IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

Doc/26

BARBARA MANNING, Executrix
of the Estate of EULALIE SCHULTZ,
Deceased,

Plaintiff,

-vs-

JUDGE WELLS
CASE NO. 166785

J.A. RAMOS, et al.,

Defendants.

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Deposition of DALE COWAN, M.D., taken as if upon cross-examination before Sandra L. Mazzola, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Dale Cowan, M.D., 6681 Ridge Road, Parma, Ohio, at 10:35 a.m. on Wednesday, March 14, 1990, pursuant to notice and/or stipulation: of counsel, on behalf of the Plaintiff in this cause.

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DALE COWAN, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF DALE COWAN, M.D.

BY MR. KAMPINSKI:

Q. Would you state your full name, please?

A. Dale Cowan. Last name is spelled C O W A N.

Q. And where do you live, Dr. Cowan?

A. I live at 19600 Shaker Boulevard in Shaker Heights.

Q. I'm going to ask you a number of questions this morning. If you don't understand any of them, please tell me. I'll be happy to rephrase any question you don't understand.

When you respond to my questions, you have to do so verbally. She is going to take down everything that's said. She can't take down a nod of your head. All right?

A. Yes, sir.

Q. I've just been handed your CV, Doctor. I see that you're also an attorney?

A. That's correct.

Q. If you would, just briefly run me through your educational background starting with college.
A. Yes. I was graduated from Harvard College in 1959 and from Harvard Medical School in 1963.
Q. What was your major in college?
A, Biomedical -- I guess biochemical sciences.
Q. And then you went straight from there into medical school also at Harvard?
A. Yes.
Q. Upon completion of medical school, what did you do?
A. I came to Cleveland Metropolitan General Hospital for internship and residency training in internal medicine. That training was interrupted by two years in the military service, which I was in the Public Health Service, so -- and I spent the years from 1965 to 1967 at the National Institutes of Health.
Q. In Washington?
A. In Bethesda, Maryland.
Q. Okay. And then what did you do after that?
A. I returned to Cleveland to complete my internal medicine training and took a traineeship in the field of hematology.
Q. Fellowship?

A. Traineeship is a -- it's equivalent -- its the same as a fellowship. It's a different program.
Q. Where did you do that?
A. Case Western Reserve University and at Cleveland Metro General.
Q. When did you do that?
A. 1968 to 1970.
Q. What did you do after that?
A. I became a member of the full-time faculty of the medical school at Case Western Reserve.
Q. Did you also have a practice aside from your teaching responsibilities?
A. I had a small practice starting at or shortly after I became full-time faculty.
Q. And where was that practice located?
A. At Metropolitan General Hospital and then later on during the '70s, I saw patients at Lutheran Medical Center, although I did not have an office there.
Q. All right. Let's go slow. I take it you have privileges at Metro?
A. Oh, yes.
Q. You have privileges at University?
A. Yes.
Q. All right. Anyplace else?

A. I have privileges at Lutheran Medical Center,
Q. So you were seeing patients at all three places then?
A. No, sir. I was not seeing patients at University. I had privileges there as a member of the faculty and for purposes of doing clinical research.
Q. What were you teaching, oncology, hematology, both?
A. Both. At that time oncology was a new specialty. There were virtually no oncology training programs as we know them now outside of cancer centers like M.D. Anderson and the National Cancer Institute itself, Sloane Kettering and Roswell Park in Buffalo. But no universities had oncology training programs. These came along during the '70s.
Q. So you were teaching hematology which included training in oncology?
A. That's correct.
Q. Are you Board-certified?
A. Yes, I am.
Q. In what?
A. In internal medicine and in subspecialty certification in both hematology and medical

oncology.

Q. When did you first obtain privileges at Parma?

A. That would have been in 1987.

Q. And how did that come about, Doctor?

A. It came about when I was advised that the person who had been the hematologist on the staff at Parma Hospital was retiring and the practice was available.

I was looking for an opportunity to expand my practice in order to have a broad enough practice base to bring in an associate, And this provided an opportunity. And so I bought in or took over that practice.

