

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.

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2

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13 On behalf of Defendant Mt. Sinai Medical Center:

14 MARC GROEDEL, ESQ.
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17 On behalf of Defendant Mira Baron, M.D.:

18 JOSEPH E. HERBERT, ESQ.
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1 MICHAEL W. DEVEREAUX, M.D.

2 a Witness ~~herein~~, called for examination by the

3 Plaintiffs, under the Rules, having been first duly

4 sworn, ~~as~~ hereinafter certified, deposed and said ~~as~~

5 follows:

6 CROSS-EXAMINATION

7 BY MR. ABAKUMOV:

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

9 A. No, but I could have one printed up for

10 you, if you would like.

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

12 my office.

13 A. Well, before we leave, when we're done,

14 remind me to ask my secretary and we'll have her make a

15 copy.

16 MR. SUMNER Just before

17 questioning begins, ~~the~~ seven hours you

18 spent on the 4th of July, is that included

19 in the \$300?

20 THE WITNESS: well,

21 obviously, that's done. I don't charge

22 for that, at least I don't ~~think~~ that's

23 policy.

24 MR. ABAKUMOV well, I assume

25 I'm just paying for the time he's talking

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1 today. I'm not paying for the time he has

2 spent reviewing material for today's

3 deposition.

4 THE WITNESS: But you know

5 preparation.

6 MR. ABAKUMOV: I didn't ask

7 you to prepare, Doctor. You can discuss

8 that.

9 MR. SUMNER: okay. Go

10 ahead.

11 BY MR. ABAKUMOV:

12 Q. Doctor, please state your full name and

13 spell it for the record.

14 A. Michael William Devereaux,

15 D-E-V-E-R-E-A-U-X.

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

17 deposition?

18 A. I reviewed the hospital records primarily,

19 and that's about a thousand pages of material.

20 Q. Which hospital records did you review?

21 A. They included the hospital admission from

22 9-30 to 10-7, the hospital admission I believe it ~~was~~

23 from 11-2-91 to about 1-22-92, plus assorted

24 out-patient records from out-patient visits, plus the

25 letters of other expert witnesses.

1 Q. Do you know which expert witness letters
2 you looked at?
3 A. Sure. **Would you** like me to --
4 Q. Yes, tell me which ones you read.
5 A. Robert Salata, M.D.
6 Q. Did you read all ~~these~~ in full?
7 A. Yes. James Schmidley, **John** Gardner, M.D.,
8 Howard Tucker, Keith Beck, Neil Crane. **I think I**
9 listed them all,
10 Q. Did you look at Elroy Kursh's?
11 A. Elroy Kursh.
12 Q. You read that one?
13 A. Yes.
14 Q. Did you read any depositions?
15 A. **No.**
16 Q. Did you read the records from the
17 MetroHealth skilled nursing home center, Sunny Acres?
18 A. No.
19 Q. How did you get ~~these~~ records, Doctor?
20 A. **Well, the** hospital records, of course, I
21 got from the hospital. The expert letters came from
22 **Mr.** Murphy's office.
23 Q. Did you receive any records from
24 Mi-. Groedel's office? Did Mr. Groedel provide you
25 anything through Reminger & Reminger or directly?

1 A. I don't believe so.
2 Q. Whatever you recollect.
3 A. **No**, I don't believe so.
4 Q. Did you meet with Mr. Groedel prior to
5 this deposition?
6 A. **No.**
7 Q. Did you meet with any other attorneys
8 prior to **this** deposition?
9 A. **No.**
10 Q. Did you have discussion on the phone about
11 this deposition?
12 A. Yes.
13 Q. Who was that with?
14 A. Mr. Murphy.
15 Q. And what was the nature of that
16 discussion?
17 A. We talked last night for about 20 or 30
18 minutes. It was my understanding that we weren't
19 allowed to talk **about the** hospitalization from **11-2** to
20 **1-22-92**, and we didn't. And we **discussed** just points
21 of the deposition, **you** know, issues about the first
22 hospitalization and so forth.
23 Q. Why did you understand you couldn't
24 discuss the second admission?
25 A. Ihavenoidea.

