State of Ohio,) SS:

County of Cuyahoga.)

- - -

IN THE COURT OF COMMON PLEAS

- - -

GAIL KAPLAN VERBITSKY, Admx. for the Estate of FREYDA KAPLAN, et al.,

Plaintiffs,

v.

NEHEMIA HAMPEL, M.D., et al.,

Defendants.

Case No. 250739
Judge Kathleen A. Sutula

- - -

THE DEPOSITION OF MICHAEL W. DEVEREAUX, M.D.

WEDNESDAY, JULY 6, 1994

- - -

The deposition of MICHAEL W. DEVEREAUX, M.D., a Witness herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Barbara A. Oser, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at Mt. Sinai Medical Center, One Mt. Sinai Drive, Cleveland, Ohio, commencing at 10:20 a.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiffs:

GEORG ABAJSUMOV, ESQ.
Reserve Square, Suite 3B
1700 13th Street
Cleveland, Ohio 44114

KEVIN T. ROBERTS, ESQ.
Ohio Savings Building
20133 Farnsleigh Road
Shaker Heights, Ohio 44122

On behalf of Defendant Nehemia Hampel, M.D.:

PATRICK J. MURPHY, ESQ.
Jacobson, Maynard, Tuschman & Kalur Co., L.P.A.
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114

On behalf of Defendant Mt. Sinai Medical Center:

MARC GROEDEL, ESQ.
Reminger & Reminger Co., L.P.A.
The 113 St. Clair Building, Suite 700
Cleveland, Ohio 44114

On behalf of Defendant Mira Baron, M.D.:

JOSEPH E. HERBERT, ESQ.
DAVID W. SUMNER, ESQ.
Jacobson, Maynard, Tuschman & Kalur Co., L.P.A.
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114

- - -

INDEX

- - -

MICHAEL W. DEVEREAUX, M.D.
a Witness herein, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. ABAKUMOV:

Q. Doctor, do you have a CV with you here?

A. No, but I could have one printed up for you, if you would like.

Q. Yes, I'd like to have you forward that to my office.

A. **Well, before we leave, when we're** done, **remind me to ask my secretary and we'll have her make a copy.**

MR. SUMNER Just before questioning begins, the seven hours you spent on the 4th of July, is that included in the $300?

THE WITNESS: well, obviously, that's done. I don't charge for that, at least I don't *think* that's policy.

MR. ABAKUMOV well, I assume I'm just paying for the time he's talking

today. I'm not paying for the time he has spent reviewing material for today's deposition.

THE WITNESS: But you know preparation.

MR. ABAKUMOV: I didn't ask you to prepare, Doctor. You can discuss that.

MR. SUMNER: okay. Go ahead.

BY MR. ABAKUMOV:

Q. Doctor, please state your full name and spell it for the record.

A. **Michael William Devereaux, D-E-V-E-R-E-A-U-X.**

Q. What did you do to prepare for today's deposition?

A. **I reviewed the hospital records primarily, and that's about a thousand pages of material.**

Q. Which hospital records did you review?

A. **They included the hospital admission from 9-30 to 10-7, the hospital admission I believe it was from** 11-2-91 **to about** 1-22-92, **plus assorted out-patient records from out-patient visits, plus the letters of other expert witnesses.**

Page 6

Q. Do you know which expert witness letters you looked at?
A. Sure. Would you like me to --
Q. Yes, tell me which ones you read.
A. Robert Salata, M.D.
Q. Did you read all these in full?
A. Yes. James Schmidley, John Gardner, M.D., Howard Tucker, Keith Beck, Neil Crane. I think I listed them all,
Q. Did you look at Elroy Kursh's?
A. Elroy Kursh.
Q. You read that one?
A. Yes.
Q. Did you read any depositions?
A. No.
Q. Did you read the records from the MetroHealth skilled nursing home center, Sunny Acres?
A. No.
Q. How did you get these records, Doctor?
A. Well, the hospital records, of course, I got from the hospital. The expert letters came from Mr. Murphy's office.
Q. Did you receive any records from Mi-. Groedel's office? Did Mr. Groedel provide you anything through Reminger & Reminger or directly?

Page 7

A. I don't believe so.
Q. Whatever you recollect.
A. No, I don't believe so.
Q. Did you meet with Mr. Groedel prior to this deposition?
A. No.
Q. Did you meet with any other attorneys prior to this deposition?
A. No.
Q. Did you have discussion on the phone about this deposition?
A. Yes.
Q. Who was that with?
A. Mr. Murphy.
Q. And what was the nature of that discussion?
A. We talked last night for about 20 or 30 minutes. It was my understanding that we weren't allowed to talk about the hospitalization from 11-2 to 1-22-92, and we didn't. And we discussed just points of the deposition, you know, issues about the first hospitalization and so forth.
Q. Why did you understand you couldn't discuss the second admission?
A. Ihavenoidea.

Page 8

Q. Did you review the records of the second admission?
A. Yes.
Q. Were you asked to review the records of the second admission without discussing them?
A. Was I asked to review the records of the secondadmission? I'm trying to remember whether the records came from your office for the second admission or directly from the hospital.
MR. MURPHY: I didn't send you any records.
A. Then they came from the hospital. I was part of the process. I was involved in her care in the second hospital admission. And I don't member what was specifically said about whether I needed to review them, but it was obvious that they needed to be reviewed.
Q. Why was it obvious that they needed to be reviewed?
A. Because it's a three-month hospitalization and the doctors involved in her hospital care and the hospital are being sued. So it's perfectly logical that they needed to be reviewed.
Q. Doctor, are you PIE insured?
MR. MURPHY: objection.

Page 9

MR. HERBERT: objection.
MR. MURPHY: You can answer.
A. Yes.
Q. Doctor, are you being paid for the time you spent reviewing the records, this seven hours?
A. No.
Q. You're not requesting payment for reviewing the records?
A. No. But if it's all right, I will, I'd be glad to.
Q. Well, I'm just asking you if you are requesting it as you came here today.
A. No, but I would accept it.
Q. Doctor, please state all your business addresses.
A. My business address is Mt. Sinai Medical Center, Department of Neurology, One Mt. Sinai Drive, Cleveland, Ohio 44106.
Q. And is that the only office you have?
A. It is. In reality we go out half a day a week or I do to the IMC, Integrated Medical Campus, where we see outpatients.
Q. What is the IMC?
A. It stands for Integrated Medical Campus.

Page 10

Q. And is that part of Mt. Sinai Medical Center?
A. Yes.
Q. Is that an entity that is part of Mt. Sinai Medical Center?
A. The hospital built it, yes, and owns it.
Q. Now, are you an employee of Mt. Sinai Medical Center here in the neurology clinic?
A. No, I am a part-time employee. I have -- I'm not sure how it works. I'm paid a salary in part for my administrative work and what have you, and then the division of neurology is incorporated.
Q. It's incorporated into that part-time salary?
A. No, they're two separate.
Q. It's a separate entity. when you saw patients in November of 1991, particularly Freyda Kaplan, were you seeing her as a private patient?
A. No, I saw her because I was on service that month.
Q. Is the service a duty that you perform for Mt. Sinai Medical Center?
A. That's part of our teaching responsibilities to the institution.
Q. Do you get paid for your teaching at

Page 11

Mt. Sinai Medical Center?
A. I'm paid a salary for administrative work and basically all of my duties for the hospital, yes.
Q. Including teaching and seeing patients on service?
A. Right. It's a token salary.
Q. But you are paid?
A. Yes.
Q. Does your corporation pay office rent for the neurology clinic?
A. The neurology clinic?
Q. Well, this facility that you're in here. What's the name of your neurology group?
A. Mt. Sinai Medical Center Neurology, Incorporated.
Q. And you're part of that corporation?
A. Yes.
Q. Does your corporation pay rent to Mt. Sinai Medical Center for the space that they use here?
A. Yes. I'm not sure how all the arrangements, frankly, work out, but there is --
Q. Do you know how much the monthly rent is?
A. No, and I wouldn't tell you if I did.
Q. Is it nominal?

Page 12

A. No. It's really none of your business what our arrangements are with the hospital.
Q. Well, you're here to --
A. I'm here to discuss medical aspects of the case.
Q. Well, you're here to discuss aspects that are legal aspects as well or maybe because of what the facts present. So I'd just like to know --
A. I can't even tell you.
Q. So you don't know if it's nominal, a hundred dollars a month, or a thousand dollars a month; you have no idea?
A. I have no idea. I don't even handle the books.
Q. Who does?
A. One of my associates.
Q. And who is that?
A. Gerald Grossman, M.D.
Q. Grossman?
A. Yes.
Q. Is that Gerald, G-E-R-A-L-D?
A. Yes.
Q. Grossman, G-R-O-S-S-M-A-N?
A. Correct.
Q. Doctor, where did you complete medical

Page 13

school?
A. I went to Baylor College of Medicine.
Q. And where did you go to college before that?
A. Stanford.
Q. Where did you do your internship and your residency?
A. I did my internship at the University of Southern California, L.A. County Medical Center and did my residency training at the same institution.
Q. When did you come to Mt. Sinai Medical Center?
A. I came in the end of June 1977.
Q. And in what position was that?
A. Chief of Division of Neurology.
Q. And have you continued in that position since that time?
A. Yes.
Q. Do you know Dr. Howard Tucker?
A. Yes.
Q. Have you ever worked on patients With Dr. Tucker or have you ever consulted with him?
A. I'm not sure how you mean.
Q. Just tell me how you know Dr. Tucker.
A. Well, he's a neurologist in the community

Page 14

and he has worked at Mt. Sinai in the past, although not as much in recent years.
Q. Do you have an opinion of him as a neurologist in the community?
A. He's a competent practitioner of neurology.
Q. And how would you describe yourself, also as a competent practitioner of neurology or something more or less than that?
A. I'm a competent practitioner of neurology.
Q. Now, since 1977 coming to head up the Department of Neurology at Mt. Sinai Medical Center, have you held any other positions?
A. Yes.
Q. What else have you held?
A. Well, I'm currently Associate Professor of Neurology at Case Western Reserve University, I am the Associate Director of the Department of Medicine at Mt. Sinai and I'm currently Chief of Staff at Mt. Sinai.
Q. And are those all positions that you get paid for separately? Which of these positions that you mentioned do you get paid for?
A. In part as Associate Director of the Department of Medicine. The others are done gratis.

Page 15

Q. Is the teaching position also gratis at Case Western Reserve University?
A. Correct.
Q. Do you know if you sent any bills to Freyda Kaplan for the service you provided during her second admission?
A. I have no idea. I don't know if we took care of her for free since she was an immigrant or whether part of it may have been covered by Medicaid. I have no idea. She would have probably gotten no bills.
Q. Do you know Dr. Salata whose report you read?
A. No.
Q. Dr. Schmidley?
A. I know James Schmidley.
Q. As a neurologist?
A. Yes.
Q. Do you know Dr. Keith Beck from California by any chance?
A. No.
Q. Dr. John Gardner?
A. I know John Gardner.
Q. Elroy Kursh?
A. I know Elroy Kursh.

Page 16

Q. How do you know Elroy Kursh?
A. He's a urologist in the community, he's interested in neuro-urology, a very competent urologist.
Q. Have you treated patients together?
A. Well, he's mainly at University Hospitals, so there certainly have been cases that we have crossed on but not on a regular basis.
Q. And you don't happen to know Neil Crane from Chevy Chase, Maryland?
A. No.
Q. Do you have an independent recollection or did you have an independent recollection before you looked at the records of Freyda Kaplan?
A. I'm not sure what that means.
Q. Before you looked at the records at the time that Mr. Murphy called you about this patient, did you remember who she was?
A. Yes.
Q. Or did you have to be reminded?
A. Well, I can't remember a name like Freyda Kaplan. I can't recall whether it took me a brief review or a mention of what the case was about before I recalled details. I can't remember whether that's the case. You'd have to ask Mr. Murphy when we spoke. But

Page 17

certainly once we connected, I did remember the details.
Q. What did you remember about her before you read the records?
A. That she was a woman with prolonged hospitalization; that she had Candida meningitis, unusual -- that's one of the reasons why I remember her case -- that she had bilateral thalamic strokes -- I remember that -- and that she was just a very difficult management problem.
Q. Did you remember what happened to her at the end of her course of treatment at Mt. Sinai Medical Center or did you have to review the records?
A. I knew that she got into a chronic care facility.
Q. You knew that she had the strokes before and had gone into some type of comatose or semicomatose state; you're aware of that?
A. Yes.
Q. Do you remember her family at all?
A. I remember the daughter.
Q. Now, Doctor, are you familiar with the Russian Clinic at Mt. Sinai Medical Center?
A. Yes.
Q. Briefly tell me what that is.

Page 1

A. It's a clinic that has been established basically out of charity with hospital money put into it and also some money from the Jewish Federation, a rather small amount, to support it. Physicians contribute a lot of time at little reimbursement taking care of these patients. It's a service we provide in thecommunity.

Q. Well, doesn't the hospital bill for the service it provides to these?

A. Oh, yes, it's a big loss. In fact, we're not sure we can continue it. The clinic costs us hundreds of thousands of dollars a year to maintain and reimbursement is nill.

Q. Now, was it that expensive and troublesome -- Well, strike the word troublesome. Was it that expensive to maintain in 1991?

A. It's always been expensive to maintain.

Q. Now, is that a reason that patients that come in through the Russian Clinic may get less care or a lower standard of care than private patients?

A. That's absolutely patently ridiculous.

Q. They get the same level of care?

A. Absolutely.

Q. And would you say that the doctors who treat them perform to the same standard of care?

Page 1

A. Yes.

Q. And are held to the same standard of care?

A. Yes, and in that circumstance better.

Q. Better?

A. Yes.

Q. Could you describe that?

A. Yes, they speak the language.

Q. And how about the competence of the doctors working there?

A. They'recompetent.

Q. As competent as the --

A. Yes.

Q. -- American doctors that are working in other parts of the hospital?

A. Yes.

Q. And are all the --

A. All these doctors are on o w staff.

Q. So they also treat private patients as well as the patients they see through the Russian Clinic?

A. Correct.

Q. What is the GU clinic, if you know, at Mt. Sinai Medical Center?

A. I don't know much about its operation. GU refers to genitourinary clinic. It's probably

Page 20

urology.

Q. Is it a separate area in the office?

A. It's in the out-patient department, which continues in the building that we're in now. And those floors are shared by different clinics: Medicine clinic, orthopedic clinic, surgery clinic, OB clinic, pulmonology clinic, neurology clinic. I don't know specifically where the urology clinic holds its clinic.

Q. Okay. Now, do you know Dr. Baron, Mira Baron?

A. Yes, I do.

Q. How do youknowher?

A. Mira Baron is a physician on our staff.

Q. Have you ever treated a patient she has sent to you?

A. Yes. Mira Baron trained here and did her residency here, so I knew her as a resident and I know her as a colleague.

Q. Would your characterization of the doctors in the Russian Clinic also apply to Mira Baron as being competent and held to the same standard of care as any of the non-Russian origin doctors here at Mt. Sinai Medical Center?

A. Yes.

Q. Do you know Dr. Hampel?

Page 21

A. Yes, I do.

Q. How do youknowhim?

A. He is also a colleague and a member of the staff at Mt. Sinai.

Q. He's a foreign-born doctor, isn't he?

A. Yes.

Q. He's not a doctor in the Russian Clinic though?

A. The doctors who run the Russian Clinic are primarily primary care physicians and they refer out to other physicians. I, frankly, don't know the exact arrangementwith Dr. Hampel. Our neurology clinic accepts Russian patients. In fact, our neurology clinic happens to be physically in the Russian Clinic and it meets on a Friday afternoon.

But I don't know specifically what his arrangement is, if he has any different arrangement with the Russian Clinic than, say, I do.

Q. Do you keep any private records about patients that you see and any records that aren't part of the Mt. Sinai Medical Center records?

A. No. We will keep copies of some of the Mt. Sinai records in our files for quick referral when patients call. Those will usually include if we make a separate consultation note, a few things like that.

Page 22

But we don't add any records to that unless we see the patient as an outpatient.
Q. Do you have any records on Freyda Kaplan?
A. No, I don't believe we have any here because usually the patients that we see, if you will, that are on our service we don't xerox portions of the chart. It's in our computers that we've seen her, so we know how to get to the records. We possibly have a copy of the discharge summary, but I'm not sure about that. I'd have to check and see.
Q. Do you have any record of a phone call from Dr. Mira Baron or any recollection of a phone call from Dr. Mira Baron on October 30,1991 about a patient Freyda Kaplan?
A. No, of course not.
Q. So you don't recall discussing a neurological consultation in October --
A. Of 1991?
Q. Yes, on the 30th.
A. No.
Q. And you didn't see any note about that in your review of the records, did you?
A. I didn't specifically look for it but I don't recall seeing it.
Q. And you don't recall seeing it either?

Page 23

A. No.
Q. Do you speak any foreign languages, Doctor?
A. A little bit of Spanish.
Q. Do you know Dr. Baron to speak Russian? Have you heard her speaking Russian to patients?
A. Yes.
Q. Does Dr. Hampel speak Russian or any foreign languages that you know of?
A. No, I didn't know that.
THE WITNESS: In fact, it was you that told me last night that he didn't speak Russian but Yiddish.
A. But that was -- I just didn't know that.
Q. So you weren't aware of that from your own observation or hearing Dr. Hampel speaking?
A. I don't know what other languages he speaks other than Yiddish.
Q. Other than Yiddish?
A. I don't know what other languages he speaks. Yiddish isn't a foreign language.
Q. It isn't foreign?
A. Not in Manhattan.
Q. Well, we're in Cleveland, Doctor. When is the first time you came in contact with Freyda Kaplan, Doctor?