Q. Whose practice did you take over?

A. Dr. Elena Ceicys. That's spelled C E I C Y S. Elena, E L E N A.

Q. And what associate did you bring in?

A. I never did.

Q. At the time that you took over this practice that caused you to get privileges at Parma, what were you doing at that time before you took over that practice?

A. I was and still am practicing over at Marymount Hospital.

Q. Do you still teach at Case Western?

A. I have a clinical faculty appointment and I teach, give one lecture a year.
Q. When did you stop being active as a teacher?
A. I had a tenured faculty position and was full-time faculty up until some time in 1982.
Q. And why did you stop?
A. I went into full-time practice, and therefore, it was no longer appropriate to be -- I couldn't be full-time faculty.
Q. As a full-time practice, we're talking about a practice at Marymount?
A. At that time it was at Marymount, yes.
Q. Did it change at any time?
A, It's been at Marymount except now it's at Marymount and Parma.
Q. We are here in a Medical Arts Building. Do you also have another office somewhere near Marymount?
A. I have an office at Marymount. I pay rent to Masymount Hospital for an office in the hospital.
Q. So your address would be the hospital address?
A. That's correct.
Q. Do you have any other offices other than the two?

A, Not in medicine.
Q. Okay. Do you have a law office?
A. I have a small law office. It's in my home.
Q. When did you go to law school?
A. I started in 1976 and completed in 1981.
Q. This would have been part-time?
A. Yes.
Q. And where did you go?
A. Case Western Reserve.
Q. I take it by a previous answer that you do practice law also?
A. I have a very, very limited law practice, probably only about five percent of my total professional time.
Q. Well, do you specialize in anything in law?
A. Yes, I do.
Q. What is it?
A. In health care law, more specifically in that which pertains to medical staffs, such areas as physician contracting privileging, credentialing, medical staff bylaws.
Q. So your clients would then be physicians?
A. My clients are usually medical staffs, not individual physicians.
Q. When in 1987 did you get privileges at Parma?

A. I took over the practice either in the beginning of May or the beginning of June, I can't recall which, in 1987. My recollection is that I had temporary privileges at the time I took over the practice and that just the process of going through the various approvals in the credentials committee and the medical executive committee and then the board of trustees, it would have been some time later in 1987 that the original provisional staff privileges would have been provided.

Q. And were there any corollary requirements to your obtaining privileges? For example, did you have to be on call certain amounts of time as an adjunct to having privileges?

A, No, sir.

Q. You were involved in the care of Eulalie Schultz as a consultant, correct?

A. That's correct,

Q. How is it that you became involved?

A. I was asked by the attending physician to see the patient in consultation.

Q. Would this have been because you were around or you were on call as a hematologist at that time or he knew you or how did that come about?

A. I don't know specifically how it came about. I wasn't on call. I suspect it came about the way any of the consults. A particular physician requests a consultant in hematology or oncology, has a choice of three persons on our Parma medical staff, and can decide which of those individuals he or she wishes to consult. In this case, the doctor selected me, but I don't know why or on what basis.

Q. *So* there's three hematologists on staff at Parma?

A. That's correct.

Q. Who are the other two?

A. Dr. Byron Koffman, that's spelled K O F F M A N, and Dr. Tim Bidari, B I D A R I.

Q. Is there any type of rotational type of arrangement where the three of you would be called in order if somebody sought consultation?

A. No, sir.

Q. So whatever Dr. *Go's* reasons are, you just don't know?

A. That's correct.

Q. And when you said the attending, that's who you were talking about is Dr. Go?

A. That's correct.

Q. You have had a chance to review the chart, haven't you?
A. Yes, I have,
Q. I know, Doctor, that he apparently asked for this consultation on April 1, is that correct? Any time you need to look at the chart, go ahead.
A. I'll have to look at the record.
Q. Sure.

MR. TERRY: You're referring to something on the orders?

MR. KAMPINSKI: Yes. I think it's page 45 maybe? 53? Page 53.

A. That's correct.
Q. And your actual consult occurred when?
A. I'll have to look at the date of my consult reply.
Q. I think it's page 10, Doctor.
A. April 2.
Q. All right. So you would have seen her the following day after he had requested the consult?
A. That's correct.
Q. Your typed consultation report, is that as a result of notes that you would have taken when

you saw her? I mean how do you do that? Or do you go back to your office and do it by memory?