1 Q. Did you review the records of ~~the~~ second
2 admission?
3 A. Yes.
4 Q. Were you asked to review the records of
5 ~~the~~ second admission without discussing them?
6 A. **Was I asked to review the records of the**
7 secondadmission? I'm **trying to remember whether the**
8 **records came from your office for the second admission**
9 **or directly from the hospital.**
10 MR. MURPHY: I didn't send
11 you any records.
12 A. **Then they came from the hospital. I was**
13 **part of the process. I was** involved in her care in the
14 **second hospital admission.** And I don't member what
15 **was specifically said about whether I needed to review**
16 **them, but it was obvious that they needed to be**
17 **reviewed.**
18 Q. Why was it obvious that they needed to be
19 reviewed?
20 A. **Because it's a three-month hospitalization**
21 and the doctors involved in her hospital care and the
22 hospital **are** being sued. So it's perfectly **logical**
23 that they needed to be reviewed.
24 Q. Doctor, are you PIE insured?
25 MR. MURPHY: objection.

1 MR. HERBERT: objection.
2 MR. MURPHY: You can
3 answer.
4 A. Yes.
5 Q. Doctor, are you being paid for ~~the~~ time
6 you spent reviewing the records, this seven hours?
7 A. No.
8 Q. You're not requesting payment for
9 reviewing the records?
10 A. No. But if it's all **right, I will, I'd be**
11 **glad to.**
12 Q. Well, I'm just asking you if you are
13 requesting it **as** you came here today.
14 A. No, but I would accept it.
15 Q. Doctor, please state all your business
16 addresses.
17 A. **My** business address is **Mt. Sinai Medical**
18 **Center, Department of Neurology, One Mt. Sinai Drive,**
19 **Cleveland, Ohio 44106.**
20 Q. And is that the only office you have?
21 A. It is. In reality we go out **half a day a**
22 **week or I do to the IMC, Integrated Medical Campus,**
23 **where we see outpatients.**
24 Q. What is the IMC?
25 A. **It stands for Integrated Medical Campus.**

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1 Q. And is that part of Mt. Sinai Medical
2 Center?
3 A. Yes.
4 Q. Is that an entity that is part of
5 Mt. Sinai Medical Center?
6 A. The hospital built it, yes, and owns it.
7 Q. Now, are you an employee of Mt. Sinai
8 Medical Center here in the neurology clinic?
9 A. No, I **am** a part-time employee. I have --
10 I'm not sure how it works. I'm paid a salary in part
11 for **my administrative work and what have you, and then**
12 the division of neurology is incorporated.
13 Q. It's incorporated into that part-time
14 salary?
15 A. No, they're **two** separate.
16 Q. It's a separate entity. when you saw
17 patients in November of 1991, particularly Freyda
18 Kaplan, were you seeing her as a private patient?
19 A. No, I saw her because I was **on** service
20 that month.
21 Q. Is the service a duty that you **perform** for
22 Mt. Sinai Medical Center?
23 A. That's part of our teaching
24 responsibilities to **the** institution.
25 Q. Do you get paid for your teaching at

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1 Mt. Sinai Medical Center?
2 A. I'm paid a salary for administrative work
3 and basically all of my duties for **the** hospital, yes.
4 Q. Including teaching and seeing patients on
5 service?
6 A. Right. It's a token salary.
7 Q. But you are paid?
8 A. Yes.
9 Q. Does your corporation pay office rent for
10 the neurology clinic?
11 A. The neurology clinic?
12 Q. Well, this facility that you're in here.
13 What's the name of your neurology group?
14 A. Mt. Sinai Medical Center Neurology,
15 Incorporated.
16 Q. And you're part of that corporation?
17 A. Yes.
18 Q. Does your corporation pay rent to
19 Mt. Sinai Medical Center for the space that they use
20 here?
21 A. Yes. I'm not sure how **all** the
22 arrangements, frankly, work out, but **there** is --
23 Q. Do you know how much the monthly rent is?
24 A. No, and I wouldn't tell you if I did.
25 Q. Is it nominal?