Page 24

A. 11-3-91 I believe.
MR. MURPHY. Dr. Devereaux, did you bring in the original charts with you? I just want to take a look at that while you're testifying. If you need them, I'll give them right back to you.
MR. ABAKUMOV Do you want to pull something from those charts?
MR. MURPHY: No.
BY MR. ABAKUMOV
Q. How is it that you happened to have --
A. I was called by the house officer to see her and came in I can't remember what day of the week that was. And I have a vague recollection. I saw her at a very off hour but I didn't write it in my note at the exact time and I did an examination on her.
Q. Were you her admitting physician for that admission?
A. Well, I'm not sure how that's characterized. Staff patients, the way we work it here and the way it's worked in most institutions, don't have a private physician. The primary physicians are the residents, and then we attend on the case. Obviously, in a situation like this, I was very

Page 25

much involved and I suppose legally I am the physician of record, at least for the first part of her hospitalization.
Q. Well, you weren't there when she came into the hospital?
A. No.
Q. Do you know who admitted her?
A. I can't remember the house officer's name.
Q. Would it have been a resident?
A. Generally speaking, she probably would have been seen by staff in the emergency room, staff physicians and probably seen by the medicine resident in the emergency room, admitted to the hospital and then I was contacted.
Q. Now, do these people also have a responsibility for the patient, or are you the person who is responsible for the care of this patient during the second admission?
A. Well, I'll take responsibility.
Q. And why is that?
A. Well, because I was the attending on the service at that time, the teaching attending. And, again, if we look in our records -- I'm not sure it's available -- we may have billed Medicaid for her, if she even had Medicaid. So I may have billed her as her

Page 26

treating physician. The house officers, of course, don't send a bill.
Q. Mt. Sinai Medical Center sends a bill for the services that the residents and the interns provide?
A. No.
Q. That's just lumped into the hospital stay bill?
A. Basically the hospital just sucks up the cost. That's why teaching hospitals are going to be destroyed. Nobody cares about teaching hospitals.
Q. Do you know Dr. Gardner?
A. Yes.
Q. And was that a he or a she?
A. Dr. John Gardner is a he.
Q. Was there a Dr. Gardner that was a resident during the second admission?
A. I can't recall, Possibly.
Q. Do you recall from your review of the notes who the residents and interns were during the first admission?
A. No.
Q. Could you look at your notes and tell me?
A. Yes, because that's something I would have paid no attention to, and I probably will not be able

Page 27

to identify their handwriting.
(Thereupon, Plaintiffs' Exhibits 68 through 77 to the deposition of Michael W. Devereaux, M.D., were marked for identification.)
BY MR. ABAKUMOV:
Q. Doctor, showing you what have been marked as Plaintiffs' Exhibits 68 through 77, would you take a look at those and --
A. I can't read his or her name.
Q. Can you identify what the records are first?
A. This is a house officer's admission note.
Q. That's 68?
A. Yes.
Q. And you don't know who the intern is from thatnote?
A. No, I can't read the signature. Really I'm not sure that this is the -- Let's see.
Q. You're looking at Plaintiffs' Exhibit 77, a progress note?
A. No, 74.
Q. Exhibit 74, a progress note?
A. No, this is an addendum to the progress note. It looks like it's a continuation of the same

Page 28

note because this isn't the final. He may have waited for some laboratory results and then finished his note because I don't see his signature at the end of the page on Plaintiffs' Exhibit 73. So I presume it's the same person. It looks like the same handwriting that's on Exhibit 74. And I'm not sure. It's M-A-L-F and it looks like I and then it sort of tapers off there, and I'm just not sure who that is. We'd have to find out who the house officers were on rotation that shift who might have seen the patient.
Q. I'm going to show you Plaintiffs' Exhibit 71. Whose signature is that?
A. I told you I couldn't read that. Is that a G? I just can't read it. Or maybe it's an A. I have no idea.
Q. Do you remember a Dr. Gita Moceuf or Moceuf? Does that name ring a bell?
A. I remember the name, yes. I don't remember much about her.
Q. Was she a resident at the time?
A. A house officer, yes, I believe so. It almostlookslike a G. I'm just not sure. I'm not sure. Sorry. Ican'thelpyou. We'd have to get the list of the teaching rotations for that month of November. That's probably available. Those names

Page 29

would be available, and we could see if they match up withthosenames there. They may have been night coverage house officers depending on when the patient was admitted. It was late at night, so they probably would have been not the neurology rotators but the people who were on night call.
Q. Well, some of these notes are even from November 4, which is more than a day after the admission.
A. Yes. Ijustcan't help you.
Q. Okay. When was the first time you saw this patient?
A. My note is dated 11-3.
Q. And where is your note here?
A. The first part of it is right here, neuro 11-3. And my signature is on Exhibit 76.
Q. Exhibit 76?
A. Right.
Q. Doctor, what did Freyda Kaplan present with on 11-3-91?
A. Change in mental status dating back, oh, we didn't know for sure, but probably a week. At least that's the information that we had at the time
Q. Does it indicate there that there was some perhaps correlation between mental status changes and

Page 30

the taking of Cipro?
A. You mean did I make note of that?
Q. Did you or anyone else make a note about that? Were you aware of that information?
A. At that particular point I was not.
Q. Did you later become aware of that information?
A. Yes, that there was -- that question had arisen prior to her being hospitalized.
Q. Does Cipro cause confusion?
A. Many of the antibiotics can and Cipro can, yes.
Q. And is that listed in the PDR as one of the side effects of Cipro; do you know?
A. A variety of cognitive and non-cognitive changes are listed.
Q. Now, in a patient that has -- you didn't put her on Cipro during the second admission, did you? Did you put her on Cipro again during the second admission?
A. I did not. With a two-and-a-half-month hospitalization, I can't sit here and tell you that somewhere later on in the course that somebody -- The ID, infectious disease, people might have, but I did not.

Page 31

Q. If she was put on Cipro during the second admission, would you expect her to have confusion again if she had reported it a week earlier?
A. She was confused throughout the entire admission, so it would be very difficult.
Q. Well, what if she had Cipro earlier and had not been confused?
MR. HERBERT objection.
You're asking fact questions or opinion questions, just so it's clear?
MR. ABAKUMOV: A fact question.
A. I was looking at my note here. And this happened two and a half years ago. I make a note that Cipro was stopped and that the patient remained afebrile plus very confused and obtunded today, unable to cooperate for examination,
So I don't know what the source of that information was. The daughter couldn't speak much English. I don't know what records I had available at that point. So I can't tell you for sure where that information came from.
Q. Were there any other symptoms or signs that the patient presented with that you were aware of on November 3?

Page 32

A. Well, there was -- I make note here that she was started on Cipro one week ago prior to my seeing her and was progressively confused during the week with decreased ambulation, began complaining of headache at one point and also vomiting I wasn't sure when that was from the quality of the history available to me at the time. So that there was an overall change in her mental status.
As I say, she had some headache in the days that preceded admission and also some vomiting and decreased ambulation, decreased walking. That was her history.
Q. Was this history important to you?
A. History is always important.
Q. What was significant about this history and what did it point to in terms of possible problems?
A. That she was encephalopathic.
Q. She had some involvement of her central nervous system with infection perhaps?
A. Well, perhaps. At that point, I believe, it was not clear to us certainly because she was afebrile, if I recall correctly, on admission. So we weren't at all sure what was going on as indicated by my note. I'mmissing Page 75 here.
Q. Exhibit 75?
A. Yes. And, indeed, I put down as an

Page 33

impression progressive encephalopathy times one week on the basis of the history without focal deficit. About the only finding that really troubled me was the fact that she appeared to have some nuchal rigidity. And so on the basis of that, I had to consider the diagnosis of meningitis but I did not rule out a metabolic/toxic encephalopathy.
Q. This patient had nuchal rigidity on the 3rd?
A. When I saw her on the 3rd, right.
Q. How long does it take to develop nuchal rigidity?
A. It depends. It can take hours. It depends on the cause of the infection, the circumstances when you see the patient. It, obviously, has a beginning; it appears at one point. So it depends on when you see the patient along the continuum.
Q. Well, she was finally diagnosed with having Candida albicans meningitis, correct?
A. Yes.
Q. And do you know that to be a chronic meningitis or an acute form of meningitis?
A. Well, it can make different presentations. It can be subacute or chronic. Obviously, it depends

Page 34

on when it gets diagnosed as to whether it's subacute orchronic.
Q. Well, when you finally diagnosed it in Freyda Kaplan, did you determine whether it was a chronic or acute meningitis, and if a determination was made, what was that?
A. I'd have to look at the records to see exactly what I said. But from the information available to me, looking over the records now, it would be probably subacute beginning sometime during the days prior to her hospitalization.
Q. And by days do you mean the week before her hospitalization, do you mean two days before her hospitalization or do you mean three weeks before her hospitalization?
A. No, I don't mean three weeks. It would be somewhere in the week prior to her hospitalization she probably developed the first signs of it.
Q. What was the significance of her confusion on the second admission to you as her treating doctor at that time?
A. Well, it was significant. It meant that there was -- that she was encephalopathic; that she had a disturbance of the encephalon, the brain, and that it was a very nonspecific disturbance. And that's why I

Page 35

could not make a specific diagnosis.
Q. What were the possible diagnoses at that point before you narrowed it down because you suspected several things?
A. I suspected meningitis or I suspected a metabolic or toxic encephalopathy. At that point I was uncertain of the etiology because there was just --
Q. Go ahead.
A. -- because there just wasn't enough information available to be too much more specific than that.
Q. Had you looked at her history at that point when you made the first diagnosis, her history from the first admission?
A. At that point I make no mention of having seen the history of the first admission. And, again, I am reconstructing this, and that always leads to problems. I may at that point not have even known -- I'd have to look at my records -- whether or not she was hospitalized because, again, the family couldn't speak much English.
So I certainly became aware of it. But whether it was at the moment that I saw the patient initially or whether it was in the hours or days that followed, I can't tell you at this point when I became aware of it.

Page 36

I, obviously, knew some information in the week that precededher hospitalization because of the fact that she -- because I knew that she was on Cipro and I knew that she was being followed though the Russian Clinic.
Q. Okay. Now, Doctor, based on what you saw on November 3, would you have expected that she had the same symptoms and signs on October 30 as she had on November 3, and if she didn't, what would be the difference or what would be the similarity between those two dates?
A. Well, my impression would be, particularly looking over the information on October 30, that she was a great deal worse on November 3.
Q. How bad was she on October 30 having looked over your notes?
A. Evidently, in looking over the chart, the information given was that there was some mild confusion at that point, increased -- well, that there were complaints, yes, of weakness and confusion. And the comment in the notes was, as you have undoubtedly read, that the confusion started after Cipro was started and there was fever and that this might be a drug-induced encephalopathy and the Cipro was stopped and she was started on another antibiotic. So at that point she was not as impaired as she was on November 3.

Page 37

Q. Now, Doctor, would she then be encephalopathic at the time she first became confused?
A. Well, the terms are somewhat synonymous. And the fact was that she was confused so she had some encephalopathy at that point.
Q. What kind of diseases does encephalopathy encompass, what kind of diseases of the central nervous system?
A. Virtually all potential diseases.
Q. Is candidal meningitis among them?
A. Among them, surely.
Q. Doctor, you're looking at some notes there?
A. Yes.
Q. Did you take some notes from the records?
A. Yes.
Q. Could I see those for a second, please?
A. Sure.
Q. And you have another note there?
A. Oh, that's just some scratchings I made.
MR. ABAKUMOV: would you just mark these, please?
(Thereupon, Plaintiffs' Exhibit 78 to the deposition of Michael W. Devereaux, M.D. was marked for identification.)

Page 38

BY MR. ABAKUMOV:
Q. I'm returning to you what's marked Plaintiffs' Exhibit 78, Pages 1 through 4. Are those the notes that you prepared for the deposition today?
A. Yes.
Q. We'll just get a copy of those before we go.
A. Certainly.
Q. Now, Doctor, you said that you feel she had a subacute meningitis at the time that you saw her?
A. Well, I don't think anywhere in the notes from that hospitalization I tried to classify -- again, I could be wrong -- that it was acute or chronic or subacute. I don't recall specifically seeing myself using these terms. In this case I don't think they really mean a lot medically.
Q. Well, are you saying subacute and chronic are synonymous or what?
A. No. What I'm saying is that she was discovered to have a Candida albicans meningitis. From a medical standpoint, I don't *think* it makes a lot of difference. Those terms lack specificity. It was probably -- She was probably symptomatic, as I say, for somewhere in the vicinity of a week prior to my first evaluation, so I would call that subacute.

Page 39

Q. If it had developed over a period of two or three weeks, would you consider that chronic?
A. I suppose you could argue that that would be chronic. Again, the terms lack specificity, or at least I don't apply specific times to what's acute, subacute and chronic.
Q. But if another doctor described it as being chronic candidal meningitis, you wouldn't disagree with that terminology?
A. No.
Q. Your possible diagnosis was meningitis. What type of meningitis did you suspect on that first admission?
A. Well, I wasn't sure. And, I think, you can read from my notes on 11-4 that I went through a rather lengthy differential of meningitis, actually of inflammation, of which infection is only one cause, including even discussing bacterial meningitis, which I didn't *think* she had, although I didn't note it.
One of the things we thought about at the time was TB meningitis. We talked about -- I mentioned fungal meningitis. Actually at that point I didn't think that was what she had because her course seemed too acute and the fact that she had a fever and what have you. And we wondered about other causes of

Page 40

inflammation outside of infection, including things like sarcoid, and we wondered about carcinomatous meningitis secondary to cancer. So there's a spectrum of things that you can read that we wondered about.
Q. But you didn't suspect a fungal meningitis or you didn't think of that as being a possible --
A. I thought it was possible but it wasn't my first consideration, it wasn't my most-likely diagnosis.
Q. And that was based on the fact that your information at the time was that the signs and symptoms she had, the confusion, primarily had developed over a period of a few days?
A. Why don't I just look at my note --
Q. Sure.
A. -- because I make a specific comment. These aren't the notes that I need to look at. It would be the next note that I wrote in the chart on 11-4 where I went through my differential.
This is where I went through my differential, and fairly rapid onset of symptoms now without fever unlikely but not impossible is what I wrote.
Q. Fairly rapid --
A. Fairly rapid onset of symptoms now without fever unlikely but not impossible. This rapid onset of

Page 41

her symptoms in the absence of fever, in my mind, wasn't strongly suggestive of the diagnosis of a fungal meningitis and of the fungal meningitides. That wouldn't be my first choice.
Q. Well, she had a normal temperature or close to normal temperature when she came in?
A. Yes.
Q. What was her temperature?
A. There are several temperatures. Obviously, her one temperature at the time of admission was 99.2, which wouldn't even be abnormal for the evening. And, I think, there were some other temperatures that were in the normal or near-normal range.
So that's what I wrote, that in the absence of any significant fever, rapid onset wasn't typical, and that wouldn't have been my first choice for a fungal -- anyway, Candida.
Q. What kind of fever would you have been looking for?
A. There's no specific temperature curve. With fungal meningitides, depending on the individual and a number of factors, the temperature can range from normal to significantly elevated. Frequently they run lower-grade temperatures, 101.

Page 42

Q. So a temperature of --
A. The most important thing is that it was not the picture of infection. The only thing that suggested the possibility of infection was that she had signs of meningismus, she had nuchal rigidity or a suggestion of nuchal rigidity, which suggested inflammationof meninges, and one of the etiologies of meningeal involvement, of course, would be an infection, of which there are many other causes.
Q. Well, why did you suspect tubercular meningitis?
A. I didn't write it down. But a tuberculous meningitisand tuberculosis is much more common in Russiathan in the United States and it is one of the things that she had been chronically ill with for months prior to coming into the hospital debilitated, and, therefore, it was a consideration.
It was the first consideration on the basis of the indices of the spinal fluid of the infectious disease people. That was their first thought. That's why she was started on anti-tuberculous therapy without a proven organism just on the basis of the fact that she had meningeal inflammation with no proven cause and was from Russia. And as you know, that proved not to be the correct diagnosis. But she was treated just on

Page 43

the likelihood that that's what she would turn out to have.
Q. Could you explain this toxic/metabolic encephalopathy to me? That was one of your considerations.
A. Toxic/metabolic is really a catch phrase almost that includes virtually any disturbance in the internal milieu, It would include systemic illnesses of a number of types, environmental toxins, if you have somebody that comes from another country with nothing about her history, heavy-metal toxicity. It's a whole variety of conditions that defies easy diagnosis.
You frequently have to go on a fishing expedition looking for causes, getting heavy-metal screens, drug screens, looking for disturbances in liver function, electrolytes, any other disturbance in the internal milieu to try to determine what is going on in the brain.
Q. Is that because the signs and symptoms she presented with could point to a number of serious diseases?
A. Yes. Not even necessarily serious diseases.
Q. Some serious, some not serious?
A. Well, anytime you could *argue* that a

Page 44

disturbance of the brain is a serious illness. But a toxic encephalopathy, for example, most mothers have taken care of that in their children who have high fevers. That would be one cause of the toxic encephalopathy that is quite reversible. Viral illnesses. I mean, a whole host of things could produce it.
Q. Which of the illnesses that you suspected on that first admission that she might have had could cause stroke or death?
A. At the very beginning when I first saw her?
Q. Right, the ones you suspected, not the ones that you narrowed it down to later when you got your labs back, but just your preliminary concerns at that point, the diseases you wanted to examine.
A. To rule out -- to treat -- I'm not thinking in terms of what would cause stroke or what would cause death. That doesn't really enter in on the initial evaluation. What I'm thinking about is conditions that we need to do something about as quickly as possible in order to change the course of the patient. You're always looking for things that you can effect an illness, that you can change.
If it turns out that she has metastatic cancer,

Page 45

for example, with carcinomatous meningitis, that's not so important because there's not much you can do about that the literature shows.
So what you're looking for is conditions in which immediate diagnosis will benefit the patient. That's one of the reasons why I picked up on the nuchal rigidity. A lot of patients may have the appearance of nuchal rigidity. Many patients that I've done a spinal tap on who I suspected had nuchal rigidity didn't have it. They may have paratonia or osteoarthritis or other things that *can* look like nuchal rigidity due to nuchal rigidity. If she had sarcoidosis or something else, immediate diagnosis is less important.
Q. Did you suspect candidal meningitis --
A. Initially?
Q. -- initially as something to be ruled out?
A. No.
Q. And that was because of a lack of fever?
A. Well, it's a lot of reasons. But it's rare. There are very few cases reported even in the literature. It's a very uncommon infection.
As I say, I was thinking more in categories of disturbance, does she have an infectious disease. That's the major category because once you lock into that, then you take your approach in the differential

Page 46

diagnosis in the infectious disease. So the initial approach here is to try to establish a category of illness.