A. No, sir.

Q What do you do?

A I review the chart, go in and see the patient, ask the patient questions, and examine the patient. Sometimes the patient may not be in a position to answer questions by virtue of the nature of the problem if they're not coherent for whatever reason or if they cannot recall for whatever reason.

And if there's a family member there, which sometimes there is and sometimes there's not -- and I don't recall whether there was at this time -- then often the family members can provide me with a history.

And then after I've completed the review, the history and the physical exam, I go immediately and dictate this note. I don't take any specific notes.

Q. So you do do it from memory in terms of what occurred during your visit with the patient?

A. Yes, but it's only a matter of a few minutes. I mean I go see the patient and then I have the chart in front of me when I'm dictating the

note.

Q. Okay. Did you have any discussions with Dr. Go before you went to see the patient?

A. I do not recall.

Q. All right. That would be pretty typical though, I mean for the attending to have some discussion with you or you with him before you see the patient, wouldn't it?

A. Not necessarily, no, sir.

Q. All right. There's nothing in the chart indicating that the two of you did have a conversation beforehand, I take it?

A. No, sir.

Q. And you are telling me you just don't remember if you did?

A. I don't recall it.

Q. What was the reason then that you were called in on consult?

A. I stated on the first line of the typed consult reply, I was asked to see the patient to evaluate the pancytopenia, the fact that all the blood counts were subnormal.

Q. The information that's set forth, I'd say up until the last paragraph on the first page, is that all from history?

A. Give me a minute to review this, please.
Q. Sure.
A. Okay. Would you repeat your question?
Q. Yes. Up until the last paragraph of that first page, I mean that's all history either from the chart or from the patient?
A. That's correct.
Q. And then the last paragraph begins with your findings on physical examination?
A. That's correct.
Q. And that goes through to the middle of the next page where we have the heading, assessment?
A. Yes.
Q. In the history, the paragraph before you start your physical examination on the first page, it's got, Patient was started on antibiotic therapy here with Claforan and more recently with erythromycin and was given blood transfusions.

Were you involved in any of those orders or had that all preceded your consult?
A. That preceded my consult.
Q. Your assessment, Doctor, was based, I take it, both on the history and physical examination, would that be correct?

A. That's correct.
Q. And you reached the conclusion that her significant pancytopenia was due to the -- it says congestion, but did you mean ingestion?
A. Ingestion, yes. That would have been a typo.
Q. All right. So your opinion was that her problem, that is, the pancytopenia, was due to the chronic ingestion of methotrexate on a weekly basis for the past four years?
A. That's correct.
Q. In your histosy that you obtained it indicated that she had not had -- well, let me find it specifically. In the first full paragraph, that she had not had any recent blood counts measured to determine what the level of the white count, red count and platelets are or have been in her blood, but that she has been fairly regular in taking this medication.
A, Uh-huh.
Q. Is that appropriate in your opinion, Doctor, in terms of prescription of methotrexate?
MR. TERRY: Objection. Go ahead. You can answer.
A. Is it appropriate not to have measured the blood counts on a regular basis? No, it's not

appropriate.

Q. And this is a drug that should not be given on a long-term basis unless you were monitoring certain functions, is that correct?

A. That's correct.

Q. You also found evidence of infection, did you not?

A. Yes.

Q. And I take it that you were somewhat pleased with the response that she was making to the therapy that she was on at the time? I mean you say that. She has shown a nice response to antibiotic therapy.

A. Yes.

Q. Did you indicate that that therapy should be continued? Not a trick question. Under recommendation on the next page, that's what you said.

A. Yes.

Q. Okay. And how long, Doctor, should erythromycin be given once it's begun?

A. I think that depends on the situation.

Q. Well, doesn't the PDR indicate how long it should be given?

A. Well, it may. I haven't reviewed the PDR for

erythromycin recently.

Q. Well, in your opinion how long should she have been getting it?

A. Ordinarily a drug like this would be given for a period of seven to ten days, depending on the response.

Q. Well, when you say depending on the response, are you saying that once the infection is cleared, there's no necessity of continuing to give it?