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1 A. No. It's really none of your business
2 **what our arrangements are** with **the** hospital.
3 Q. Well, you're here to --
4 **A. I'm here to discuss medical aspects of the**
5 case.
6 Q. Well, you're here to discuss aspects that
7 **are** legal **aspects** as well or maybe because of what the
8 facts present. **So** I'd just like to know --
9 A. I can't even tell you.
10 Q. **So** you don't know if it's nominal, a
11 hundred dollars a month, or a thousand dollars a month;
12 you have no idea?
13 A. I have **no** idea. I don't even handle **the**
14 books.
15 Q. Who does?
16 A. One of my associates.
17 Q. And who is that?
18 A. **Gerald Grossman, M.D.**
19 Q. Grossman?
20 A. **Yes.**
21 Q. Is that Gerald, G-E-R-A-L-D?
22 A. **Yes.**
23 Q. Grossman, G-R-O-S-S-M-A-N?
24 A. **Correct.**
25 Q. Doctor, where did you complete medical

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1 school?
2 A. I went to Baylor College of **Medicine.**
3 Q. And where did you go to college before
4 that?
5 A. Stanford.
6 Q. Where did you **do** your internship and your
7 residency?
8 A. I did my internship at **the University of**
9 **Southern California, L.A. County Medical Center and did**
10 my residency training at the **same** institution.
11 Q. **When** did you come to Mt. Sinai Medical
12 Center?
13 A. I came in **the** end of June **1977.**
14 Q. And in what position was that?
15 A. Chief of Division of Neurology.
16 Q. And have you continued in that position
17 since that time?
18 A. **Yes.**
19 Q. Do you know Dr. Howard Tucker?
20 A. **Yes.**
21 Q. Have you ever worked on patients With
22 Dr. Tucker or have you ever consulted with him?
23 A. I'm not sure how you mean.
24 Q. Just tell me how you know Dr. Tucker.
25 A. Well, he's a neurologist in **the** community

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1 and he has worked at Mt. Sinai in **the** past, **although**
 2 not **as** much in recent years.
 3 Q. Do you have an opinion of **him** as a
 4 neurologist in the community?
 5 A. He's a competent practitioner of
 6 neurology.
 7 Q. And how would you describe yourself, also
 8 as a competent practitioner of neurology or something
 9 more or less than that?
 10 A. I'm a competent practitioner of neurology.
 11 Q. Now, since 1977 coming to head up the
 12 Department of Neurology at Mt. Sinai Medical Center,
 13 have you held any other positions?
 14 A. Yes.
 15 Q. What else have you held?
 16 A. **Well**, I'm currently Associate Professor of
 17 Neurology at **Case** Western Reserve University, I **am** the
 18 Associate Director of **the Department of Medicine**
 19 at Mt. Sinai and I'm currently Chief of Staff at
 20 Mt. Sinai.
 21 Q. And are those all positions that you get
 22 paid for separately? Which of these positions that you
 23 mentioned do you get paid for?
 24 A. In part as Associate Director of **the**
 25 Department of Medicine. The others are done gratis.

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1 Q. Is the teaching position also gratis at
 2 Case Western Reserve University?
 3 A. **Correct**.
 4 Q. Do you know if you sent any bills to
 5 Freyda Kaplan for the **service** you provided during her
 6 second admission?
 7 A. I have no idea. I don't know if we took
 8 care of her for **free** since she was an **immigrant or**
 9 whether part of it may have been covered by Medicaid.
 10 I have **no** idea. She would have probably gotten no
 11 bills.
 12 Q. Do you know Dr. Salata whose report you
 13 read?
 14 A. **No**.
 15 Q. Dr. Schmidley?
 16 A. I **know** James **Schmidley**.
 17 Q. As a neurologist?
 18 A. Yes.
 19 Q. Do you know Dr. Keith Beck from California
 20 by any chance?
 21 A. **No**.
 22 Q. Dr. John Gardner?
 23 A. I know **John** Gardner.
 24 Q. Elroy Kursh?
 25 A. I **know** Elroy Kursh.