We established soon after admission that she had inflammation of the meninges, one cause of which -- an important cause of which is infection, and then we started down that road looking for that cause. And as you saw in my note, a fungal meningitis was not high on my list. She certainly was going to be cultured up for it, but that wouldn't have been my first choice, my firstguess.

At that point if somebody had told me this lady has an infectious agent, Candida would not have by any stretch of my imagination been the first choice. It wouldn't have even been my first choice if she had a fungal meningitis.

If someone told me that she had a fungal meningitis, my first choice for statistical reasons would be Cryptococcus, for example, because certain of these infections are endemic to certain areas. In her case I don't know what's more prevalent in which part of Russia.

But Candida albicans meningitis has a very low incidence, it's a very infrequent infection. So that wouldn't have been my fiist choice. It was identified

Page 47

because, again, we put out a fishnet trying to catch anything that we could that was abnormal.

Q. What is significant about the part of Russia that she came from?

A. Well, various fungal infections will have certain habitats. In the United States Cryptococcus may be around certain life-styles, people who take care of pigeons, for example. Coccidioidomycosis is, generally, in the San Joaquin Valley. Histoplasmosis and other conditions will be located in other areas. I don't know the epidemiology of the various and sundry fungal organisms in Russia.

Q. How would you have found that out?

A. I would have probably first checked with Phil Lerner, our Chief of Infectious Disease, and then probably made a quick call to Adel Mahmoud who is Chief of the Department of Medicine at University and world expert on tropical infections.

Q. Did you ever make that call in this case?

A. I didn't have to.

Q. Why was that?

A. Well, we, ultimately, made a diagnosis, and I just didn't do it. And as I say, fungal meningitis was not high on my list at that point. Phil Lerner was involved in the case and he would have

Page 48

called if he thought it was necessary.

Q. Did you have her prior history available to you when you saw her on November 3, 1991?

A. I had some information. I cannot tell you at this point whether I had the information of the initial hospitalization. Frequently we don't have it, particularly when the hospitalization is only a month old The charts are often hard to get because they're going through the process of billing and medical records and what have you, and it, generally, takes a day to get those charts.

Q. Do you know when you got those charts?

A. I cannot tell you.

Q. From your recollection or from your notes, is there anything that reminds you of your awareness of her records and her prior history, her auto accident in Russia, her course of treatment, treatment during the first admission at Mt. Sinai Hospital?

A. Well, I was aware that she was a recent immigrant to the United States. And I made mention in my initial note that she had injuries in Russia and was hospitalized there for a long time, at least I believe I do. I knew about that. I did not know about the details of her hospitalization.

Again, we were dealing with a special

Page 49

circumstance, and that is I had no history because she's Russian and her daughter didn't speak a lot of English. Normally that would be information that a lot of times if you don't get from the patient, the family will tell you. That's something we always ask for but may not always get.

Q. What symptoms or signs would you need, other than what she presented with, to have clued you in on 11-3-91 of a possible candida1 meningitis? What is it that you feel is lacking here as something to explore because you didn't feel this was initially on the list of --

A. I would define almost under any circumstance an individual looking at a patient and doing a neurologic examination and making the diagnosis of Candida meningitis. I'm not sure that's ever been done.

Q. So how do you make a --

A. There might be certain circumstances where you would suspect it much more so. One would be, for example, in patients with AIDS who are immunologically compromised. Another would be if you had a patient, for example, who was immunologically compromised from chemotherapy from cancer or AIDS who had thrush or a cutaneous infection that you could immediately

Page 50

identify.
Thrush would be one of the most identifiable. That's one that you can look and see and just from the physical features determine that that's a Candida infection. Then if you saw somebody who was febrile and who was encephalopathic with a stiff neck and who had AIDS and who had thrush, you might say I bet that patient has Candida meningitis, and you'd probably be wrong.
Q. But you would have investigated the candida1 meningitis in that case that you just described?
A. Well, you would do nothing different than what we did.
Q. Which is what?
A. An LP, spinal tap, and evaluate the fluid. And you get a CT scan because that would help in terms of when you're dealing with abscess.
Q. How soon do you do the spinal tap after you're presented with those symptoms you just described?
A. Soon after.
Q. Within hours?
A. Within hours. It was not done within hours here. I'm aware of that.

Page 51

Q. Do you know why it wasn't done within hours here?
A. No, I do not. The house officer was instructed to do so. And I have discovered in reviewing the records and I probably knew it at the t h e that -- well, I did know at the time, obviously, that it was not done right away.
Q. Well, there's a note here on our Exhibit 76, which is indicated as a progress from Mt. Sinai, and it indicates a lumbar puncture. And when was that --
A. The t h e is listed as, I believe, 7:20 p.m.
Q. Is that an order there or is that the progress note?
A. That's the progress note.
Q. And 7:20 p.m. on what day; do you know?
A. I believe it's 11-4.
Q. You can look at the pages before that, Doctor.
A. 11-4.
Q. Take a look at Exhibits 74 and 75 and tell me if that helps you recall which day.
A. I saw the patient listed here as 11-3, and the LP is listed as 7:20. You know, it's interesting

Page 52

it's not dated. It's just time. I presume it's 11-4.
Q. Well, doesn't that follow the pages which indicate 11-3?
A. Yes. As I tell you, I don't know. I have seen in other notes actually from the expert witnesses that it was over 24 hours. So I'm actually surmising from that. I can't tell specifically from this when it was done. I could probably look at when the fluids were received in the laboratory. That might help determine when it was done because those would have been sent down --
MR. ABAKUMOV: could you mark these, please, consecutively?
MR. GROEDEL Doctor, look at your neuro note of 11-4 after that. Maybe that will help.
BY MR. ABAKUMOV:
Q. Doctor, if you would just look at those silently for a moment while we mark the next group of exhibits.
A. I would prefer that it was done on 11-3, frankly. I hope that's right.
Q. If she had come in on 11-2, would you have preferred it had been done on 11-2?
A. Well, she was actually seen at midnight.

Page 53

She came in late in the evening on 11-2. She was seen by house officers. I think most of the notes are dated 11-3. And then I saw her -- I didn't time when I saw her. As I say, I have this image that I saw her at an unusual time. But I can't substantiate that. And then the LP was done thereafter. I don't know the precise time or the date. It says 7:20. I would be comforted by that. I should have looked this up, but I didn't.
(Thereupon, Plaintiffs' Exhibits 79 through 90 to the deposition of Michael W. Devereaux, M.D. were marked for identification.)
BY MR. ABAKUMOV:
Q. Doctor, you indicated that you would like to see the LP, lumbar puncture, done as soon as possible?
A. correct.
Q. why is that?
A. Well, it depends on the organism. But let's just say if it's a bacterial meningitis, meningococcal meningitis, hours and even minutes can have an effect on the outcome on the patient. But once you make a decision to do a procedure, there is very little advantage in waiting for the procedure to be done no matter what the procedure, if, for no other

Page 54

reason, that's not cost effective.
In this case there are academic reasons why the tap should be done very quickly, and I was bothered by the fact that I thought the tap was done on 11-4. In the expert witness notes I see a 27-hour delay is mentioned. But, obviously, if it was done on 11-3 and I saw the patient on 11-3, it couldn't have been 27 hours. So that's a mistake.
I understand because these records are always hard to review for those kinds of details. So it would have had to have been sometime within hours after I saw the patient.
Q. Why are these records hard to review, Doctor?
A. You have a thousand pages of handwritten notes, and physicians don't record information in charts with the idea of them being reviewed legally three years later. We're interested in recording information for the ongoing process of taking care of the patient, and recording exact times and dates becomes less important.
That's why most notes, as mine are, list the date but not the time I saw the patient. It's just, generally, not that important in terms of the care of the case. So when you go back looking for things like

Page 55

this, it can be somewhat difficult. Undoubtedly you've had that experience before in reviewing records,
Q. Is that to say that doctors don't always have an opportunity to record everything that happens; they record the things which they feel are important for the patient's care at that point?
A. Well, of course.
Q. So details sometimes are selectively omitted?
A. Part of any profession, of any endeavor is to select important from the unimportant, whether you're a teacher, a physician, a preacher or a lawyer.
Q. So what you're saying is just because a doctor didn't write something down doesn't mean that something wasn't performed; it's just the doctor chose not to record that particular item?
A. What are you referring to? When you say something is performed -- When an operation is performed, that would not be acceptable, of course. If you don't write down the time that a blood was drawn, that would be somewhat less important.
Q. How about a temperature wrap?
A. Well, those are, generally, not recorded by physicians. You see in the charts the temperature 99.6 or whatever the temperature may be written down.

Page 56

Generally, we don't talk in terms in most progress notes of the exact time.
Sometimes the T max or the maximum temperature of the day will be recorded in the progress notes because most of that is available from looking at the flow charts that are elsewhere in the chart in the nurse's notes and so forth if that becomes an issue.
In certain circumstances it becomes an issue. It depends on the case. It's not important to record the exact times and temperatures when you're doing a foot surgery. It depends on the situation.
Q. In treating Freyda Kaplan and as a physician, do you record all the complaints that a patient makes about their condition as part of their history?
A. All the complaints, no. You would -- Again, it depends what you mean by complaints.
Q. Well, complaints about condition, about health.
A. There's going to be some selectivity in going through and looking when a patient provides you information and you make a report from that, certainly.
Q. What is it based on, that selectivity?
A. Hopefully on my expertise of what is important and what is not important.

Page 57

Q. Now, you gave an example a little bit earlier about a patient you would have tapped. You talked about someone who was perhaps immunosuppressed through AIDS and had confusion?
A. Oh, sure. I will say one thing. There's another concern that hasn't been talked much about here that would have arisen.
This patient had large ventricles that was shown on the CT scan on 11-2. That was done in the emergency room, and that's why she was in the emergency room on 11-2 but probably didn't get up to the floor -- that would be in the nursing notes -- until sometime in the early morning of 11-3. But she had large ventricles, and a tap in somebody with large ventricles is not something you do lightly.
Q. She had large ventricles in the brain?
A. Yes.
Q. Is that a sign of hydrocephalus? Is it hydrocephalus?
A. Well, that's such a nonspecific term. But certainly that term encompasses large ventricles, many, many causes. But a tap in that particular situation can be lethal.
Q. Well, when do you do a tap on someone With enlarged ventricles?

Page 58

A. When the risk of not doing a tap is outweighed by the risk of doing the tap, if I said that correctly.
Q. Now, getting back again to that example with the AIDS patient who was immunosuppressed and presented with confusion, you would tap that patient?
A. In most circumstances. Again, in situations like that patients, generally, have scans initially. And if you found a large mass in the head from an abscess or presumed abscess or cysts that looked like toxoplasmosis, you might choose not to tap the patient because the risks of doing so are increased because you can kill a patient with a tap.
Q. You said you would be more likely to expect candidal meningitis in that type of a patient?
A. No, that's not what I said.
Q. I asked you for a hypothetical of a patient that you've treated that would be a person presenting with signs and symptoms of candidal meningitis.
A. I'd have to go back, and I'm not even sure I've ever treated a patient with Candida meningitis. It's uncommon.
Q. Other than Freyda Kaplan, yes.
A. I'm not sure. I'd have to look back at my

Page 59

records. It's a very unusual meningitis. We treat a lot of AIDS patients here, so I may well have seen it in AIDS cases. But I didn't say just in an immunologically suppressed AIDS patient. The first thing there would be toxoplasmosis.
I said an AIDS patient who is clearly immunologically suppressed who has clinical evidence of meningitis who comes in with thrush, I said in that case Candida meningitis would be high on my list and it would still probably turn out to be another organism but it would be high on my list.
Q. Thrush is an albicans or a tropicalis fungus?
A. It's a Candida fungus, yes.
Q. Both tropicalis and albicans?
A. I believe they can both produce thrush. I'd have to check that.
Q. And they can exist in the pubic area?
A. Well, Candida is present as a normal flora in the mouth and the gut in a high incidence in individuals.
Q. Now, in this example that you gave, would that AIDS patient have to have fever before you began doing tests on him if he presented with confusion and--

Page 60

A. It would depend on the circumstance. It would depend on the circumstance.
Q. Would you send this patient home?
A. Of course not.
Q. What would you do?
A. We'd evaluate the patient. AIDS is a neurotoxic virus. It affects primarily the central nervous system and it can affect the central and peripheral nervous system in a hundred different ways, both primarily and secondarily.
So it would depend entirely on the evaluation of the patient, the history, the physical examination and then perhaps certain laboratory features such as a CT or an MRI scan, whether or not the patient had fever, a whole variety of issues that would go into making the decision whether it was safe to do a spinal tap. I mean, if you're looking for an algorithm, I won't give you one. There is no algorithm. It depends on the circumstances.
Q. And that gets back to the fact that so many signs and symptoms point to many illnesses, some serious, some not?
A. Yes.
Q. And the duty of the physician is to rule out the ones that aren't a factor in a particular

Page 61

patient and find the ones that are; would that be a fair statement?
A. I suppose so.
Q. Isn't that how a doctor treats a patient?
A. Well, it's certainly part of it, yes, trying to decipher out illness. The American population is unhappy with that right now, but that's because they want us to deal in wellness. But if we deal through disease process, which is a traditional approach of allopathic medicine, that's what would happen, yes.
Q. Are you unhappy with the medical care system or the population demands on the medical care system?
A. No, I'm not unhappy with the population demands. I'm unhappy about the medical care system.
MR. MURPHY: Just note an objection to relevance.
MR. HERBERT objection.
MR. GROEDEL: objection.
BY MR. ABAKUMOV:
Q. Well, give me a one-sentence or two-sentence explanation why.
A. I think we need a single-payer system. I think we need a system that is managed more directly by

Page 62

the physician health care delivery, a system itself with the government paying for it but managed by the providers with significant tort reform.
Q. Do you feel there are problems With the medical malpractice system?
A. Of course there are.
Q. And the legal aspects of that?
A. Oh, certainly.
Q. Do you believe it's inappropriate for a patient who feels he has been injured or has suffered damages as a result of alleged malpractice to bring his action to court?
MR. MURPHY: objection as to relevance.
A. No, I don't.
MR. GROEDEL objection.
BY MR. ABAKUMOV:
Q. You don't have a problem with that?
A. No, I just have a problem with the way it's done.
Q. Doctor, I hope we can sit down and talk about that at some other time in the future.
A. I'll give you my ideas. They're circulating around Washington, too.
Q. Do you sit on any PIE review boards,

Page 63

Doctor?
MR. HERBERT objection.
MR. MURPHY: objection.
A. I don't believe I do. And I say it in that way because on a couple of occasions, perhaps two that I can recall in the 17 years I've been here, I have been invited, if that's the right word, to come down and review cases that the lawyers have with a series of physicians to see if these are cases that should be defended or should be settled.
Q. You didn't, by any chance, sit on the review board for this case or --
A. No.
Q. -- were asked for an opinion on whether Freyda Kaplan's case should be settled or paid?
A. My first knowledge of this case even being a case was --
THE WITNESS: And I asked you that question, Mr. Murphy.
A. -- I believe June 1.
Q. Have you ever been sued, Doctor?
A. No.
MR. HERBERT: objection.
MR. MURPHY: objection.
///

Page 64

BY MR. ABAKUMOV.
Q. Have you ever reviewed cases or testified for Reminger & Reminger or Jacobson, Maynard, Tuschman & Kalur or any of their attorneys?
MR. MURPHY: objection.
A. Yes.
Q. When was that, Doctor?
A. I can't tell you. It's not something I do frequently. I know I had a case that I testified for for Jacobson, Maynard this year. They won.
Q. What type of case was that, Doctor?
A. A case of femoral nerve injury associated with a birth at University Hospitals.
Q. Okay. Doctor, I'm going to show you Exhibits 86 through 90, and if you can take a look at those records, and then I Will also give you Exhibits 79 through 85, which are labs. Could you tell me when the patient was admitted, when the spinal tap was done as specifically as you can, the time of day and what did the spinal tap show?
A. Here is the answer to your question about time of admission. She was admitted from the emergency room at 1:30 a.m. on 11-3.
Q. And what time was the tap done?
A. Let's see. There's a note here of

Page 65

6:50 p.m. on 11-3. So it would have been done right at about that time. I'm pleased to know that. This is my note, yes.
Q. When did you discuss this? What does your note indicate there, Doctor?
A. When the fluid came back, there is a discussion of the differential diagnosis of the fluid.
Q. That's Exhibit 89?
A. Yes, sir.
Q. Cou d you identify Exhibit 90 for us?
A. Well, it's a conclusion of my note listing recommendations.
Q. What are your recommendations?
A. That we do an EEG, an electroencephalogram. I wanted a sedimentation rate and ANA, an ACE test. That's an angio-tensin converting enzyme. I was considering sarcoid. I wanted a repeat lumbar puncture possibly tomorrow. Probably tomorrow I wrote actually. Just the fluid, the spinal fluid results trickle in over a period of days depending what test it is. And I was particularly interested in the cytology looking for an infection of cancer, an infectious disease consult and temperatures every four hours.
The next is a note from infectious disease that

Page 6

they had seen the patient. And then there's a note on -- well, later on on that page by Dr. Hampel talking about the vesicocutaneous fistula. Let's see. The EEG tech left a note on 11-5 that the EEG had been completed.

