do a VQ lung scan, a person would have to have a high suspicion of pulmonary embolism before the standard of care would require such a test. Would you agree with that?

A. You know, I don't know that those terms are very useful: low, medium or high degree of suspicion. You have

to suspect it, obviously. If you don't suspect it, you're not going to do the tests. If you don't do the tests, you're not going to make the diagnosis.

Q. Okay. And maybe what I'm getting at is this: There are certainly -- you've heard the term "differential diagnosis," correct?

A. Sure.

Q. Differential diagnosis, in it's broadest sense, can refer to every single disease that could be the possible

cause *of* any given symptom, correct?

A. Yes.

Q. And you're not suggesting that every time pulmonary embolism comes into a differential diagnosis, using that definition -- meaning, say possible cause -- you're not suggesting that every time that happens the physician should be led to performing a VQ lung scan, are you?

A. No.

Q. Okay. And what I'm trying to get at it is you would at least agree with me, would you not, sir, that there is a certain amount of judgment, clinical judgment, that goes into the decision-making process by a physician as to whether or not the symptoms and the signs that they're presented with rise to the level to where it is incumbent upon them to get additional tests such as a VQ lung scan?

A. Absolutely. That's what this is all about. And what we're talking about is my red light-green light analogy, that in the light of documented proven hypoxemia by multiple methods and multiple times on the 24th, she was

clearly proven to be hypoxemic, and the cause of that was felt to be bronchospasm. She had a clear chest x-ray, and you can't have bronchospasm as the cause to that degree and have hypoxia without wheezing, which means that you are in a group where you are hard-pressed to think of another diagnosis besides pulmonary embolus. That makes her in what you call the high-suspicion category, whatever term you used.

MR. RYAN: Objection, nonresponsive to everything after "absolutely."

Q. (By Mr. Ryan) Doctor, would you agree with me that all delays in diagnosis do not constitute breaches of the standard of care?

A. Clearly.

Q. And by the same token, would you agree that all missed diagnoses do not, in and of themselves, constitute breaches of the standard of care?

A. Yes. I agree with that statement.

MR. RYAN: That's all the questions I have right now, Doctor, appreciate your time

(5:56 p.m.)

(Exhibit No. 12 marked.)

MR. STEED: For the record, we're marking Exhibit 12, which is the deposition transcripts of Godfrey, Novotny and Welch.

I would just ask the court reporter to COPY that as is with the highlighted portions in the notes.

MR. FREEMAN: Can we include Steven Deutsch and Stillwagoner too?

MR. STEED: Make those 13 and 14.

(Exhibit Nos. 13 and 14 marked.)

THE WITNESS: And return them to Dr. Baker when you're done.

E X A M I N A T I O N

(On the record at 5:58 p.m.)

BY MR. FREEMAN:

Q. Doctor, you had said, regarding this ten-fold increase risk business, that any general medical textbook would have that sort of stuff in it. Do you recall that?

A. Yes, sir.

Q. Would you name one so I can go look it up?

A. Sure. Harrison's Principles and Practice of

Internal Medicine.

Q. You had mentioned guidelines at previous hospitals

regarding oxygen saturation. Do you recall that?

A. Guidelines.

Q. Guidelines, protocols at the MacNeal --

A. Oh, no, I can tell you what we did. But I don't --

Q. Sir --

A. -- they're codified.

Q. -- I'm sorry. You had mentioned some guidelines. I want to know who at the hospital I could ask to get a COPY of those. That's all I want to know.

A. I think what I told you was this is what we did, but I don't think that they're written down anywhere.

Q. Who at the previous hospital would I contact to find out? Who would I call?

A. You mean, to see if they're written down anywhere?

Q. Yes, sir.

A. Well, I suppose you would call the director of intensive care, but I don't know who that is now.

MR. FREEMAN: Thank you.

MR. HAYES: I'll reserve the remainder of my questions until the time of trial

A. Or you know what? Or you could talk to the chairman of pediatric.

MR. FREEMAN: Thank you.

And let the record reflect that at 6 o'clock

we've finally gotten the undated report from Dr. Youngblood

(End of proceedings at 6:00 p.m.)

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S I G N A T U R E O F W I T N E S S

I, FRANK J. BAKER II, M.D., solemnly swear or affirm under the pains and penalties of perjury that the foregoing pages contain a true and correct transcript of the testimony given by me at the time and place stated, with the corrections, if any, noted on a separate sheet of paper and attached hereto, and that I am signing this before a Notary Public.