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

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1 certainly once we connected, **I did remember the**
 2 details.
 3 Q. What did you remember about her before you
 4 read the records?
 5 A. That she **was a woman with prolonged**
 6 hospitalization; that **she had Candida meningitis**,
 7 **unusual --** that's one of the **reasons why I remember her**
 8 case -- that she **had bilateral thalamic strokes --** I
 9 remember that -- and that she was just **a very difficult**
 10 management problem.
 11 Q. Did you remember what happened to her at
 12 the end of her course of treatment at Mt. Sinai Medical
 13 Center or did you have to review the records?
 14 **A. I knew that she** got into a chronic care
 15 **facility**.
 16 Q. You knew that she had the strokes before
 17 **and had** gone into some type of comatose or semicomatose
 18 state; you're aware of that?
 19 A. Yes.
 20 Q. Do you remember her family at all?
 21 A. **I remember the daughter**.
 22 Q. Now, Doctor, are you familiar with the
 23 Russian Clinic at Mt. Sinai Medical Center?
 24 A. Yes.
 25 Q. Briefly tell me what that is.

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

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

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

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

17 A. It's always **been** expensive to maintain.

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

21 A. That's absolutely patently ridiculous.

22 Q. They get the same level of care?

23 A. Absolutely.

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

1 A. Yes.

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

3 A. Yes, and in that circumstance better.

4 Q. Better?

5 A. Yes.

6 Q. Could you describe that?

7 A. Yes, they speak **the** language.

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

10 A. They're competent.

11 Q. As competent as the --

12 A. Yes.

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

15 A. Yes.

16 Q. And are all the --

17 A. All **these** doctors are **on o w** staff.

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

21 A. Correct.

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

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

1 urology.

2 Q. Is it a separate area in the office?

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

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

1 A. Yes, I do.

2 Q. How do you know her?

3 A. **Mira** Baron is a physician **on** our staff.

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

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

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

4 A. Yes.

5 Q. Do you know Dr. Hampel?

1 A. Yes, I do.

2 Q. How do you know him?

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

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

6 A. Yes.

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

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

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

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

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

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

1 A. No.
2 Q. Do you speak any foreign languages,
3 Doctor?
4 A. A little bit of Spanish.
5 Q. Do you know Dr. Baron to speak Russian?
6 Have you heard her speaking Russian to patients?
7 A. Yes.
8 Q. Does Dr. Hampel speak Russian or any
9 foreign languages that you know of?
10 A. No, I didn't know that.
11 THE WITNESS: In fact, it
12 was you that told me last night that he
13 didn't speak Russian but Yiddish.
14 A. But that was -- I just didn't know that.
15 Q. So you weren't aware of that from your own
16 observation or hearing Dr. Hampel speaking?
17 A. I don't know what other languages he
18 speaks other than Yiddish.
19 Q. Other than Yiddish?
20 A. I don't know what other languages he
21 speaks. Yiddish isn't a foreign language.
22 Q. It isn't foreign?
23 A. Not in Manhattan.
24 Q. Well, we're in Cleveland, Doctor.
25 When is the first time you came in contact with

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

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

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1 treating physician. **The** house officers, of course,
 2 don't send a bill.
 3 Q. Mt. Sinai Medical Center ~~sends~~ a bill for
 4 the **services** that the residents and the interns
 5 provide?
 6 A. **No.**
 7 Q. That's just lumped into the hospital stay
 8 bill?
 9 A. Basically ~~the~~ hospital just sucks up **the**
 10 cost. That's why teaching hospitals **are** going to **be**
 11 destroyed. Nobody cares about teaching hospitals.
 12 Q. Do you know Dr. Gardner?
 13 A. Yes.
 14 Q. And was that a he or a she?
 15 A. Dr. **John** Gardner is a **he**.
 16 Q. Was there a Dr. Gardner that was a
 17 resident during the second admission?
 18 A. I can't recall. Possibly.
 19 Q. Do you recall from your review of the
 20 notes who the residents and interns were during the
 21 first admission?
 22 A. **No.**
 23 Q. Could you look at your notes and tell me?
 24 A. Yes, because that's something I would have
 25 paid **no** attention to, and I probably will not be able