Q. Now, I see you're looking at the labs there?

A. Yes. These are the results of the cultures on the cerebral spinal fluid; that there's no growth and --

Q. Before you get into that, I want to ask you one question. Did you visually examine the cerebral spinal fluid or look at it under microscope or through any other means?

A. No, it was done by the house officer. I cannot tell you how much of that spinal tap I directed. I just don't know. I don't keep records to that effect. I often monitor them.

Q. Is that because residents do a lot of the work here on the service?

A. Yes. In fact, that's the rule. But this was early in the month, and so I very probably observed the LP. But I can't prove that.

Q. Is that a way of examining the spinal fluid?

Page 6

A. Well, that's the actual procedure where you take fluid off and look at the spinal fluid for the presence of blood, for the presence of pus. It's important --

Q. Signs of fungus?

A. You can't see signs of fungus.

Q. Could you see them under microscope?

A. No, except for signs of infection. Except for under a microscope, if you do the India ink test, a very old test, you can sometimes see --

Q. The cells?

A. -- the cells of the budding yeast and other fungi.

Q. And that would perhaps indicate that Candida fungi might be among them?

A. It would indicate that there was a fungus because Cryptococcus would look the same.

Q. And then you investigate further to find out what type it is?

A. Yes.

Q. What are the other labs?

A. Well, there is a TB culture and -- I take that back. There's the initial TB stain.

Q. You're looking at Exhibit 79, Doctor?

A. Yes. There's the stain for TB of the spinal fluid, which is a test done on the fluid soon after it comes in looking for acid-fast bacilli. There was no evidence that they could see it. That doesn't mean it's not there; it just means they couldn't see it. Then there's other information here indicating that they're culturing the urine for TB. And the collection date which you have in pink here is listed as November 3, 1959. That would be the time probably that the laboratory recorded the information as reaching them. So it would have reached the lab or they would have registered those fluids at 1959 hours.

Q. What do these labs as you look through them -- identify the exhibit numbers -- tell you about Freyda Kaplan's cerebral spinal fluid and the eventual diagnosis of candidal meningitis?

A. Well, there's not much here. This is just a portion of the studies. Well, I'm sorry. I haven't turned enough pages.

Q. You're looking at Exhibit 80 now, Doctor?

A. Yes, I am. This shows that her syphilis test of the CSF is negative. She doesn't have serologic evidence of syphilis. The Cryptococcal antibody test is negative. These dates, of course, go up here. There's a November 11 test. We, of course, tested her for HIV, for AIDS, and that was negative.

Page 69

Q. You're looking now at Exhibit 81, and what does that tell you?

A. Again, it's another test looking for syphilis doing a darkfield preparation, and there were no syphilitic spirochetes or treponemal pallidum reported. There's a fungal culture that there is no growth to date. That's November 12. Fungi tend to grow very slowly. It takes a long time, which you have probably come to know.

There's a gram stain looking for evidence of certain bacteria. No organisms were seen. There were some rare white blood cells seen. And then on, I guess, this is November 8 Candida albicans cultured from broth only is listed as -- let me repeat that -- Candida albicans cultured from broth only.

Q. Now, we're looking at Exhibit 82, and that's an 11-19-91 result or submission date?

A. This is the fluid that is -- It listed here interestingly enough collected November 4, and that's confusing. Again, their collected and received times are exactly the same, and they have no way of knowing when it was collected. So that was when it was processed through the laboratory.

Q. Do you have any idea when that was collected?

Page 70

A. The laboratory would. There's somebody down there with a computer that receives it. And they punched in the date November 4, 1991, 1245 collected and received at the same time. So that's impossible.
Q. Right. And the result came back on the 19th of November?
A. I thought it was the -- Didn't I say the 8th? No, that's the date -- See, you're confused. These are the dates that the final laboratory sheets are printed up.
Q. So the result was returned on the 8th?
A. Yes.
Q. Any indications of candidal meningitis there?
A. It says Candida albicans cultured from broth only. I presume that cerebral spinal fluid and that would then indicate if you take that at face value that she has a meningitis of Candida albicans. You will recall looking at the progress notes it's so unusual that the ID people, the infectious disease people, first considered the possibility of it being a contaminant, if I remember correctly, which would be their first thought in a situation like that since it can be a contaminant since Candida is everywhere This Page 83 doesn't really give you too much

Page 71

information here. Well, it does list the cytology, and the cytology is that no malignant cells were identified, that the cells seen were inflammatory. Then the initial chemistries --
Q. Now, that last comment you made, Doctor, that was in reference to Plaintiffs' Exhibit 83?
A. Yes, sir.
Q. And now you're referring to Plaintiff's Exhibit 84?
A. Yes.
Q. And what was your comment?
A. The spinal tap glucose was 22. The protein was 248. The glucose of 22 would be low. The protein of 248 would be elevated. The fluid was xanthochromic or not xanthochromic.
Q. What does that mean?
A. Discolored. Xanthochromic refers to a yellow coloration of fluid, which can be the effect of usually high proteins or more a result of subarachnoid hemorrhage, bleeding. There were 27 red blood cells and 94 white blood cells.
Q. And what is the significance in terms of this patient and her final diagnosis? Was it pointing in this direction? Have we decided at this point, or are we still rolling things out?

Page 72

A. Well, you have it in my notes from 11-4. I think that details the thinking that was going on from the laboratory tests more than looking at the lab tests.
And my impression in my 11-4 note was that she had an inflammatory process involving the cerebral spinal fluid, she had a meningitis, an inflammation of the meninges and that then began our direction towards discovering the cause of her meningitis.
Q. Well, could you wrap up and just complete looking at those labs there and tell us what they indicate?
A. Well, there are a bunch of cerebral spinal fluid studies here.
Q. I'm just referring to the lumbar puncture now, Doctor, the ones that refer to the lumbar puncture.
A. That's what I'm saying. There are about 50 listed here from the 3rd to the 31st. I don't know how many of those were lumbar punctures and how many of those were fluids taken from the ventriculostomy. They were all cerebral spinal fluid, but she was having fluid taken from several different sources.
Q. And what do they tell us about this patient?

Page 73

A. A large number of these spinal fluids show evidence of inflammation and certainly some of them are much more consistent specifically with infection. But most of them could be just the result of inflammation and somewhat nonspecific.
Q. Anything else on Plaintiffs' Exhibit 84 in response to my question about the patient's condition?
A. On the cell differential at the bottom 77 percent of her initial cell count, white blood cell count was lymphocytes and only --
Q. Is that an elevated count?
A. Yes. She had an elevated white blood cell count of 94. But if you look at the differential of those white blood cells, 4 percent of them were segs, polymorphonuclear leukocytes, 19 percent were mononuclear and 77 percent were lymphocytes.
So this was not the picture of a rapidly-progressive bacterial meningitis, which usually is virtually all polymorphonuclear leukocytes.
Q. What would a normal white blood count at this point in time have indicated with this patient but just assuming for a moment that you had a normal white blood cell count in the blood?
A. That would reduce my concerns about a meningitis, obviously. It doesn't absolutely rule it

Page 74

out. But if her cerebral spinal fluid were normal, then I would have gone the other route and started looking for toxic and metabolic causes for her confusional state.
Q. In her blood or cerebral spinal fluid?
A. Allover.
Q. Any other comments on Plaintiffs' Exhibit 84, Doctor?
A. No.
Q. Do you want to turn to Exhibit 85 and tell me what that tells us about this patient and her condition?
A. This is a continuation of the previous page looking at the differential --
Q. It's a continuation of 84?
A. Yes -- looking at the differential of the white blood cell counts for the specific spinal fluids that are done on the specific dates that are given above on Plaintiffs' Exhibit 84.
Q. Any other information about this patient's condition and her ultimate diagnosis?
A. Well, they all confirm that she has an inflammatory process in the meninges certainly.
Q. Now, anything else on that, Doctor?
A. No.

Page 75

MR. ABAKUMOV: Mark this, please.
(Thereupon, Plaintiffs' Exhibit 91 to the deposition of Michael W. Devereaux, M.D. was marked for identification.)
BY MR. ABAKUMOV
Q. Of all the numerous possible illnesses that had to be investigated and ruled out on 11-3 and on 11-4-1991, which, in your mind, was the most serious in terms of possible morbidity of Freyda Kaplan?
A. That really doesn't enter into the picture. I think that what is the most important question, as I've already mentioned *going* through my mind, is what does this patient have that I could do something about. That's the most important.
Obviously, the most serious condition would be something like metastatic cancer with carcinomatous meningitis. That's a death *sentence,* nothing I can do about it.
Q. How about candidal meningitis, is that a deathsentence?
A. No, it's an infection with a significant morbidity.
Q. Stroke is a consequence, sometimes short of morbidity?

Page 76

A. Vasculitis, yes. And vasculitis is a manifestation virtually of any meningitis.
Q. Is that what, ultimately, happened to Freyda Kaplan here, vasculitis leading to stroke?
A. Well, that's our presumption, yes.
Q. Is that based upon a reasonable degree of medical certainty that she had vasculitis which led to astroke?
A. Yes. Can we prove it? No.
Q. Why not?
A. Well, we'd have to biopsy her brain and look at the blood vessels. Then I would be in trouble with the law.
Q. Because Freyda Kaplan is not dead at this point?
A. Right.
Q. What's the treatment of choice for candidal meningitis?
A. Antifungal agents are used. Probably the standard is Amphotericin B.
Q. Was that the standard back in November and December of '91, intravenous?
A. Correct.
Q. Does Amphotericin B treat any other types of central nervous system infections?

Page 77

A. Other fungal, cryptococcus.
Q. Strictly fungal; it's not effective against any tuberculosis or bacterial meningitis or viral meningitis?
A. Not to my knowledge. Even if it were, you wouldn't use it where you have anything better to use because it's very toxic.
Q. What do you have better to use for candidal meningitis?
A. Nothing.
Q. When was Freyda Kaplan started on Amphotericin B?
A. I believe 11-8, but let me --
Q. You can refer to your notes, Doctor. Doctor, I'm going to give you something.
A. She was started on Amphotericin on 11-8.
(Thereupon, Plaintiffs' Exhibit 92 to the deposition of Michael W. Devereaux, M.D. was marked for identification.)
BY MR. ABAKUMOV
Q. Doctor, showing you Plaintiffs' Exhibit 92, I'm directing you to the top of that page, a note of 11-8, does that indicate to you when the Amphotericin B was started?
A. Yes, 11-8.

Page 78

Q. Why was it started on 11-8?
A. Because there was confirmation -- No, that's when the diagnosis was essentially established With the cultures.
Q. So that was when the culture results came back showing Candida albicans?
A. I think from the laboratory results, which we reviewed earlier in the deposition, that's when the broth grew out Candida albicans. So that's when the diagnosis would have been established.
Q. And it took you approximately six days, five and a half to six days from the date of her admission to make this diagnosis?
A. Correct, five days.
Q. Why not start the Amphotericin B when she came in or on November 3 or November 4?
A. No one does that. First of all, the general, not just the general, I *think* total agreement here is that you never treat a fungal meningitis on suspicion. Amphotericin B is too toxic. It's nephrotoxic. It's toxic to the blood stream. It's a very toxic agent. And anybody who uses it enough will tell you that they've seen patients severely impaired by it.
Q. Showing you a note of 11-8, which is

Page 79

marked as Plaintiffs' Exhibit 91, do you recognize that note or the signature?
A. I believe that's Dr. Lerner.
Q. What is his recommendation at that point in terms of the treatment of Freyda Kaplan?
A. Dr. Lerner has very difficult writing. His first sentence is a discussion -- he's talking about it may be a contaminant, which I've already told you about is often the first suspicion when you see Candida.
Q. Doctor, I just have a question. How could you treat a patient if these notes are so hard to read?
A. Because we deal With patients and With physicians face to face. Dr. Lerner is full time and I'm full time here. I average 75 hours a week in this hospital and I've done it for 17 years and I do most of my work face to face. That's why most of the notes here, if you'll see, are written by house officers.
In any event, what he is saying here, even though I can't read it word for word, is that there's a possible Candida infection; that he thinks it still may be a contaminant but because it is there and because they haven't proven that it's tuberculous meningitis, he feels it's probably reasonable now to begin the antifungal meningeal therapy on the basis of that

Page 80

culture. But as he indicates here, he's not absolutely sure that the culture is correct.
Q. He doesn't have the Candida profile yet from that culture, but due to the fact that he believes its no longer tubercular, he's recommending Amphotericin B?
A. It is what you do in the practice of medicine. You make logical deductions. This is a sick patient. We're pretty certain at this point that she's infected. It hasn't absolutely been proven.
He made the deduction on the circumstances of the patient and the situation that she might have TB meningitis. He treated that for the better part of a week and he then comes in and sees this Candida growth. There is the possibility that this is going to turn out to be a contaminant. But he basically says that I'm *going* to treat her as a Candida infection but continue trying to prove the diagnosis. I think that's a very rationale approach, but that is not a casual starting of Amphotericin B.
Q. I appreciate your statement, Doctor. And neither you nor Dr. Lerner could have gotten to the decisions you made about the Amphotericin B and its application unless you had done the prior examinations, evaluations, testing, ruling out, looking at the

Page 81

symptoms, looking at the signs of this patient; isn't that correct?
A. Over a five-day period, I suspect, yes. But, overall, the main thing that makes the diagnosis is once you do the spinal tap, following the trail of the spinal fluid, we found an abnormality.
Q. So you do a series of tests, which gave you its results, and you began the Amphotericin B treatment?
A. Well, we didn't do a series of tests. We did a CT scan and made a judgment that although there's danger in doing an LP, it was a risk because had she herniated from her hydrocephalus, I probably would have been in Mira Baron's place and you would have been suing me.
Q. Is that a herniation of the brain?
A. Yes, which is a risk with anybody who has hydrocephalus. You do a tap. So we made that deduction. We took a chance, tapped her and she didn't herniate and we, ultimately, followed the fluid and made diagnosis.
Q. What is the rate of cure with Amphotericin B treatment for patients like Freyda Kaplan?
A. That's too nonspecific a question to get an answer. It depends on what the infectious process

Page 82

is.
MR. MURPHY. what stage are you talking about?
BY MR. ABAKUMOV:
Q. Let's look at 11-3 and 11-4 of '91. What were your expectations of Freyda Kaplan at that point? And actually let's look at 11-8-91 when you began the Amphotericin B treatment. What were your expectations?
A. My expectations were probably -- Again, I'd have to -- it's always difficult to look back two and a half years and know exactly what the state of your mind was at that point.
But Candida meningitis you know from looking at the literature, which I'm sure you've done, has a very poor prognosis. Patients don't do well. And the fungal meningitides have a high rate of neurologic disturbances, neurological residuals associated with treatment.
So it is not an infection in which you approach the family and say, well, we've discovered Candida meningitis and we're starting treatment, everything is going to be fine. Everything is very likely not to be fine.
Q. You wouldn't say that?
A. Absolutelynot.

Page 83

Q. Are you familiar with Gorbach, editor and author of a textbook Infectious Diseases?
A. Iknowthebook.
Q. Are you familiar with his chapter in that bookfungi?
A. I've looked at it.
Q. I'm going to show you Plaintiffs' Exhibit 41, and just tell me if this Xerox copy of what we represent to be that chapter looks familiar.
A. Yes.
Q. Now, do you consider Gorbach to be an authoritative text?
MR. HERBERT objection.
A. Infectious disease is not my area of expertise, but it is.
Q. Now, referring to Page 1890 of the exhibit, and there's a section there central nervous system infections and the third paragraph of that, could you take a look at that and indicate to us what it states about prognosis and cure rate and what is required to obtain that type of cure rate stated?
A. Increased mortality has been associated with a low glucose level, longer than a two-week delay in the diagnosis, and signs of increased intracranial pressure.

Page 84

Let's see. This is a combination -- Well, what do you want me to read here?
Q. Well, would you agree that a two-week delay in the diagnosis impairs the cure rate?
A. Well, it would for any infection. But it also says in the same section that the mean time from onset until diagnosis is two months.
Q. So then would you agree that Freyda Kaplan had a candidal meningitis two months prior to its diagnosis?
A. Absolutely not, absolutely not.
Q. That's just a mean time?
A. No, that's what they say here, that the mean time from onset until diagnosis is two months. And as you've recognized from all the expert testimony, they give us credit for making the diagnosis very rapidly.
Q. Well, that's only one expert doctor, and, I believe, that was the expert for Jacobson, Maynard.
MR. HERBERT Move to strike.
A. That's Dr. Gardner. And he may be an expert for them but he's also an intellectually-competentneurologist who tells the truth.