_____

FRANK J. BAKER 11, M.D.

STATE OF _____ *

COUNTY OF _____ *

SUBSCRIBED AND SWORN TO BEFORE ME by FRANK J. BAKER II, M.D. on this, the _____ day of _____, 1999.

_____

NOTARY PUBLIC

My Commission Expires: _____

PREFERRED LEGAL SERVICES, INC.
(214) 706-9016

C O R R E C T I O N S T O T H E

D E P O S I T I O N O F

FRANK J. BAKER II, M.D.

PAGE/LINE	READS	SHOULD READ	REASON

FRANK J. BAKER 11, M.D.

CAUSE NO. 141-172582-98

SIMEON EDEN McLEAN, Individually and as Heir to the Estate of DELORES McLEAN, Deceased, and SIMEON EDEN McLEAN, as Next Friend of JAMILA IMARI McLEAN, IMANI ZAKIYA McLEAN and MAHLON McLEAN, Minors, Plaintiffs	*	IN THE DISTRICT COURT
v.	*	141ST JUDICIAL DISTRICT
HARRIS METHODIST H-E-B, JEROME DOUGLAS NOVOTNY, JR., M.D., ROBERT MORROW WELCH, M.D., MARK ALAN GODFREY, M.D., HEALTH PARTNERS MEDICAL GROUP, P.A. and MID-CITIES FAMILY PRACTICE ASSOCIATION, P A. Defendants	*	TARRANT COUNTY, TEXAS

REPORTER'S CERTIFICATE/FILING CERTIFICATE
ORAL DEPOSITION OF FRANK J. BAKER 11, M.D.
TAKEN ON MARCH 15, 1999

I, JANET ARGO, a Certified Shorthand Reporter in and for the State of Texas, hereby certify pursuant to the Texas Rules of Civil Procedure and/or agreement of the parties present to the following:

That this deposition transcript is a true record of the testimony given by FRANK J. BAKER 11, M.D., the witness named herein, on March 15, 1999, after said witness was duly sworn/affirmed by me;

That $_____ is the charge for the preparation of the completed deposition transcript and any copies of exhibits charged to Larry F. Smith, M.D., J.D., Attorney for the Plaintiffs;

That the original deposition transcript was submitted on the _____ day of _____, 1999, to Larry F. Smith, M.D., J.D., for the witness to examine, sign, and return to Preferred Legal Services, Inc., by the _____ day of _____, 1999;

That the deposition transcript _____ was returned to Preferred Legal Services, Inc., properly executed by the witness, to the deposition officer, and the attached change/correction sheet contains any changes, and the reasons therefor, made by the witness;

That the deposition transcript _____ was not returned

to the deposition officer by the witness;

That the original deposition transcript, or a copy thereof, together with copies of all exhibits, was delivered on _____, 1999, pursuant to Rule 203.3, to Larry F. Smith, M.D., J.D., Attorney €or the Plaintiffs;

That pursuant to the information made a part of the record at the time said testimony was taken, the following includes all parties of record:

LARRY F. SMITH, M.D., J.D, COUNSEL FOR PLAINTIFFS
Amount of time used: Zero

JEFFREY W. RYAN, ESQ.
COUNSEL FOR DEFENDANT, MARK ALAN GODFREY, M.D.; HEALTH PARTNERS MEDICAL GROUP, P.A.; and MID-CITIES FAMILY PRACTICE ASSOCIATION, P.A.
Amount of time used: 48 minutes

JOEL J. STEED, ESQ.
COUNSEL FOR DEFENDANT, JEROME DOUGLAS NOVOTNY, JR.
Amount of time used: 109 minutes

LARRY HAYES, ESQ.
COUNSEL FOR DEFENDANT, ROBERT MORROW WELCH, M.D.
Amount of time used: 80 minutes

MAX E. FREEMAN, 11, ESQ.
COUNSEL FOR DEFENDANT, HARRIS METHODIST H-E-B
Amount of time used: 81 minutes

That a copy of this certificate was served on all

parties shown herein.

CERTIFIED TO on this the _____day of _____,
1999.

_____
JANET ARGO, CSR
Certified Shorthand Reporter
Certification No. 6295
Expires 12/31/2000

PREFERRED LEGAL SERVICES, INC.
8300 Douglas Avenue, Suite 800
Dallas, Texas 75225
(214) 706-9016