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1 to identify their handwriting.
 2 (Thereupon, Plaintiffs' Exhibits 68
 3 through **77 to the** deposition of Michael W.
 4 Devereaux, **M.D.**, were marked for
 5 identification.)
 6 BY MR. ABAKUMOV:
 7 Q. Doctor, showing you what have been marked
 8 as Plaintiffs' Exhibits 68 through 77, would you take a
 9 look at **those** and --
 10 A. I can't read his or her name.
 11 Q. Can you identify what the records are
 12 first?
 13 A. **This** is a house officer's **admission note**.
 14 Q. That's 68?
 15 A. Yes.
 16 Q. And you don't know who the intern is from
 17 that note?
 18 A. **No**, I can't read **the** signature. Really
 19 I'm not sure that this is **the** -- Let's **see**.
 20 Q. You're looking at Plaintiffs' Exhibit 77,
 21 a progress note?
 22 A. **No, 74.**
 23 Q. Exhibit 74, a progress note?
 24 A. No, this is an addendum to **the** progress
 25 note. It **looks** like it's a continuation of **the** same

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

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1 would **be** available, and we could **see** if they match up
 2 with **those names there.** **They may have been night**
 3 **coverage house officers depending on when the patient**
 4 **was admitted.** It **was late at night, so they probably**
 5 **would have been not the neurology rotators but the**
 6 **people who were on night call.**
 7 Q. Well, some of these notes are even from
 8 November **4**, which is more than a day after ~~the~~
 9 admission.
 10 A. Yes. I **just can't help you.**
 11 Q. Okay. When was **the first time** you saw
 12 **this patient?**
 13 A. **My note** is dated 11-3.
 14 Q. And where is your note **here?**
 15 A. The first part of it is **right here, neuro**
 16 **11-3.** And my signature is **on Exhibit 76.**
 17 Q. Exhibit 76?
 18 A. **Right.**
 19 Q. Doctor, what did Freyda Kaplan present
 20 with on 11-3-91?
 21 A. Change in mental **status dating back, oh,**
 22 **we didn't know for sure, but probably a week.** At least
 23 that's **the** information that we had **at the time**
 24 Q. Does it indicate there that there was some
 25 perhaps correlation between mental status changes and

1 the taking of Cipro?
 2 A. You mean did I make note of that?
 3 Q. Did you or anyone else make a note about
 4 that? Were you aware of that information?
 5 A. At that particular point I was not.
 6 Q. Did you later become aware of that
 7 information?
 8 A. Yes, that **there** was -- that question had
 9 arisen prior to her **being** hospitalized.
 10 Q. Does Cipro cause confusion?
 11 A. Many of **the** antibiotics can and Cipro can,
 12 yes.
 13 Q. And is that listed in the PDR as one of
 14 the side effects of Cipro; do you know?
 15 A. A variety of cognitive and non-cognitive
 16 changes **are** listed.
 17 Q. Now, in a patient that has -- you didn't
 18 put her on Cipro during the second admission, did you?
 19 Did you put her on Cipro again during the second
 20 admission?
 21 A. I did not. **With** a two-and-a-half-month
 22 hospitalization, I can't sit **here** and tell you that
 23 somewhere later on in the **course** that somebody -- The
 24 ID, infectious disease, people might have, but I did
 25 not.

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

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

1 **impression progressive encephalopathy times one week on**
 2 **the basis of the history without focal deficit. About**
 3 **the only finding that really troubled me was the fact**
 4 **that she appeared to have some nuchal rigidity. And so**
 5 **on the basis of that, I had to consider the diagnosis**
 6 **of meningitis but I did not rule out a metabolic/toxic**
 7 **encephalopathy.**
 8 Q. This patient had nuchal rigidity on the
 9 3rd?
 10 A. **When I saw her on the 3rd, right.**
 11 Q. How long does it take to develop nuchal
 12 rigidity?
 13 A. It depends. It **can take hours. It**
 14 **depends on the cause of the infection, the**
 15 **circumstances when you see the patient. It, obviously,**
 16 **has a beginning; it appears at one point. So it**
 17 **depends on when you see the patient along the**
 18 **continuum.**
 19 Q. Well, **she** was finally diagnosed with
 20 having Candida albicans meningitis, correct?
 21 A. Yes.
 22 Q. And do you know that to be a chronic
 23 meningitis or an acute form of meningitis?
 24 A. Well, it can **make different presentations.**
 25 **It can be subacute or chronic. Obviously, it depends**