Page 85

Q. Now, Doctor, would you agree with this statement? Therapy is a combination of Amphotericin B, .6 to 1.0 milligrams/kilograms per day, and 5 flucytosine. With this regimen, the cure rate is 75 to 100 percent.
A. That's what they say there.
Q. You don't agree with that statement?
A. That wouldn't be my experience. And, again, it has to do with the fact that some of these patients are so immunologicallycompromised to begin with, they have so many problems. But I'd want to see that substantiated in the literature.
Q. Well, there's a further statement here in Gorbach's book in the fungi chapter that single-agent Amphotericin B therapy has a cure rate of 87 percent. Would you agree with that statement?
A. For fungal meningitides or for Candida?
Q. This is for -- Why don't you take a look at that chapter. Why don't you look at Footnote 34, Doctor.
A. I know the article. I'd have to look at the -- I haven't looked at it in preparation for this deposition though. But the point is still that it comes down to the individual case by your own reference and at least by one of the expert witnesses, whatever

Page 86

side he's on.
This was a diagnosis that was made quickly and treatment was begun quickly. Every evidence by which you have come to learn is that the infection began a week or so before her hospitalization, the second hospitalization. So instead of being a two-month course, this woman had probably a two-week course before treatment was begun.
Q. Well, to what do you attribute your conclusion that this occurred two weeks before?
A. The history.
Q. And what specifically about the history?
A. She had a change in mental status.
Q. On the 22nd or 23rd of --
A. About a week prior to the admission.
Q. Concurrent with taking of Cipro?
A. Yes. That's in retrospect.
Q. As a neurologist, Doctor, if you had seen her on the 22nd or 23rd, if you were brought in as a consulting physician and the doctor who called you in said this lady, Freyda Kaplan, says she's having confusion associated with Cipro, what would you do at that point, Doctor?
MR. HERBERT objection.
MR. GROEDEL objection.

Page 87

A. Well, she wasn't seen on the 22nd. Cipro was started on the 22nd. She was seen on the 30th.
Q. She was Seen on the 22nd also, Doctor.
A. Yes. But then she wasn't confused and she was placed on Cipro at that time for a cloudy urine, and there was no evidence of any confusion at that point, at least in the notes. She didn't really demonstrate confusion until thereafter.
So let's keep the times correct here because that seems to be an important part of this whole issue. And the times are that on 10-30-91, several days before admission, she was developing confusion at that point. it was recognized by the physicians that she was confused. She was not recognized to be confused prior to that by anyone. Even her family told me that she was not confused.
Q. Do you remember that?
A. It's in my note, change in mental status times one week.
Q. Do you remember who you talked to in the family?
A. I probably tried to get some information from the daughter. I doubt that we had Russian interpreters available at that point. I can't tell you the exact source of the information.

Page 88

Q. Now, could you refer to that note, change in mental status one week?
A. Times one week, yes. Problem, change in mental status times one week.
Q. One week in relationship to what, Doctor?
A. For admission. For the week prior to admission, there had been a change in mental status.
Q. Now, the October 30, 1991 note of the GU clinic, do you recall reading that note?
MR. HERBERT: The October 30 note?
MR. ABAKmov of the Russian Clinic.
A. Yes, I looked at that note.
Q. Now, that says confusion reported with Cipro?
MR. HERBERT objection.
Are you going to let him look at the note?
MR. ABAKmov Sure.
A. If I recall correctly, she was noted to be confused, and the deduction was that this might be due to the Cipro. And so what the physician did was stopped the Cipro and started her on Keflex.
Q. Now, if a patient presented to you with -- if you were called in to consult -- You were here at

Page 89

the hospital on the 30th?
A. Yes.
Q. If you were called in as a neurologist, would you do a mental status exam as a neurologist, would you do a mental status exam at that point?
MR. HERBERT objection.
A. On this patient probably not effectively.
Q. Why not?
A. Because the mental status means that I have to know and be able to speak her language. Even through an interpreter, a mental status exam is difficult.
Q. Well, how do you determine mental status in your Russian patients?
A. With an interpreter as best we can or from observations. If she gives me the answer, that doesn't mean she's confused. Confusion is a -- The mental status examination is the longest single part of the neurologic examination. It's done during the course of the history taking on the quality of the information I receive and it often takes ten minutes or more as part of the general neurological examination.
Q. So you wouldn't do that for Freyda Kaplan because she spoke Russian or because the exam takes ten minutes or more?

Page 90

A. No, because she spoke Russian. You cannot do a decent mental status examination when you can't speak the language. Obviously, you can make deductions from other observations. If the patient is behaving irrationally, taking their clothes off and urinating in the corner of the room, then you can say I can't speak her language, but that's not normal behavior.

I just got through with a Russian case that they thought was confused, even with the Russian interpreters, that we determined that she was dysphasic.

Q. Did you do a mental status examination for that patient?

A. Yes, we brought in Russian physicians and I did the best that I could do, and it was my impression that she was dysphasic and not confused.

Q. Well, you did the exam and you ruled out one possibility and you came to a proper conclusion?

A. Sure.

Q. But if you didn't --

A. I came to a conclusion that was proven to be proper.

Q. That's right. And you ruled out conclusions which were improper?

A. As best as I could. I don't always do

Page 91

that.

Q. Well, you can't do that unless you do the tests? If you don't do a mental status exam, you can't rule out what the mental status exam shows?

A. Dr. Baron is in a better position in this particular patient to do a mental status examination than I am. If she made the diagnosis that the patient was confused, I would with great trepidation argue against her diagnosis when she speaks the language.

Q. So you're saying an internal medicine doctor, even not Board certified, is competent to do a mental status examination --

MR. HERBERT objection.

BY MR. ABAKUMOV

Q. -- and neurological examination?

MR. HERBERT objection.

Move to strike.

A. That really is kind of a ridiculous question.

Q. Well, I don't think it is.

A. Yes, I do, indeed, because part of dealing with medicine is the whole issue. You better look and read what's going on around you right now is the whole role of the primary care physician trying to make rationale deductions because we can no longer afford

Page 92

the subspecialty fragmented approach we're taking to medicine at the present time.

She saw this patient, made a rationale -- made an evaluation, made a rationale deduction and made some recommendations based on the best information that she had available at that time. It was not an unreasonable thing to do. And if you as a lawyer demand more than that, then you're going to bring this system crashing down.

Q. Now, Doctor, that wasn't really the question I asked you, and I appreciate your answer, anyway.

A. Thank you.

Q. The question is what type of neurological exam or mental status exam is Dr. Baron as an internal medicine, non-Board certified physician in that field competent to do? Is she competent to do a neurological evaluation or does she need to call in a neurologist or someone else?

MR. HERBERT: objection.

Move to strike.

A. I will stand by what I just said. In this particular patient, she is more competent to do a mental status examination than I am. And, indeed, during her residency, as I have with other Russian

Page 93

physicians, I brought them in, called them in to look at a case to tell me what they think about their mental status.

Q. Is that because any graduate of medical school is competent to do this examination?

A. That is not correct. But you keep gliding over the issue. When you can't speak the language, you're at a disadvantage. The mental status exam is done through communication. I admit there are other aspects of observing a patient's behavior.

Now, when I saw this patient on 11-3, you'll see that my mental status examination is very brief because I'm limited in what I can do. But I could tell that she was obtunded and confused because there are certain things that cross through language.

Q. Would you be more concerned about having an accurate evaluation when you had a language barrier?

A. Oh, sure. I'd try to get somebody to come in who speaks the language.

Q. And those people exist here at Mt. Sinai Medical Center?

A. They do, indeed.

Q. And they're available to you whenever you need a Russian translator or a translator for another language?

Page 94

A. With some effort. I mean, we have to make arrangements to have them come in. They do other jobs and so forth. But we can get that information. I wouldn't need it here though.
Q. What does your neuro exam there indicate? And that's our Exhibit 75, Doctor.
A. She is obtunded, she responds to noxious stimuli by moving all extremities and with a grimace and sometimes speech "I, I, I." That transcends language.
Q. That's a sign of pain, isn't it, Doctor, discomfort?
A. No, it's a sign that she can recognize pain. So she's functioning at a relatively low level. This isn't just a confusional state. This is a patient who is obtunded, her level of alertness is diminished. So, if anything, that would probably be qualified at that point as a delirium.
Q. Doctor, there's a notation here on 11-3-91 of low sodium and something about SIADH there.
A. Yes, sodium is 128.
Q. Was that of concern to you on that date?
A. Not particularly.
Q. What was the notation of SIADH?
A. It says question mark does she have

Page 95

inappropriate SIADH syndrome.
Q. So something that should be looked into but not a serious concern?
A. At that point sodium of 128 was not that much of a concern.
Q. How long with a sodium existing at a 128 level would be of concern to you?
A. The shorter the duration of low sodium, the greater the concern.
Q. So it had been up to 132 and dropped down to 128?
A. It's not much of an issue.
Q. Is that your note or someone else's?
A. This is the house officer that got back the initial results. Again, we had trouble with his name, if you'll recall. This is his survey of the initial results. He notes the sodium to be below the lower limits of accepted normal, which is 135, and makes, again, an observation, which is what I want the house officers to do.
Q. Was that sodium ever worked up?
A. I'd have to check later on. We checked her and, I believe, her serum osmolalities. I'm not sure.
///

Page 96

(Thereupon, Plaintiffs' Exhibit 93 to the deposition of Michael W. Devereaux, M.D. was marked for identification.)
BY MR. ABAKUMOV:
Q. Doctor, showing you what's been marked as Plaintiffs' Exhibit 93, could you identify that document?
A. Yes, it shows that her -- it's a serum osmolality and it shows on November 3 that it's 260, that that's somewhat low.
Q. That was a workup of the low sodium level?
A. Yes, we ran serum osmolalities and also serum sodiums.
Q. What was the importance of doing this test?
A. Just to understand the nature of serum sodium so we would know how to treat it. If it's inappropriate ADH, you do it with fluid restriction. If it's nutritional sodium depletion, you would probably put her on a rich sodium diet.
Q. And you felt this was an important test to do at the time?
A. Yes. I mean, particularly if the sodium were to worsen, the main thing is you want to keep it from going much lower than that, getting into the low

Page 97

120s because then with a rapid drop in sodium, you'll face the issue of seizures and so forth
Q. What does this low sodium level indicate in terms of any nervous system process?
A. Inappropriate ADH is caused by everything, anything and nothing. It's a sign of chronic illness, primary CNS infection, central nervous system tumors, lung cancers, COPD, essentially chronic illness. It's a very lengthy list. It's a very nonspecific problem. We see it after patients have strokes. It's a very nonspecific phenomenon. The most important thing to do is to treat it.
I mean, our ultimate deduction here would be and why we weren't terribly concerned about it is when we discovered she had a meningeal process, no matter what the cause, it would have been a safe deduction that if she had inappropriate ADH, it was due to that. So it really wasn't a major issue. It's something I see all the time.
Q. Now, does this rule out central nervous system involvement if you have a normal test?
A. Oh, of course not.
Q. And this test doesn't rule out central nervous system involvement; in fact, it indicates that it should be examined further?

Page 98

A. It basically says the patient is significantly ill, and it certainly can be seen with central nervous system disorders of many types.
Q. So you go further beyond this test?
A. I wouldn't use inappropriate ADH, or a low sodium is too nonspecific to start searching for neurologic problems.
Q. What tests would you do after this one?
A. It would depend on the circumstances.
Q. Well, in Freyda Kaplan's case.
A. It had nothing to do with my decision to LP her, nothing, nothing. My decision to LP her was based on, as I indicated in my note, there's no mention of the low sodium.
Q. Does this indicate any other tests?
A. Youmean atthatpoint? No. At this point it tells me that her hyponatremia, her low sodium, is very possibly the result of SIADH; that she's hemodiluted instead of hemoconcentrated and that the treatment would best be directed to watching intake and output of fluids and trying to make sure she doesn't get fluid overload.
So it helps more in treatment rather than diagnosis. Diagnosis was already set. She had a far more important and a far more specific test, which was

Page 99

the spinal tap.
Q. Yes. And you did the spinal tap for reasons you say that weren't related to the results in this test?
A. Absolutely. We didn't know it.
Q. Atthetime you did this test you didn't know the --
A. No, at the time I did the spinal tap I didn't know her serum osmolality. That would have been alaterresult.
Q. But this test indicates a possibility of central nervous system involvement, which indicates other tests? I mean, do you stop with this test?
A. No, it's a cul-de-sac in this particular case. It might in other circumstances. Remember what I told you before. You don't practice medicine by an algorithm. This particular test was probably ordered by the house officer when he noted the low sodium. That's an important piece of information. But for the treatment of the patient, I don't care a wit about it in terms of the diagnosis.
If her sodium had been 150, my workup would have been the *same*. It would have only meant that she was dehydrated, which is seen in meningitis. It doesn't meananything.

Page 100

Q. Does this type of result tell you to stop doing further tests and start treating the patient?
A. Absolutelynot. I've already told you that.
Q. Ijust wanted to get that clear. Doctor, I'm going to ask you to identify a couple signatures at the bottom of Plaintiffs' Exhibit 86. There seems to be two doctors there.
A. There is a Dr. Gardner. And is that Kovozec?
Q. I don't know.
A. Yes.
Q. No recollection of those doctors?
A. No.
Q. Doctor, are you aware that -- how did Freyda Kaplan do after treatment was commenced?
A. Poorly. I mean, she had her ups and she had her downs. But the obvious answer to that question is in the pudding, and --
Q. Well, she had her ups and downs and eventually she had a down; is that what you're saying?
A. Yes, and she did very poorly and was discharged to a chronic care facility. If she did well, we wouldn't be here.
Q. Are you aware that a ventricular shunt was

Page 101

placed into her cranium?
A. Yes.
Q. What was the purpose of that?
A. Enlargedventricles to see if she was obstructed and needed to be decompressed.
Q. Did she have a hydrocephalus, continuing hydrocephalus at that time?
A. Yes.
Q. Was it to relieve the hydrocephalus?
A. Well, it was part diagnostic, and if the diagnosis was correct, it would have been therapeutic as well. As it turns out, her pressures were not that elevated, her ventricular pressures. So she had probably a communicating hydrocephalus secondary to the meningitis.
Q. Communicating between the --
A. Ventricles and the subarachnoid space.
Q. And the spinal fluid?
A. Well, the spinal fluid is everywhere. Communicatingmeans that there's no obstruction within the ventricular system that prevents the egress of spinal fluid outside the ventricular system where it's absorbed over the top of the head in the subarachnoid villi of the superior sagittal sinus.
So basically anywhere along -- the fluid is

Page 102

produced in the ventricular system and then flows out into the subarachnoid space, down in the spinal cord and around the brain and is absorbed over the surface of the brain, superior surface of the brain, and disruption of that flow anywhere along the way can lead to literally a backup in fluid. And the presumption here is that she did not have a high pressure, obstructive hydrocephalus, meaning that there was a block within the ventricular system.

We came to believe that this was a communicating hydrocephalus and that the problem was probably with the fluid getting out of the surface of the brain up to the top of the brain where the fluid is absorbed. That was our thinking. That's one of the reasons we got away with the tap. If it had been an obstructive hydrocephalus with an internal obstruction within the ventricular system, we probably would have herniated herbrain.

Q. If you couldn't have done the tap, the lumbar puncture -- we've used those terms synonymously during the deposition --

A. Yes.

Q. -- would you have started her on Amphotericin B?

A. Absolutely, unequivocally, emphatically,

Page 103

no.

Q. So you would have risked the possible candidal meningitis?

A. Absolutely, yes.

Q. And what would the probable outcome have been in that case of Freyda Kaplan?

A. Well, if she had a meningitis that we didn't treat, poor. But her outcome with the cavalier use of Amphotericin B is that you would kill more patients than you would serve by those that would be treated with the drug who, ultimately, needed it.

Q. Is morbidity higher With a treatment of Amphotericin B than it is by being infected with candidal meningitis in the central nervous system?

A. Not in patients with Candida meningitis in the central nervous system. But it certainly is in patients who don't have it and don't need it. You don't practice medicine that way.

Q. Any other tests for candidal meningitis besides spinal tap?

A. Spinal tap.

Q. So if you couldn't do that, you couldn't treat this patient?

A. No. We would do a ventriculostomy and drain fluid from the ventricles, and that was, if I

Page 104

recall correctly, one of the things we were thinking about.

Q. So you could drain it and do the tap?

A. Yes, and take fluid from the ventricles as was done through her hospitalization.

Q. Are you aware that the ventricular shunt became dislodged during her second admission?

A. Yes.

Q. Doyouhave those notes available to you?

A. It didn't become dislodged.

Q. Isn't that the word that was used?

A. Possibly so. But it became disconnected.

Q. what's the difference?

A. Well, dislodged would have meant that it was removed, and it wasn't removed. It was sewn in. I've reviewed this with neurosurgeons because I didn't know what it meant, and it's the opinion of the neurosurgeons who are involved in the case that it was disconnected.

Q. Was it based on the fact that it's indicated that it's sewn in?

A. Well, they always are. You always sew them in.

Q. Do you sew them in before you put them in?

A. No. When you insert it, you make an

Page 105

incision through the scalp, drill a hole through the skull, pass the ventricle in and sew it in place usually with --

Q. So that a patient moving around who pulls her head bandages off couldn't dislodge that shunt?

A. Right. Soitprobably should have been disconnected. That's the best we can say.

(Thereupon, Plaintiffs' Exhibit 94 to the deposition of Michael W. Devereaux, M.D. was marked for identification.)

BY MR. ABAKUMOV:

Q. I'm going to show you Plaintiffs' Exhibit 94, which are notes from 11-12-91. Is that the note you were referring to on the --

A. Yes.

Q. Doctor, take a moment to review that quietly. I'm going to mark another exhibit here.

(Thereupon, Plaintiffs' Exhibit 95 to the deposition of Michael W. Devereaux, M.D. was marked for identification.)