A. Ordinarily after the infection is cleared, the patient is afebrile, and there's no evidence of an infectious problem, then the antibiotic could be discontinued.

Q. Well, is an elevated white count an indication that there is an existence of an infection?

a. It may be, but not necessarily so.

Q. Okay. It's certainly some evidence that there's a potential problem?

A. It is evidence that that is one possible consideration.

Q. Sure. Well, she had an infection. I mean you knew that?

A. Exactly.

Q. And it was your opinion to continue antibiotic

therapy?
A. Exactly.
Q. Dr. Go has been deposed. Have you reviewed his testimony?
A. No, I have not seen it.
Q. He testified that he stopped the antibiotics on the 6th without consulting you. Do you have any recollection about having any discussions with Dr. Go after you made your consultation report on the 2nd about whether to continue or stop antibiotics?
A. I have no recollection of that, no.
Q. Did you see her again after this consultation?
A. I don't believe I saw the patient after this consultation.
Q. Your last sentence in the consultation is, I shall be pleased to follow the patient along with you?
A. That's correct,
Q. Did you anticipate that he would let you know how she was doing and ask your further advice?
A. In this instance to the best of my recollection, I reviewed the blood count that I had ordered --
Q. Okay.
A. -- the following day or two days later, and was

satisfied that the myelosuppression was corrected or in the process of being corrected and didn't have any further indication to do anything further for the reason that I was called in to see her.

Q. The pancytopenia?

A. That's correct.

Q. And so do I understand correctly that you were not all that concerned with the infection aspect of it?

A. That's correct.

Q. And would you then have anticipated Dr. Go would have consulted with an infectious disease expert if in fact he felt that that was appropriate?

MR. TERRY: Objection.

a. Yes.

MR. TERRY: Go ahead, You can answer.

A. I would expect so, yes,

Q. So that when you're the one that indicated or made a recommendation to continue current antibiotic therapy, why did you do that? I mean if you're not the infectious disease consult, why would you make that recommendation?

A. Well, I think that one wants to take general

cognizance of the various events that are going on, and I think it's a general recommendation in a patient who had at that time still a low white count and a --

Q. Low white count or high white count?

A. At the time I saw the patient the most recent white count was, I believe, still low. I'll be more precise. Let me just look it up for you.

Q. Sure.

A. I saw the patient on April 2, and the most recent preceding white count was 600, and that was done on March 30th. And I think that it's -- because it's standard practice for hematology oncology to be -- to take notes of these low white counts, and in a situation where a patient at least presented with a fever, it was appropriate to indicate that the patient, having been started on antibiotics and not at that time, that is to say, on April 2, knowing what the white count was, to have recommended that the antibiotics be continued.

Q. Okay. You ordered platelet transfusions, did you not?

A. That's correct.

Q. And the reason for that was what?

A. The patient had -- the most recent platelet count on the record was 11,000 and the patient had evidence of hemorrhagic findings, and I think they're documented in my consult reply when I describe the patient having extensive ecchymosis over the upper extremities, to a lesser extent over the lower extremities where scattered petechiae -- these are scattered pinpoint hemorrhages -- are also seen.

So I think that there's a general rule of thumb that in a patient who has a thrombocytopenia that is associated with bleeding, that the administration of platelets can reduce the risk of additional or further bleeding.

Q. Okay. And there was a good response for both the white and red blood cells during that hospitalization, were there not?

A. I'm sorry?

Q. There was a good response of her white and red blood cell counts during her hospitalization, were there not?

A. Yes.

Q. All right. Did you continue to monitor those or you just checked the one that you ordered?

A. After I checked the one I ordered, I did not monitor it any further.
Q. You were not aware then that on April 8 the white blood count was 34,288.1 granulocytes?
A. Is that a question? No, I was not aware of that.
Q. Should you have been made aware of that?
MR. TERRY: Objection.
A. I don't know whether I should have or not.
Q. Well, in your opinion, should somebody have brought that to your attention, Doctor?
A, Not necessarily. It's a matter -- would have been a matter of judgment on the part of the attending physician in light of everything that was occurring in the patient at the time.
Q. Well, everything, I take it, is a matter of judgment, but did he show good judgment in not letting you know?
MR. TERRY: Objection.
A. In all honesty I don't know if I could really second guess that. Perhaps if it had been persistent over a longer time, he might have inquired into it.
Q. All right. Were you involved at all in analyzing or assessing whether or not she had

pneumonia?