Q. I'm going to also show you a progress note, which is marked Plaintiffs' Exhibit 95. Do you recognize that note?

A. Yes, it's my note.

MR. GROEDEL: what's the

Page 106

date of that note?
THE WITNESS: It's 11-12.
BY MR. ABAKUMOV:
Q. I guess all the notes are 11-12; isn't that correct, Doctor?
A. Yes.
Q. What does it say about the dislodged shunt and what language were you referring to to indicate to me that it was disconnected instead of dislodged?
A. I'm talking about the neurosurgeons are. This really has nothing to do with the question. What we're talking about here is whether or not to externalize or what to do with her shunt. I think this is a discussion we were going through at the time of whether we were going to leave a permanent shunt in place and shunt it into her abdomen or some other place or whether we were going to just -- do we need the shunt anymore, whether we're going to oversew the shunt and just make it a reservoir, which you can tap fluid from through the skin and you just close off the incision and put the shunt with a small fluid reservoir in, or whether to continue to keep it externalized as it is draining into literally a bottle at the patient's bedside. That's not the issue --
Q. Is that the discussion that occurred after

Page 107

the dislodgement of the shunt?
MR. GROEDEL objection.
A. Yes, it does say dislodge. It's in quotes. What happened here is I suspect that he is quoting, whoever wrote this, what the nurse said. I am telling you that I spoke with the neurosurgeons, and you can speak with them yourself, and you don't pull out -- the nurse wouldn't put the shunt back in if it came out. What you would do is call the neurosurgeon.
What clearly happened here, according to what the neurosurgeons say and my understanding as well, is that the tube became disconnected, it's a low-pressure system, air was sucked into the tube and entered up in the ventricles and that's why you have -- basically have done a pneumoencephalogram on the patient.
Q. Who is the neurosurgeon?
A. Both Colombi and Shafron. Shafron was on call. That may have been a weekend. I'd have to check the calendar. Or he spoke -- It indicates he spoke with Shafron. Colombi was the main surgeon dealing with this, the shunt.
Q. Wasn't the first shunt an external shunt?
A. Yes.
Q. Why did you go to internal?
A. Because you don't need the external

Page 108

anymore.
Q. That didn't have anythmg to do with it becoming dislodged?
A. No. One of the main problems with an external shunt is the separation of the tube.
Q. And that's what happened here?
A. That's what we think happened here. That's what I think happened. An internal shunt -- It depends what shunt you're talking about.
Q. Let's talk about the internal shunt that Freyda Kaplan had.
A. What about them?
Q. So you went to an internal shunt after that shunt was dislodged?
MR. GROEDEL: Objection.
A. I'm trying to remember without going through the notes what the exact course of her shunt was. I believe it was, ultimately, if my memory serves me correctly, that we never, ultimately, shunted her into her abdomen, if my memory serves me correctly; that she was -- obviously, an external shunt is a short-term phenomenon -- that she was removed from the external shunt. But I cannot remember specifically if she had a VG or a VA shunt into the abdomen or if we just closed it off. I honestly can't remember that.

Page 109

Q. Wouldn't that be indicated in the records?
A. I would have to review the records.
Q. It's not there?
A. It's not here, no. We're talking here about the fact that if we internalize her shunt in the abdomen, then we may seed the abdomen with her infectious agent.
(Thereupon, Plaintiffs' Exhibits 96 and 97 to the deposition of Michael W. Devereaux, M.D. were marked for identification.)
BY MR. ABAKUMOV:
Q. I show you Plaintiffs' Exhibits 96 and 97. Could you identify those documents and the dates they refer to?
A. 11-13-91, this is an ID note and a house officernote.
Q. What happened following the dislodgement of her shunt, Doctor?
MR. GROEDEL objection. He told you it didn't dislodge.
Q. Don't the records say it dislodged?
A. I'm telling you what happened. What happened is it was disconnected.
Q. I understand you feel it was disconnected.
A. No, the neurosurgeons feel it was

Page 110

disconnected, Colombi; that there was evidence of cultures of CSF from the collection bag, presumably from the external shunt bag; that it grew out gram-positive cocci, probably strep, and, I think, she was finally determined to have a strep.

Q. Is that confirmed in Plaintiffs' Exhibit 96, which is a microbiology routine lab?

A. Let's see. Yes. Butthisis from a -- Well, the final report is November 15. Fluid collected November 13, right

Q. So it was following the date of dislodgement or disconnection as you've indicated?

A. Yes.

Q. Did that Streptococcus virus --

A. Bacteria.

Q. -- bacteria enter as a consequence of the dislodgement or disconnection of the shunt?

A. I can't tell you for sure, but it's certainly a possibility.

Q. Is it a probability given the fact that she didn't have it before and it appeared on a lab approximately one day after the --

A. Again, I honestly can't say that, can I?

Q. Well, I don't know. I'm asking you.

A. Well, I can't. It's certainly a

Page 111

possibility.

Q. What are some of the other possibilities?

A. That it's a superinfection because she's so immunologically compromised that she could get infections, fungal meningitides from other superinfections.

Q. What is immunocompromised?

A. Chronic use of antibiotics. That's probably why she got it in the first place. But what happens in a situation like this is you develop bacterial strains that don't react to antibiotics anymore and they go beyond -- you develop what we sometimes call a superinfection or nosocomial infection because of lack of response to antibiotics. That's very much in the news today. It's a very real problem. And this woman was on multiple antibiotics for a period of months.

Q. Well, that's something that was known in '91 also? We knew this in '91 also?

A. We knew this in '81. We've known this for a long time. The race is going on to come up with different antibiotics.

So she had a strep infection. There is no question about that. The cultures grew out several days after the disruption, whatever it might have been

Page 112

in the ventricular system, the drainage system, and very possibly there's a connection, of course.

Q. You used the term immunocompromised. Is thatthesameas immunosuppressed?

A. Yes. In her case those terms are used, admittedly, somewhat cavalierly because how much of this is -- she's been chronically ill, she's on a number of antibiotics. There probably is some immunosuppression. People like this are more susceptible to serious infections.

Part of that is probably also that she's growing new and wonderful bacteria in a medium that's had four or five months of different antibiotic use.

Q. And that's what made her subject to picking up an infection like -- more susceptible to picking up an infection like Streptococcus during the second admission?

A. Well, to be completely honest, how much would be due to that, how much would have been due to the possible contamination of her spinal fluid through a disrupted ventricular system is difficult to know. One could certainly develop a meningitis from a disrupted ventricular system It's a common complication of an external shunting process, as you no doubt have come to know.

Page 113

So you don't have to be immunologically compromised. Perhaps 15 percent of the patients develop meningitis from an external shunt.

Q. Are you more susceptible to infection when you're immunologically compromised?

A. Absolutely. That's what AIDS is.

Q. This vasculitis which she developed, was that caused by Streptococcus, was it caused by Candida albicans, was it caused by something else?

A. Who knows? Again, vasculitis is a deduction. We never proved it. Then to go one step further and say something that we haven't proved, is it due to this or that or the other thing is folly.

Q. So all you know, Doctor, is that she had a stroke and you don't know if it was caused by vasculitis?

A. Sure. I mean, it could have been long term and we may have never found a cause for it. It's probably a vertebral basilar distribution stroke. Since it's the vertebral basilar system that has input into the thalamic structures, she could have embolized from somewhere else in her body, from her heart. I don't know. We don't how. You frequently cannot prove the etiologic mechanism in a stroke.

Q. Well, do you think it's probable that she

Page 114

had the stroke as a result of the hypothalamic infarcts, I guess would be more precise, as a result of the vasculitis?

A. Well, I think that's a reasonable deduction because we know it happens. But what I'm telling you is here is a woman who has been infirmed for months and she's also 69. I've had 69-year-old people who have had thalamic infarcts and no preceding illness.

So the first question is is it connected to her illness at all. If it's connected to her illness, what is the exact etiologic mechanism? We suspected that it might be a vasculitis, but there is no proof. In fact, you'll never know. Even an autopsy couldn't prove it at this late date. It could prove another cause. She might have advanced atherosclerosis, which we never really ruled out in the type of workup that we did.

Q. Do you *think* it's more probable that the vasculitis was caused by the Candida albicans meningitis or the Streptococcus?

A. I just told you that's folly. I don't know.

Q. I just had to ask you that question, Doctor. You've only treated one patient with a candidal meningitis that you can recall?

Page 115

A. I haven't treated very many. I don't know. I've seen a fair number of cases with fungal meningitis because I trained in Los Angeles, and that's where--

Q. A lot of AIDS patients?

A. No, I trained in the '60s before the AIDS. But that's where coccidioidomycosis comes from. And so I have probably treated more cases of coccidioidomycosis meningitis than anybody certainly in Cleveland. But the specific fungal agent, whether -- I just can't tell you how many cases of Candida meningitis.

Q. Did any of those patients stroke?

A. Withcocci?

Q. Yes.

A. Sure.

Q. Was that related to the cocci?

A. Vasculitis means inflammation of the blood vessels, and you can determine indirectly by observation, by angiography that may show characteristic pictures. You can do biopsies of muscle and skin if it's a systemic illness that's associated with vasculitis such as lupus. But in a situation like this it becomes conjecture.

Q. How about postmortem studies, Doctor,

Page 116

would those reveal the vasculitis?

A. Probably not. You might -- It would depend on the nature of the problem. You might, conceivably, find some evidence, but I doubt it because the inflammatory process, I suspect, would have been self-limited and long since gone away. But I would -- I mean, if it's important for you to know that, it would be something that we probably should ask a neuropathologist.

Q. Well, you treated Freyda Kaplan throughout this second admission as her neurologist?

A. Not throughout. I followed her case, but I was the teaching attending for the month of November She was seen by Dr. Riley, one of my associates, in the month of December, and you'll note that her discharge summary was signed out by Dr. Chandar who covered the month of January. But, obviously, most of the interest in her case was in the month of November, and then I continued to follow her along.

Q. Do you know what her status is today?

A. At this particular moment, no.

Q. Do you know what it was when she left?

A. Yes. She was significantly impaired, markedly encephalopathic and --

Q. Would you use the terms comatose,

Page 117

semicomatose?

A. I don't think she was comatose. She was probably at that point probably more in a vegetative state. But I'd have to look at the records.

Q. How is that different from comatose?

A. Well, it's an interesting question. Patients who are vegetative usually pass through a state of coma where there's absolutely no evidence of any kind of consciousness, no sleep/wake cycle, no eye following. Individuals who move into a vegetative state have often preservation of the sleep/wake cycle, the brain stem is functioning, may show some evidence of eye following, may even occasionally take food, although often they won't. But the main difference is that there's preservation of the sleep/wake cycle.

Q. These people can speak?

A. No, no. From the standpoint of neurologic function, it doesn't mean much. You're non-functioning in both states.

Q. What's the life expectancy for a 69-year-old woman in the kind of condition that you last saw her? Is it a normal life expectancy?

MR. GROEDEL: objection.

A. Well, the only answer I would give to you is that if she remains as neurologically impaired now

Page 118

as she was then, I hope not.
Q. But you have no idea if her normal life expectancy is 13 years, she would live those 13 years out?
MR. GROEDEL: objection.
A. Of course I don't. If I did, you should pray to me.
Q. I guess I'll have to pray to the statisticians then, Doctor.
A. We all do.
Q. Thenumbercrunchers.
Are you aware that Ampho B irrigations were --
A. Amphotericin B?
Q. Yes -- were prescribed or ordered on October 13, 1991?
MR. MURPHY: October 13?
MR. ABAKmov: November 13.
I thank my colleagues.
A. Oh, you're not talking about the first admission; you're talking about the second admission.
Q. I'm talking about November 13.
A. I can't specifically recall it. If she had Candida in her urine, that would be a reasonabl thing to do. It's something that's not uncommonly done.

Page 119

Q. Is that the treatment of choice for Candida in the urine to your knowledge?
A. If it's just the presence of Candida in the urine, it may not even be treated. If it is treated, yes, you usually use flushes with Amphotericin B or Bicarb solutions, what have you
Q. Doctor, before we wrap up -- I asked you about your business addresses here -- do you have a private business address outside of Mt. Sinai Medical Center?
A. No. Well, my home address is sometimes -- I think is actually the physical address of our corporation just so stuff doesn't get lost in the hospital mail.
Q. What is that?
A. That's 2886 Litchfield, L-I-T-C-H-F-I-E-L-D, Road, Shaker Heights.
Q. And what's your zip there?
A. 44120. But, again, my professional address is here.
Q. But the corporate address is there?
A. I believe it is listed as there. I wouldn't even -- You know, I don't think so. I think the corporate address is officially -- I think we have a mailing address there for the bank and so forth, but

Page 120

I, genuinely, am not sure.
Q. And that's also your home address?
A. That'smy home address.
Q. Doctor, were you asked to testify at any point as an expert in the Freyda Kaplan case by any attorney?
A. You know what I know, and the letters are here. I was contacted June 1.
MR. MURPHY: YOU were contacted when Mr. Abakumov asked me to contact you and schedule your deposition.
A. Then you know.
Q. Could I see the letter of June 1? Could I take a look at your file?
A. Sure. Here is a May 16 letter. This looks like the initial letter. I have a July 1. I may have read that as June.
Q. Can I see your other letters there, Doctor?
A. Yes.
Q. Did you discuss this case yesterday evening with Mr. Murphy?
A. By telephone briefly, yes.
Q. Did he mention or discuss With you any of Dr. Howard Tucker's testimony?

Page 121

A. There were some comments made about it. Yes, he did. But, frankly, it was more a chitchat. It really didn't have too much to do with what I was doing here.
Q. Do you remember the chitchat?
THE WITNESS: YOU told me you had come from his deposition.
A. I can't recall too much else. I guess something--
THE WITNESS: And, again, if I misspeak, correct me.
A. -- something to the effect that he didn't have much argument about the patient's hospitalization in November through January, if I'm remembering correctly.
Also, what he is mentioning in his letter, which was merely just confirmation of a letter, that he is making the assertion that this patient had meningitis that was missed, Candida meningitis that was missed during the first hospitalization.
Q. Anything else? Anything critical about you that was discussed?
A. No.
Q. So that was pretty much the entire 20-minute conversation?

Page 122

A. Well, we discussed that. We discussed the fact that he couldn't say anything. See, I started to ask some questions or something about this, the admission that we spent virtually all of our time on today, and he said he couldn't talk about that. You know, there were, undoubtedly, 20 minutes of other things that were said but, obviously, nothing substantive for today, nothing that I would want to keep a secret from you.

Q. Well, is there anything else that you can remember other than what you've said here today?

A. No.

Q. Is there anything that was in your file or in your possession, any letters that aren't here today in this file that we're looking at at the deposition? Did you pull anything out of here before you came into the deposition?

A. The only thing I can remember throwing out was remember our original date for this deposition was a week or so ago and one of the letters you sent me gave that date just like this, and, I think, I threw that out when I reviewed the chart. And it was past that date. I think that was about it.

Q. when you say you, you mean Patrick Murphy or are you referring to me, Doctor?

Page 123

A. Patrick Murphy.

THE WITNESS: I believe it was one of the letters you or somebody in your office sent me, very possibly your secretary.

A. I can't recall any other letters. Certainly no medical material.

Q. Doctor, you would agree that Freyda Kaplan had a very tragic result here for whatever reason?

A. Absolutely.

Q. Would you have liked to see her on October 30 as opposed to November 3?

MR. MURPHY: objection.

A. That's medicine by retrospect. And you do that; I don't. I mean, the fact of the matter is every -- many cases I've seen, when I have to go back and look at the case, I wish I would have done something differently on the basis of hindsight. I don't do that. I can't tell you what I would have done in that clinic on the 30th of October. I can't even begin to conjecture. I can only say that what was done from my vantage point as a neurologist was perfectly rationale and it didn't affect the outcome of this case as far as I'm concerned.

Q. Well, do you feel that if you had

Page 124

commenced your testing and procedures and they had taken the same amount of time as they did following the November 2 admission, which is approximately six days before you had a result on the lumbar puncture analysis for purposes of commencing Amphotericin B, do you feel that she would have had a better result if you would have commenced this on October 15 perhaps, if she had come in on October 15 and then the six days brought you to October 21 for the --

A. I don't think she would have been diagnosable then. But it comes **back to that old adage. If the** dog had not stopped to **take a crap, he might have caught the rabbit. You can't look back and know what you might have done. Every case has a beginning, and it is impossible most of the time on the basis of ongoing information to know when that very beginning occurs and you can make a diagnosis. When is the earliest time you can make a diagnosis? For all I know, if we would have tapped her on the 30th, the** fluidwould **not have grown out Candida and we might have taken longer to make the diagnosis.**

Q. Well, if the fluid had grown out Candida on October 22 and treatment had been commenced for Freyda Kaplan --

A. On what date?

Page 125

Q. Well, if we had grown it out on October 22.

A. If you had grown fluid out on October 22?

Q. Sure. She comes in on October 16, and six days later you've completed your studies, you've done your spinal tap, you've got a fluid profile.

A. Well, you're making up a fairy tale here.

Q. It's called a hypothesis.

A. Well, for me, this is really a fairy tale because this is not a hypothesis. What we're saying here is if we would have **diagnosed Candida albicans meningitis earlier than we diagnosed it and begun treatment** --

Q. On October 22?

A. Well, this is where the fairy tale is. You're saying it **was diagnosable on October 22.** I don't really know **that it is. There's really no** evidence to prove that she had **diagnosable meningitis** at that point.

Q. You never use hypothesis in your training?

A. Yes, I do and I distinguish them from fairy tales. And what I'm telling you here is there is no evidence. Now, if, indeed, you have Candida meningitis right now and I were to tap you and found evidence of it and you were doing fine and I started

Page 126

you on Amphotericin B, you will do better than if I diagnose it two months from now when you become symptomatic.
Q. And I'm less probable to have a stroke than if you diagnose it two weeks later?
MR. HERBERT objection.
MR. GROEDEL: objection.
You're asking a lot of expert opinion questions here even though you've called him as a fact witness. I assume then it's okay by you that all the other attorneys here have the opportunity to ask expert opinion questions, too.
MR. ABAKUMOV I feel this is his question as a treating physician of this patient. I'm asking him a specific question about this patient.
MR. GROEDEL You're asking him questions beyond what he did from a factual standpoint. You've been doing it all day. You've opened the door to use him as an expert witness, which we intend to do. But go ahead.
BY MR. ABAKUMOV
Q. Answer the question, Doctor.

Page 127

A. The questionis?
Q. Would it have made a difference?
A. If she had Candida meningitis at that time? Of course. The earlier you make a diagnosis in almost any condition, the better it is for the patient.
Q. Where did the Candida meningitis come from in this patient as her treating physician?
A. Probably her urine.
Q. And how did it get into the cerebral spinal fluid?
A. Probably through hematologic spread.
Q. Throughthe blood?
A. Probably.
Q. How do you detect it in the blood?
A. Blood cultures. They were negative.
Q. Which blood cultures?
A. I think *the* blood cultures we drew initially on 11-3, 11-4 were negative.
Q. Is that because it was already in the cerebral spinal fluid?
A. No, that's because it's hard to grow and you don't always get it.
Q. But not impossible to grow?
A. No. But with blood-borne infections, you can't have negative cultures as can the CSF if you have

Page 128

meningitis.
MR. ABAKUMOV okay. Thank you very much, Doctor.
MR. GROEDEL I have no questions.
MR. MURPHY: I've got a few questions. We've been here a long time, but --
MR. ABAKWOV: Doctor, before Pat asks --
THE WITNESS: I can talk forever.
MR. ABAKUMOV: -- before Pat Murphy starts speaking here, I would just like to object for the record as to your being an expert in this case, and all the questions I directed to you here today were as a treating physician of Freyda Kaplan during her second admission and whatever part thereof you treated her.
MR. HERBERT The record speaks for itself.
CROSS-EXAMINATION
BY MR. MURPHY:
Q. You indicated you reviewed the record from

Page 129

the first admission, too, earlier this morning?
A. Yes, sir.
Q. Mr. Abakumov asked you questions about the low sodium level on the second admission. I'm going to hand you the blood chemistry sheet where I highlighted the low sodium readings from the first admission and just have you look at that for a minute, please.
A. Yes.
Q. Dr. Tucker has testified to the effect that those low sodium levels had to be worked up more thoroughly before the patient was discharged on October 10 to see what their etiology was, presumably that it might just be meningitis. Do you agree or disagree with that assessment?
MR. ABAKUMOV objection.
A. I disagree.
Q. Why so, Doctor?
MR. ABAKUMOV: Note a continuing objection.
A. Because probably half of the patients on the T8 unit have sodiums of this level, 132, which is 3 milli-equivalentsbelow the lower limits of normal, which really doesn't mean that much. Plus her sodium was *going* up. At the time of discharge her BUN was 15. And, if anything, I would suspect that that very low

Page 130

sodium with a rapid drop in BUN from October 2 to October 9 or October 4 with a rapid climb to October 6 is more a result of hemodilution and fluid overload. To me, it's just not an issue. Too much has been made out of this issue of whether or not she has an appropriate ADH. And I wouldn't keep a patient in the hospital any longer than that.

Q. You were discussing with Mr. Abakumov various etiologies for her bilateral thalamic infarcts or stroke?

A. Yes.

Q. You talked about vasculitis as one possibility, embolization as another?

A. Yes.

Q. Her age as one?

A. Well, the age just makes her more susceptible to stroke.

Q. Would that tie in with atherosclerosis?

A. Sure, at that time. You can have about one percent per year.

Q. Are there any other etiologies you can think of, giving what you know for Freyda Kaplan, other than those that we've just mentioned?

A. No, not off the top of my head.

Q. As a doctor who followed Freyda Kaplan

Page 131

during her second admission at Mt. Sinai Hospital, given what you know about her and given what you know about strokes, do you believe anybody can truly state an opinion with reasonable medical probability as to what the etiology of her stroke was?

MR. ABAKUMOV objection.

A. No. I certainly can't. Icould--

Q. Can you render such an opinion as to the etiology of her stroke?

A. For sure?

Q. No, with reasonable medical probability or certainty.

A. I understand the meaning of that term, and you're asking me to a 51 percent certainty to tell you what the etiology of what her diagnosis is. I put it in this chart as vasculitis, and, I think, others felt that possibility. And that's conjecture. And to try to fit that into a legal definition of probability I think loses meaning. I think it's a reasonable deduction. It certainly happens. Whether it's right or not is another issue.

MR. ABAKUMOV Move to strike.

BY MR. MURPHY.

Q. Is it your opinion with reasonable medical

Page 132

probability that as a physician you don't really have enough data or information to make a call as to her etiology for her stroke --

MR. ABAKUMOV. objection.

BY MR. MURPHY:

Q. -- to a 51 percent certainty?

A. Correct. We would have had to do angiography and so forth. And to take a woman this neurologically impaired, to make an academic diagnosis would have been a moral outrage.

MR. ABAKUMOV Move to Strike that opinion.

Q. When Mr. Abakumov was showing you that article from Gorbach's text, you made a statement to the effect that you reviewed the article but you don't believe the meningitis was present back at the time of the first admission; is that true?

A. That is correct.

Q. Is that your opinion to a reasonable degree of medical probability based upon what you know about this first admission?

A. Yes.

MR. ABAKUMOV. objection. Move to strike.

Q. Can you explain why you state that

Page 133

opinion?

A. Because there's no evidence that she had meningitis at that time.

Q. Do you recall seeing her fluctuating temperature during the first admission?

A. Well, it was a low-grade temperature. By fluctuating it wasn't wide peaks and valleys but it was mainly in the 99 to 100 and a fraction range. So it was what I would call a low-grade temperature.

Q. Given Freyda Kaplan's presentation at that time with that low-grade temperature, in your opinion, to a reasonable degree of medical probability, was such low-grade temperature an indication to tap her at that time?

A. No.

Q. Why not?

MR. ABAKUMOV objection.

A. If I were to tap everybody in this hospital that had that temperature curve, I wouldn't be guilty of malpractice; I would be guilty of a criminal act. The basis for a tap is not a fever. Every mother would have her child tapped ten times by the time he was twenty years of age. You don't tap people because they have a fever. You tap them if there is reason to tap them based on the history, the physical examination

Page 134

and the information on hand at that time. You do not do spinal taps cavalierly.
MR. ABAKUMOV objection.
Move to strike.
A. It's expensive, it causes discomfort and it is not something that you do. You don't do any test unless it needs to be done.
Q. You're aware that one of the urine cultures during that first admission grew out Candida tropicalis, or are you aware of that?
A. Yes, I am.
Q. Given your background as a neurologist and your understanding of Candida infections and Candida central nervous system infections, in your opinion, to a reasonable degree of probability, is the finding of candiduria in this first admission something that should cause the physicians watching her and taking care of her at that time to have a heightened suspicion of her developing a systemic Candida infection and subsequently Candida meningitis?
A. No, I don't think so. But I do think that it's fair to say --
MR. ABAKUMOV. objection.
A. -- that this is a patient who had a history of chronic recurrent infections throughout her

Page 135

hospitalization in Russia and was known to already be having infections in the United States and was, obviously, going to be a patient to be followed up and observed. She's a candidate for infection, sure. That's why she was followed.
Q. Is it your opinion that the diagnosis of Candida meningitis was made in a timely manner in the second admission and treatment started --
MR. ABAKmov objection.
BY MR. MURPHY:
Q. -- started in a timely manner?
A. I, obviously, have a bias. And all I can say is, I *think*, it was made in a timely manner. If I had it to do all over again, obviously, I would have done the -- knowing the information that I know, I would have done the LP myself.
Q. The first time you saw her?
A. Sure.
Q. But that's retrospective, true?
A. I'm much better retrospectively than I am prospectively.
Q. In your opinion was the appropriate workup done in the second admission to lead to the diagnosis of Candida meningitis, the tap and the culture and so forth and so on?

Page 136

A. To quote you, the act speaks for itself. Yes, we made the diagnosis.
Q. Was it the nuchal rigidity that led you to request the tap be done?
A. Yes. Well, maybe it's a little better to say the nuchal rigidity suggested to me the possibility of a *meningeal* inflammation and that possibility led me to do the tap. Again, lots of people have stiff necks, and I don't tap them just for a stiff neck alone.
THE WITNESS: Could I make a phone call?
(Thereupon, there was a brief recess.)
BY MR. MURPHY:
Q. Dr. Devereaux, given your knowledge of Candida meningitis, can the patient's presentation, the signs and symptoms that she would exhibit, change rather dramatically in a period of days such as comparing Dr. Baron's October 30 note with your note when you saw her on the first day of admission?
A. Yes.
Q. Why is that?
A. Well, she has an evolving process, and, of course, different people are going to react differently to it. That's where you get into a problem answering a question like this. We know one thing that's a

Page 137

certainty; that there was a major change in a week. We know that. That's beyond question.
So what you're asking me then is could there have been a significant change in the last four or so of those seven days, and the answer is yes. I mean, this patient when she *came* into -- you just look at the record -- when she came into the hospital here, she was on a gurney. I mean, this patient couldn't walk as near as I can tell. She was obtunded. This was a patient who came into a clinic three or four days before
So forgetting about all the legal stuff, there was, obviously, a change, whatever the cause may be. If it wasn't the meningitis, then it was something else.
Q. In response to one of Mr. Abakumov's questions, you said you couldn't really conjecture what you would have done on November 30 had you seen the patient on that day?
A. You mean October 30?
Q. October 30 I meant to say, yes. And then you went on to say that you didn't think that would affect the outcome, anyway?
A. I don't believe *so*.
Q. Why do you state that, that you don't

Page 138

believe the outcome would have changed?
A. Well, again, we're dealing with the type of infectious process that usually doesn't do dramatic damage over hours, where I said literally minutes can make a difference in the quality of survival. You're dealing with an infectious process which is somewhat more indolent and usually doesn't produce dramatic change that fast.
Again, the biggest delay is not between Dr. Baron and my seeing the patient which was three days, four days. The biggest delay was between my seeing the patient and starting treatment. So if we use that time line, I'm more guilty than she is, if we're talking strictly about time. The patient waited five days in the hospital before we started Amphotericin B.
Q. Your opinion though, if I understand it, is even had you started it --
MR. ABAKUMOV objection.
BY MR. MURPHY:
Q. -- on November 3, the Amphotericin B, in all probability, her condition would not have changed?
A. Probably. Again, the obvious answer that we would all agree with is that --
Q. Well, probability is all I'm asking.

Page 139

A. -- it's always better to treat something as fast as you can. No one is going to dispute that. But in reality, had she been started on October 30 versus or had the diagnosis been made on October 30 versus November 8, and that's really when the diagnosis was made, you have some argument for saying that it would have made a difference. However, the diagnosis wouldn't have been made on October 30 even if I, for some reason, would have seen her and suspected it. It would have been made on November 4. So we're talking about a three- or four-day delay versus an eight-day delay. And my suspicion is that it wouldn't have made a lot of difference.
Q. I'm just asking in the scheme of responsibilities, in your opinion, would it make a difference in her outcome?
MR. ABAKUMOV objection.
A. I suspect not.
MR. MURPHY: That's all I have.
MR. SUMNER Let me ask a couple questions.
CROSS-EXAMINATION
BY MR. SUMNER:
Q. Doctor, I'm Dave Sumner, and I represent Mira Baron in this case.

Page 140

I take it from what you've already said that you don't believe medical standards of care as might apply to my client Mira Baron when she evaluated this patient on October 30 given the presentation that you see documented in the Russian Clinic record mandated that she refer this patient on that date for a neurologic workup to include a spinal tap?
MR. ABAKUMOV: objection.
A. Your question is then do I agree with that she didn't need to?
Q. Do you --
A. I think the case was handled appropriately. I would not have -- Looking over the records, there doesn't appear to be enough evidence to make an immediate referral to a neurologist or admit the patient. I think the case was handled appropriately.
Q. You, I think, have made an assumption from reading the record from that date that Dr. Baron actually determined upon interaction with the patient or observations of the patient that there may have been some mental status changes or slight confusion. Is that how you read the record?
A. That was my interpretation from what she said.

Page 141

Q. So is it your opinion that you believe she met reasonable standards of care in how she handled this visit even if she determined upon interacting and observing the patient that there were, indeed, mental status changes by that patient on that visit?
A. Yes. You certainly don't refer everybody to a neurologist who might have some confusion.
MR. ABAKUMOV Objection.
A. Goodness, no. It would be wonderful for my business if they did.
Q. Would you agree that given the Vital signs that were taken and the accompanying laboratory workup for that visit that there were no signs on this visit that this patient had an acute infection or an acute systemic infection or chronic systemic infection?
A. No. The temperature was 98.2. There were reports of fever but, again, no determination that she was febrile at the time of that evaluation. And she talked about hematuria, weakness, confusion, and then we made a deduction that perhaps it's the Cipro that's producing the problem and switched her to another antibiotic.
Q. It seemed to be a very reasonable judgment and decision?

Page 142

MR. ABAKUMOV objection.
A. Correct.
Q. And if the facts are determined to be that, in fact, Dr. Baron did not determine from interacting with the patient that day that there were clear indications of mental status changes or confusion but this was merely something reported to her by way of history by the family members --
MR. ABAKUMOV objection.
BY MR. SUMNER
Q. -- that the patient may have had confusion as reported by the family but was not evident on that visit?
A. I'd have to look at that note again before I really answered that. That's an important question because they were also reporting that she was febrile and her temperature was 98.2. So perhaps I could look at that note. I can't recall -- If I can pull it out of here.
MR. ABAKUMOV. could you identify what you're referring to, Doctor?
A. I'm sorry. I'm reading the October 30 note written by Mira Baron after, I presume, her evaluation of the patient.
I, frankly, can't tell you whether she found

Page 143

evidence of confusion. I made a deduction and it may be the wrong one that she listed under the complaint section that there was confusion, and you're right that in the physical examination she didn't mention it. So that may have been -- the way this note is written, that could have been merely a complaint and not a finding.
MR. ABAKUMOV Objection.
A. We'd have to ask her. I think the other important point to bring out, which I noted when I reviewed the records Monday, is that she notes that the neck was supple. That's further indication that there was a change between my seeing her a few days later and this evaluation because when I saw her, there was enough evidence of a stiff neck to make me want to do a spinal tap. So this could have been a complaint just like the fever was a complaint and yet her temperature was 98.2.
Q. Well, let me just ask you two more questions.
A. Please.
Q. The physician recording on the physical examination as a physical examination comment neck supple would mean to other physicians reviewing the chart that there was an absence of nuchal rigidity?

Page 144

A. Correct. She specifically checked for that.
Q. And if someone were going to assess the risk a patient was having, perhaps a meningeal process or infection, that absence of nuchal rigidity would be significant?
A. Absolutely.
MR. ABAKUMOV objection.
BY MR. SUMNER
Q. And in this particular case if I have you assume that Mira Baron did not actually observe mental status changes and confusion during this visit but it was something reported to her by history, would that change your opinion about whether or not she met reasonable standards of care in how she managed this evaluation and visit?
MR. ABAKUMOV Objection.
A. Well, I've already said that, making my own interpretation, that if the patient was mildly confused, I thought it was appropriate.
MR. ABAKUMOV Objection.
A. But certainly if she wasn't confused and that was merely history, it was even more appropriate. I say that and use as an example that one of the complaints was fever, and yet the physical examination

Page 145

revealedthat her temperature was normal. So sure.
MR. SUMNER Okay. I don't have anything else.
MR. ABAKUMOV: I have a few questions.
FURTHER CROSS-EXAMINATION
BY MR. ABAKUMOV
Q. Doctor, does a patient running a febrile course always have the same temperature?
A. Well, no, it fluctuates.
Q. It goes up and down?
A. Sure.
Q. So the fact that she had a temperature of 98.9 or whatever it was --
A. 98.2, which is lower than our 98.6 legendary normal.
Q. Does that mean she had 98.2 the entire month of October and --
A. No. It's just that every time we have it checked that it was normal.
Q. How many times was it checked in October after the first discharge?
A. Let's see. In the urology clinic 10-22 it was 98.6.
Q. What time of day was that taken?

Page 146

A. I'd have to check. I didn't look, but it's normal.
Q. Would it make a difference to you what time of day it was taken?
A. Yes. You allow for a little bit higher temperature at night. On Hampel's visit it was 98.2, and I don't have that record for review.
THE WITNESS: That was one of the things I asked about when we talked last night, the October 28 visit, because I couldn't find any record of it and yet it was alluded to in some of the expert testimony. So I didn't have that available.
A. So that was one of the things that we talked about that you asked me about before and I forgot.
Temperature is 98.2, and then on October 30 it was 98.2. You're not painting a picture of a ferocious infectious process here.
Q. Well, can you paint a picture with four temperatures during the course of four weeks?
A. No, but you don't take a patient like that who has normal temperatures coming into the hospital and being examined and make dramatic shifts in your

Page 147

treatment course if all of her temperatures are normal.
Q. Do you disregard the patient's or the family's complaint of fever just because there's a temperature of 98.2?
A. It depends on what they mean by fever. And, again, I don't know this, but are they feeling her forehead? My forehead is hot right now. It's a hot environment. Is the room air conditioned, do they leave the heat on a lot? I don't know what the circumstances are.
The thing that we have here is that we have a controlled environment. We know that in that controlled environment during her hospitalization in early October she ran a fluctuating low-grade temperature course. We know that three or four temperature checks between that hospitalization and the later hospitalization her temperature is normal. I mean, what can you say?
Q. That's a controlled environment on October 30 and October 28?
A. Well, it's controlled in the sense that you have somebody who knows how to take a temperature who is taking a temperature with a thermometer.
Q. Was it an oral or an axillary temperature?
A. Presumably oral.