A. No, sir, I was not.

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(Thereupon, a discussion was had off the record.)

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Q. Doctor, in your assessment, the very last paragraph --

A. Yes, sir.

Q. -- that's page 2 of your consult report.

A. Yes.

Q. You state that -- well, you anticipated that she was going to recover from her infectious problem, correct?

A. That's correct.

Q. All right. And the reason you anticipated that was what?

A. Her temperature had decreased to normal during the five days or so from the time of admission to the time I saw her on the antibiotic therapy that she had been provided.

Q. And based on that, you felt that the infectious problem would resolve?

A. I thought it was in the process of resolving, yes.

Q. All right. You then say, and from the suppression of methotrexate. What did you mean when you put that in? That you thought that that would resolve or is that modifying the rest of the sentence or -- why don't you read the sentence and then maybe we can discuss it intelligently.

A. All right. The first clause up to the first comma, I think after she recovers from her infectious problems and from the suppression of methotrexate, one has to consider why she has the abdominal bloating, et cetera -- the interpretation of what I was saying is after she recovers from the infectious problems and after she recovers from the suppression of methotrexate, that would be the pancytopenia.

Q. Okay. Did you anticipate that that would occur?

A. Yes.

Q. And why is it that you anticipated that?

A. There was no reason for it not to recover. In other words, methotrexate is a myelosuppressive drug and I had uncovered no other explanation to account for the pancytopenia. With the removal of the drug virtually a hundred percent of the time the bone marrow recovers and the counts

return to normal.

Q. Is that with chronic use of the drug or is that with periodic use of the drug?

A. Both. You may have a protracted pancytopenia from chronic use, and I think that that is a possibility. I suspect that's why I ordered the follow-up blood count that I ordered.

Q. Can methotrexate, chronic use of methotrexate, cause hepatitis associated with vascular changes of the portal, splenic and mesentery arteries and splenic end parts?

MR. TERRY: Objection.

Q. Well, let me withdraw that. Let me ask that differently. Is hepatitis a well-known complication of methotrexate therapy?

A. I'm trying to think the best way to respond. It is known that administration of methotrexate over time can in some patients be associated with a, if you will, a chemical hepatitis, inflammation of the liver.

Q. And that's one of the reasons that you would be checking liver function if you're prescribing methotrexate, correct?

A. That's correct.

Q. Do you have any opinions in this case, Doctor,

regarding the relationship of the methotrexate to Mrs. Schultz's death?

A. I do not.

Q. All right. Have you reviewed any records for that purpose?

A. No, I have not. I really had no involvement with the case after I saw her in consultation, and as I said, looked at the follow-up blood count, but that was the end of my involvement with her.

Q. You go on to say before the comma, one bas to consider why she has the abdominal bloating. Would that have been within your province to determine that?

A. No, sir.

Q. Or you were just commenting on the existence of something that you physically saw?

A. Right. That's correct.

Q. And just as any doctor would, even though you weren't consulting for that problem, you were noting the problem for somebody else to deal with?

A. That's correct.

Q. Would that also be true with the rest of the sentence then, and what the reason is for the

anoxia, the 25-pound weight loss, and why her albumin is only 2.5?

A. That's correct.

Q. So none of that would have been within your expertise?

A. No, sir.

Q. All right. In terms of recommendations, the third one then, says, Evaluate her GI tract after she recovers from the present acute episode. It should be noted that patient states she's been passing some black stool. I think we have to look into this. Would that have been within your province to follow up on that?

A, No, sir.

Q. Whose would it be then?

A. Well, all of these would have been within the province of the attending physician.

Q. All right. Other than giving her platelet transfusions which you indicate that you had done or you had ordered?

A. I'm sorry. I don't understand the question.

Q. Other than giving her the platelet transfusions, which you indicated in your recommendation that you had done.

A. Yes.

Q. All right. That would have been within your province, you did it?

A. Yes.

Q. Do you have any opinions, Doctor, as to whether or not she should have been discharged with -- well, first of all, do you have any opinion as to whether she should have been discharged when she was?

MR. TERRY: Objection.

MR. JEFFERS: Objection.

A. I don't have any opinion because I was really not involved with her care at the time.

Q. Did you stop in to see her at all again after you saw her on this consultation?

A. Only the one time. The only recollection I have, and 1 did not write a note on it, but the only recollection I have is after -- is to review the results of the blood test I had ordered. And that would have been the day after the blood test, which would have been the 4th of April. The blood test -- I saw the patient April 2. The blood test was done on April 3.

And I did take the liberty of looking at the calendar. April 2 was a Saturday. April 3 was a Sunday. So I would have stopped in on

Monday, April 4, and having satisfied myself that it was up, I suspect I went in and told the patient that her blood counts were resolving and there was really -- you know, basically my role was finished.

Q. All right. You were trying to do what with the blood counts, get the white blood count up?

A. My responsibility was to evaluate the mechanism of the pancytopenia.

Q. Okay.

A. There are --

Q. And pancytopenia is what? That's bleeding?

A. No, sir,

Q. What is it?

A. Pancytopenia means suppression of all the blood cell elements, okay?

Q. Okay. And why are the blood cell elements suppressed?

A. Because the bone marrow which is the site where blood cells are made is suppressed because of the action of the drug, methotrexate.

Q. Okay. But there was also associated bleeding, was there not?

A. Bleeding will not deplete blood cells ordinarily. As a matter of fact, very often

when you have patients who have GI bleeding, there may be an increase in blood counts,

Q. Okay.

A. Except for the red count, obviously, which goes down, but I mean the white count and the platelet.

Q. Did she have leukopenia?

A. Leukopenia means a decrease from normal of white cells as opposed to neutropenia which is a decrease from normal of neutrophils, which is just one category or class of white cells. So she had leukopenia as well as neutropenia.

Q. So your purpose then was to what? Or your goal was to do what?

A, My goal or purpose was to evaluate the mechanism for the pancytopenia and then to prescribe appropriate treatment for it,

Q. Which was the platelet administration?

A, In this instance at the time I saw the patient that's correct.

Q. And the purpose of platelets would be to what?

A. The platelets are small cells that circulate in the blood and promote blood clotting. When the platelets are low, a patient is at risk for increased bleeding. So the purpose of the

A. The blood counts I reviewed would have been those that had been obtained before I saw the patient in consultation.
Q. Well, and you said you ordered one?
A. There were three blood counts that I reviewed that were available before I saw the patient in consultation,
Q. 28th, 29th and 30th?
A. That's correct.
Q. Okay.
A. And then I ordered one that was done on the 3rd of April, and I reviewed that,
Q. All right. And the white blood count was up?
A. 8,700 on April 3.
Q. Hematocrit?
A. Was 9.9 grams.
Q. Is that okay?
A. I'm sorry. The hemoglobin was 9.9 grams. The hematocrit was 29 percent, Well, it's a mild anemia, but it was not significantly different from what it had been on March 30.
Q. All right. Which was 30?
A. Yes.
Q. Platelets?
A. The platelet count had increased to 51,000 which

may have been due in part to the preceding platelet transfusion.

Q. Okay. You're talking now about on the 3rd?

A. I'm talking about April 3, yes.

Q. All right. Did you ever review the laboratory findings for April 8?

A. No, sir, not to my recollection.

Q. Would you look at them now, please?

A. Certainly.

Q. What's the white blood count?

A. On that day the white blood count is 34,200.

Q. How about the differential?

A. The differential reveals 71 percent polys, these are neutrophils. 9 percent lymphocytes, 7 percent monocytes, 6 percent bands, 5 percent metamyelocytes and two percent myelocytes.

Q. And what about the platelets, Doctor?

A. The platelets were 561,000.

Q. Are those normal readings?

A. The white count is elevated. The platelet count is elevated, and there's some immature white cells in the differential.