Page 148

Q. Well, you don't know that; you're presuming?
A. Well, I'm presuming because most of the time they are.
Q. What if I told you that the records didn't indicate; would you still presume it was oral?
A. I would presume it until otherwise. I'd ask the doctor. If it's important, let's go back and ask how they checked the temperature, Hampel's office, how they checked the temperature in the Russian Clinic and how they checked the temperature in the urology clinic, three different temperatures. There's not much bias here.
Q. What time of day were those temperatures taken?
A. I don't know.
Q. Well, look at the October 30 note and tell me what time of day the temperature was taken because you're basing your conclusions on the note here.
A. No, I'm basing it on the temperature. The temperature is 98.2. I don't know what time of day that was taken.
Q. Because it's not indicated there?
A. No.
Q. And the temperature route is not indicated

Page 149

either, is it?
A. correct.
Q. So you're making an assumption without knowing the temperature route or the time of day it was taken, correct?
A. That's correct.
Q. What do you know about Freyda Kaplan as a person and her educational level?
A. Very little because she had only been in the country a month before I saw her and she's Russian and didn't speak English and was encephalopathic during her whole course with a family that didn't speak a lot of English. I would suspect that the best thing to do would be to ask Mira Baron.
Q. And what if that discussion with Freyda Kaplan revealed to you she was a physicist, a college-educated woman in Russia?
A. Well, now you're building a case that because she was a physicist in Russia that I should accept the family's temperatures at home. Who is on the weakest grounds? I'm telling you you're on weaker grounds. I don't know what her temperature was. Did they bring in a temperature chart? Let's see the family's temperature chart.
Q. Was there an instruction given upon

Page 150

discharge for the family to take her temperature chart?
A. She's a physicist and she should know better. You made the point that she's intelligent and the temperature is more reliable at home than in the hospital --
Q. Are you telling me that you're disregarding her complaints of a fever?
A. I am not. I'm telling you the job of a physician is to evaluate the nature of the complaints and what they mean. We are told here that the patient has a fever. The doctor recognizes that. The doctor even writes it down. The doctor is not denying it. The doctor writes down that the temperature is 98.2. She is not febrile at that time.
You're right, I can't tell you that she wasn't febrile two hours before that. I can tell you it's not particularly likely. But I can tell you that she's had three or four temperatures scattered over the course of a month within a normal range, and you can try to challenge that.
Q. How about a temperature of 99.4 taken by the VNA on the 25th of October?
A. What time of day?
Q. Why don't you look in the notes and tell me if it's indicated what time of day.

Page 151

A. 99.4 versus 98.6 is a marginal temperature. But, I *think,* the problem that we have here is that the doctors -- it's not terrifically important and I'll tell you why it's not terrifically important -- the doctors are recognizing -- they're not denying that she had an infection; they're treating her for an infection.
Q. Are they treating her fever?
A. You never treat the fever; you treat the cause of the fever.
Q. Do they determine the source of the fever?
A. The presumption is that they thought that the source was the bladder.
Q. Based on what, Doctor?
A. Based on a history of repeated urinary tract infections, based on a history of a hospitalization in early October for a urinary tract infection, based on a deduction on what was going on, based on the fact that her urines have grown out some stuff at different times.
I mean, if you're going to challenge their treatment, then you have caused -- in that approach, then you're going to destroy the American medical system. That means you're saying that everybody has a fever, why not only --

Page 152

Q. We're talking about Freyda Kaplan here, Doctor.
A. All right. Should she get blood cultures every day along with urine cultures? I mean, where do you stop? You make rationale judgments. That's what we do; we make rationale judgments.
Q. Assume that she had a temperature of 99.4 on October 25, not an evening temperature, but perhaps a late morning, midday temperature.
A. Let's not worry about that because it depends on the environment which you're not controlling, everything else, not just the time of day. The fact is that when she was seen in the Russian Clinic, her temperature was 98.2, and that makes a temperature of 99.4 five days before less important.
Q. Okay. Doctor, did you see Freyda Kaplan's temperature chart from the first admission, did you review that?
A. Yes.
Q. Do you want to pull that out?
A. Well, I could.
Q. Here, we have it right here. Would you agree that that's her temperature route between September 30 and October 6?
A. Yes, it appears to be so.

Page 153

Q. Now, is she running a febrile course during this admission?
A. Yes, low-grade fevers.
Q. And to what do you attribute these fevers?
A. Her urinary tract infection. At least that's what they attributed it to at that point. That's why she was in the hospital being treated.
Q. Well, do you know what she was being treated with?
A. Oh, goodness. What her antibiotic course was, let's see if I wrote that down. She was on Bactrim initially and she was switched to Ciprofloxacin, Cipro, after the cultures because the agents that they cultured were evidently more sensitive to the Cipro.
Q. Was the Cipro effective in treating her urinary tract infection?
A. Yes, I presume it was effective.
Q. Why do you presume that?
A. Well, because at least for the three weeks after her hospitalization where she was evaluated, she was not running temperatures and it continued and they continued her on treatment.
Q. So the treatment was effective because after 10-7-91 she had no temperatures?

Page 154

A. Oh, I think her temperature at the time of discharge was 98.9.
Q. And then you're presuming because of the four or five temperatures we have during the month of October that you're aware of that she was not running temperatures?
A. Would you do me a favor? On every case like this would you call up Blue Cross/Blue Shield and ask them if we can keep the patients longer? You can't do it. You can't do it. You don't look at a case like this and necessarily keep them in the hospital until every electrolyte and everything else is hemodynamically perfect. You can't do that.
Q. They won't let you do that, Doctor?
A. Oh, absolutely not.
Q. Why not?
A. Because it's not necessary and they won't pay for it. That's what they're trying to do. That's what you're reading about in Congress. They won't allow that.
In fact, the real question here is today could you admit this patient. Probably not. You'd probably have to treat this patient as an outpatient. We treat lots of urinary tract infections as outpatients. The main reason she was admitted was she was new to the

Page 155

country, she had mechanical problems with the bladder.
So if this was a woman coming in with this fever curve and no bladder problems, she would be treated as outpatient. In Minnesota she would tell them her temperature curve, speak to the nurse, the nurse would speak to them over the phone and treat her with an antibiotic after talking to the doctor.
Q. And that's what you view as the problem with the health system today?
A. Well, that's one of the problems. The other problem is that it costs $900 billion a year and the system can't afford it because of the kind of thing that we're getting into here. And you can't keep this patient in the hospital. There's no reason to keep this patient in the hospital, and, believe me, they wouldn't pay for it.
Q. Well, would you have liked to follow her temperatures for another day if Blue Cross/Blue Shield had permitted or would you want to follow it on an out-patient basis?
A. I leave that up to the decision of her interns. I am a neurologist. My view of the case as a neurologist looking at this discharge is that there was nothing inappropriate about this discharge, nothing.
Q. Well, she was treated With Ciprofloxacin?

Page 156

A. Yes.
Q. Do you feel that the Ciprofloxacin cleared up her problem during the first admission?
A. In a situation like this, and, again, I'd want ID people to talk about this and a urologist, the best you're going to do in a person like this is control the bacteria. You're not going to cure this patient. This is a damaged bladder. You're going to continue to have a chronic recurrent infectious process, which has been her course before she came here and continued to be her course. That's just the problem that you have. This was a sick lady. She was run over in Russia four months before, and it's a shame.
Q. Did the Ciprofloxacin treat her Urinary tract infection? Did it treat her Urinary tract infection problem on the first admission?
A. I think that it seemed to work reasonably well given the follow-up. This is a woman that had culture stuff out of her urine probably all the time. I *think* other people more expert in that area that have been called into this case would agree with that.
The situation is that -- I mean, there's bacteria in the urine even in a normal bladder. But in a situation like this, it's going to be an ongoing

Page 157

problem and you're probably fighting a maintaining battle, hopefully, until you can get the catheters out of her and, hopefully, until that fistula closed up. Then once you establish normal anatomic integrity in the bladder, you might have a chance to stop the recurrent infections.
Q. So you're saying she had a temperature of 99.9 on discharge?
A. Yes.
Q. And that's an indication to you that Cipro had --
A. It appears to have worked. Plus I have added proof in the fact that she had subsequent visits in October to different clinics seeing different physicians and has normal temperatures.
Q. And the fact that Ciprofloxacin brought her temperature down to 98.9 and brought it under control throughout the following period until things got bad again in the month of October indicates that Cipro had worked during this first admission?
A. Either that or she got better in spite of it. They did what was appropriate. They cultured her Urine. It was sensitive, the agents that grew out. They made a change from Bactrim, which she was on before, to Cipro because that was the right thing to do

Page 158

at that point. She was discharged, and subsequent evaluations didn't appear to reveal any problems until October 30. That suggests that whatever was done, she either got better because of the Cipro or in spite of it.

(Thereupon, Plaintiffs' Exhibit 98 to the deposition of Michael W. Devereaux, M.D. was marked for identification.)

BY MR. ABAKUMOV

Q. Showing you what's been marked as Plaintiffs' Exhibit 98, could you just identify that document?

A. These look like cultures, and the dates are November 6, November 7, November 8. There's results of a Foley catheter specimen which shows Candida species. They don't subclassify.

Q. What's the count on that one?

A. Greater than 100,000. That's on November 6.

Q. Isn't that the same count she had during the urine cultures on the first admission?

A. Different Candida. We're talking about the fact that she had an albicans infection.

Q. Does it say what kind of Candida species she had?

Page 159

A. It doesn't make a difference.

Q. Well, you're making the distinction.

A. Let's just say it was Candida tropicalis, the same one she had in October. It has to be a subspecies. They didn't subclassify. We'll have to talk to the pathologist as to why.

Q. Well, they didn't subclassify in the first admission, did they?

A. They have Candida albicans. I thought it was Candida tropicalis. We're dealing with a different organism. She has a Candida albicans meningitis. She has a Candida tropicalis bladder infestation a month before.

Q. Is this from the bladder here, this urine culture?

A. Yes.

Q. Actually it's from the Foley catheter?

A. Yes, that's where they're getting her urine.

Q. We don't know if this is exactly the same organism she had on the first admission?

A. Well, take your pick. Make it 50/50. We'll make it 50 percent albicans and 50 percent tropicalis.

Q. Is that what it was on the first admission?

Page 160

A. No, it was listed as Candida tropicalis. I'm telling you this makes no difference. The issue is she had a tropicalis bladder infection and an albicans meningitis. It's different; no connection. I mean, if you can come back and tell us that the laboratory made a mistake and that was a tropicalis infection in her CSF, then we can talk.

Q. Well, this was in her bladder.

A. I know. But what's the point? We know she had Candida in her bladder. She had Candida in her bladder on the first admission. People of this process are almost always going to have a Candida of the bladder. Elroy Kursh said he wouldn't treat. You have Candida probably in your bladder right now.

The problem here isn't so much a presence of Candida. The problem is whether it is allowed to turn into an infection from just being in a symbiotic relationship.

Q. Doctor, was Freyda Kaplan at risk for systemic candidiasis at the time of her first admission?

A. Evidently.

Q. And that's because of her past history?

A. Sure.

Page 161

Q. Her suppressed condition due to long-term antibiotic use?

A. Yes.

Q. The fact that she had a Urinary tract infection?

A. People who smoke are susceptible to cancer. Yes.

Q. Elderly?

A. Elderly, yes, all those things.

Q. Doctor, to your knowledge, were there any blood cultures done between September 30,1991 and October -- other than the ones on September 30,1991, were there any other blood cultures done during the first admission?

A. I don't believe so.

Q. And is it also true that there were no blood cultures done until Amphotericin B was commenced after the second admission?

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

Q. If I represent that to you, you wouldn't disagree withthat?

A. No.

Q. Then you would agree that we don't really know what the blood would have shown between those dates of September 30 and the blood cultures on the

Page 162

second admission when Amphotericin therapy had already begun?
A. I don't know what your blood showed during then either.
Q. Because the test wasn't done; isn't that correct?
A. Yes, because it didn't need to be done. You don't do blood cultures in people that are afebrile.
Q. Now, Doctor, when a patient presents to you as a -- Well, you did a nuchal rigidity test on Freyda Kaplan, correct?
A. I checked the suppleness of her neck, yes.
Q. How didyoudothat?
A. She was supine in bed and I lifted her head up and she grimaced with discomfort and I rotated the head and she didn't show any discomfort, which is a sign of meningismus. It's pretty nonspecific. It could be paratonia, it could be other things. But in this case it raises a possibility of meningismus.
Q. In terms of a test that you do, and I'm not talking about labs now, but in terms of neurological workup, if a nuchal rigidity test of that type is indicated to you, do you do --
A. You do it on just about every patient in

Page 163

thishospital. Goahead.
Q. What other tests would be indicated if you do a nuchal rigidity test? Do you do this test in isolation or in conjunction with other tests?
A. I do the whole neurological examination. I test the cranial nerves, speech, motor strength, reflexes, coordination. I look at the spine, test for nuchal rigidity, look for masses. There's a whole panorama of things that we do, and then if we find any abnormalities in a particular area, we may pursue more testing in that area.
Q. Was systemic Candida ruled out on the first admission for Freyda Kaplan as an illness?
A. The answer is no, and neither was cancer and neither was lead poison. You look in the direction that the situation leads you to look. She did have blood cultures because she was infected, and they were negative. There was no other evidence of any other blood-borne infection elsewhere, and the treatment then was limited to what you see.
Again, that's something we do in every case we see. There are certain algorithms, I mean, cases that come in with fever that almost routinely get blood cultures. The yield is very low. But, again, you direct your attention to what the situation calls for,

Page 164

you do what needs to be done and try not to do any more.
Q. And not any less?
A. No, of course not any less.
Q. Doctor, if Freyda Kaplan came -- well, she did come to you and she complained of confusion, fever, headaches. Would you send her to the urology clinic at that point or -
A. When I saw her in the hospital?
Q. Yes. Would you send her to urology?
A. Of course not.
Q. What if you saw her as an outpatient in your office here?
A. Well, if she came in my office as an outpatient on a gurney, no. I would immediately admit her to the hospital.
Q. What if she walked in with the assistance of her daughters holding her up and complained of that, would you send her to the urology clinic?
A. It would depend on the circumstances. As a neurologist, it isn't very often that we refer to urologists on outpatients.
Q. If you had seen Freyda Kaplan on October 30, would you have sent her to urology if she came up to you through the Russian Clinic complaining

Page 165

of fevers and headaches; would you have sent her to urology?
A. No. If Mira Baron had asked me to see her, I would have not referred her to urology. I would have either referred her back to Mira Baron, which is probably what I would have done. Again, I can only speculate what I would have told her to do or suggested that she do, and that would have been her decision as the primary care physician.
Q. Did you train --
A. In fact, it would be inappropriate to refer her to a urologist if she's referred to me as a consult from another physician.
Q. Did you train Dr. Mira Baron?
A. Yes.
Q. For how long?
A. Three years I was involved
Q. Takealook at your October 30 --
A. That's why she checked the neck.
Q. Take a look at your October 30 note, Mira Baron's October 30 note. Where does it say mild confusion there?
A. It doesn't.
Q. Did you put that word in on your own?
A. No. I said -- What it says is -- Well,

Page 166

maybe I misspoke. Iwas talking in the examination. She lists hematuria, fever, weakness, confusion started after patient was prescribed Cipro by her urologist I suspect.

Q. Where did the word mild come from? I wrote that down when you said it.

A. I don't know that I said mild. Did I? It doesn't say mild here. It just says confusion.

Q. Now, Doctor, do you put or did you put into Freyda Kaplan's notes conjecture or information that you found and was somehow established to you scientifically or through history?

A. I'm not sure of your question.

Q. Do you often put things into the medical records which are conjecture in your practice as a physician?

MR. MURPHY: objection.

A. You mean do I conjecture in medical records?

Q. Yes.

A. Oh, of course.

Q. Given the fact that you trained Mira Baron and, I guess, you associate with her here regularly at Mt. Sinai Medical Center, do you feel you can be fair in this case in stating what happened here?

Page 167

A. Sure, absolutely. There's no question about it.

Q. And you have no doubt in your mind that if you felt that she or anyone else here that we've mentioned did anything wrong, you wouldn't have any problem saying that they operated below the standard of care?

A. The only thing that I would do is, as any physician would do, if I felt that I was going to be biased because of personal reasons, I would excuse myself from the case. I wouldn't lie for another doctor. I don't get paid to lie.

MR. ABAKUMOV: okay. I don't have any further questions, Doctor.

FURTHER CROSS-EXAMINATION

BY MR. SUMNER:

Q. Doctor, you're licensed in the State of Ohio?

A. Yes.

Q. And you spend greater than 50 percent of your professional time in the active clinical practice of medicine or the teaching of medicine in an accredited institution?

A. Correct.

MR. SUMNER I have nothing further.

MR. ABAKUMOV I'll object to that last statement. We'll move to strike any of your expert opinions.

- - -

(DEPOSITION CONCLUDED AT 2:15 P.M.)

- - -

Page 168

MICHAEL W. DEVEREAUX, M.D. Date

- - -

Page 169

STATE OF OHIO, COUNTY OF CUYAHOGA. } SS:

CERTIFICATE

I, BARBARA A. OSER, a Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, MICHAEL W. DEVEREAUX, M.D. was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, and afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 18th day of July, 1994.

Barbara A. Oser, RPR, Notary Public in and for the State of Ohio.