Q. What does that tell you, sir?

A. One of several things could be occurring.

Q. Well, what do you think most likely was

occurring?

A. Well, I can't say what was most likely because --

Q. Okay. Tell me the several things then.

A. I can tell you the several things.

Q. Okay.

A. Either this patient had, if you will, a rebound phenomenon from having had a severe pancytopenia and now was recovering the bone marrow, and there's an overshoot in the recovery following such a rebound phenomenon. This overshoot was on the shy side of what one would expect with respect to the white cells, but in the range of elevation with respect to platelets, normal platelets being 150,000 to 450,000.

It could -- other possibilities particularly with respect to the presence of metamyelocytes and myelocytes in the peripheral blood -- and I'm assuming for the sake of this interpretation that the technician who did the differential was correctly identifying the cells.

Q. Okay.

A. Because I did not review the smear, so I can't testify personally to that, or confirm or affirm

that this is an accurate differential.

But taking it at face value, it would occur that one of two things was occurring then. Either that this patient may in fact have had a variant of what we call the myeloproliferative disorders. Myeloproliferative disorders are a family of disorders of alteration of production of blood cells by the bone marrow, and which in this case would have been characterized by an increase in the white count and platelet count with an appearance of immature white cells in the peripheral blood.

And disorders that comprise the myeloproliferative disorders might have been chronic myelocylic leukopenia or polycythemia vera or one of those variants.

In any event, this patient may have had that type of a process, which is a prime bone marrow problem. It's not due to something else. It's an abnormality that's inherent in a disease of the bone marrow itself.

Q. All right.

A. That would have been one possibility. And the other possibility would be that this could be what is called a leukemoid reaction, which is a

reaction and response to something else going on in the body, which could be infectious, inflammatory or some other process, even an unrelated neoplastic process, cancer somewhere else.

Q. Or it could be just some type of infection?

A. Well, I included infection as one of the possible stimulants.

Q. Sure, so that should have been one of the differential diagnoses based upon this finding?

A. At 'that time, yes.

Q. All right. Could you tell me what the next blood count finding --

A. I don't see another blood count on the records that I have.

Q. Shouldn't there have been one, Doctor, after this finding --

MR. TERRY: Objection.

Q. -- in your opinion?

A. Well, I would ordinarily have expected another blood count.

Q. Do you know when she was taken off antibiotics?

A. No, I don't,

Q. If I told you that it was before this blood count was taken, would that assist you at all in

terms of your differential?

A. The differential would be the same. My differential diagnosis would be the same irrespective of when the antibiotics were discontinued, I would still be concerned with the range of possibilities that I indicated.

Q. All right. I take it that your concern would have resulted in some additional testing?

A. That's correct.

Q. Do you know if any additional testing was done with respect to this finding?

A. I do not know. I do not know if anything was done. I don't have any records of any additional blood counts.

Q. Are there even any notes in the chart by the physician after April 8?

A, Excuse me while I look at the progress notes,

Q. Sure.

A. The last note that I see in the medical record is dated April 8.

Q. I'm sorry. You said earlier that you had looked at the calendar and determined that the weekend was when, April 2?

A. I looked at a calendar and determined April 2 was a Saturday.

Q. Saturday. So the 8th would have been a Friday?
A. Yes.
Q. Were you apprised by Dr. Go or anybody else that she was discharged on April 11?
A. No, sir.
Q. Were you consulted as to whether she should be discharged?
A. No, sir.
Q. Were you told that she was readmitted on April 12?
A. No, sir.
Q. I'm sorry. I withdraw that. That she was seen in the emergency room again on April 12?
A. No, sir, I wasn't aware of it.

MR. KAMPINSKI: That's all I have.

MR. JEFFERS: No questions.

MR. TERRY: Anybody?

MR. GROEDEL: No.

MR. HURT: No.

MR. TERRY: You have the right to read this or you can waive it. I would recommend that you don't waive signature.

THE WITNESS: On the advice, I'd like to read the transcript, please.

____
DALE COWAN, M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Sandra L. Mazzola, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named DALE COWAN, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

_____
Sandra L. Mazzola, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires January 6, 1992