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

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

1 I, obviously, knew some information in the week that
2 preceded her hospitalization because of the fact that
3 she -- because I knew that she was on Cipro and I knew
4 that she was being followed through the Russian Clinic.
5 Q. Okay. Now, Doctor, based on what you saw
6 on November 3, would you have expected that she had the
7 same symptoms and signs on October 30 as she had on
8 November 3, and if she didn't, what would be the
9 difference or what would be the similarity between
10 those two dates?
11 A. Well, my impression would be, particularly
12 looking over the information on October 30, that she
13 was a great deal worse on November 3.
14 Q. How bad was she on October 30 having
15 looked over your notes?
16 A. Evidently, in looking over the chart, the
17 information given was that there was some mild
18 confusion at that point, increased -- well, that there
19 were complaints, yes, of weakness and confusion. And
20 the comment in the notes was, as you have undoubtedly
21 read, that the confusion started after Cipro was
22 started and there was fever and that this might be a
23 drug-induced encephalopathy and the Cipro was stopped
24 and she was started on another antibiotic. So at that
25 point she was not as impaired as she was on November 3.

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

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1 BY MR. ABAKUMOV:

2 Q. I'm returning to you what's marked
3 Plaintiffs' Exhibit 78, Pages 1 through 4. Are those
4 the notes that you prepared for the deposition today?

5 A. Yes.

6 Q. We'll just get a copy of those before we
7 go.

8 A. Certainly.

9 Q. Now, Doctor, you said that you feel she
10 had a subacute meningitis at the time that you saw her?

11 A. Well, I don't think anywhere in the notes
12 from that hospitalization I tried to classify -- again,
13 I could be wrong -- that it was acute or chronic or
14 subacute. I don't recall specifically seeing myself
15 using these terms. In this case I don't think they
16 really mean a lot medically.

17 Q. Well, are you saying subacute and chronic
18 are synonymous or what?

19 A. No. What I'm saying is that she was
20 discovered to have a Candida albicans meningitis. From
21 a medical standpoint, I don't think it makes a lot of
22 difference. Those terms lack specificity. It was
23 probably -- She was probably symptomatic, as I say, for
24 somewhere in the vicinity of a week prior to my first
25 evaluation, so I would call that subacute.

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1 Q. If it had developed over a period of two
2 or three weeks, would you consider that chronic?

3 A. I suppose you could argue that that would
4 be chronic. Again, the terms lack specificity, or at
5 least I don't apply specific times to what's acute,
6 subacute and chronic.

7 Q. But if another doctor described it as
8 being chronic candidal meningitis, you wouldn't
9 disagree with that terminology?

10 A. No.

11 Q. Your possible diagnosis was meningitis.
12 What type of meningitis did you suspect on that first
13 admission?

14 A. Well, I wasn't sure. And, I think, you
15 can read from my notes on 11-4 that I went through a
16 rather lengthy differential of meningitis, actually of
17 inflammation, of which infection is only one cause,
18 including even discussing bacterial meningitis, which I
19 didn't think she had, although I didn't note it.

20 One of the things we thought about at the time
21 was TB meningitis. We talked about -- I mentioned
22 fungal meningitis. Actually at that point I didn't
23 think that was what she had because her course seemed
24 too acute and the fact that she had a fever and what
25 have you. And we wondered about other causes of

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1 inflammation outside of infection, including things
2 like sarcoid, and we wondered about carcinomatous
3 meningitis secondary to cancer. So there's a spectrum
4 of things that you can read that we wondered about.

5 Q. But you didn't suspect a fungal meningitis
6 or you didn't think of that as being a possible --

7 A. I thought it was possible but it wasn't my
8 first consideration, it wasn't my most-likely
9 diagnosis.

10 Q. And that was based on the fact that your
11 information at the time was that the signs and symptoms
12 she had, the confusion, primarily had developed over a
13 period of a few days?

14 A. Why don't I just look at my note --

15 Q. Sure.

16 A. -- because I make a specific comment.
17 These aren't the notes that I need to look at. It
18 would be the next note that I wrote in the chart on
19 11-4 where I went through my differential.

20 This is where I went through my differential,
21 and fairly rapid onset of symptoms now without fever
22 unlikely but not impossible is what I wrote.

23 Q. Fairly rapid --

24 A. Fairly rapid onset of symptoms now without
25 fever unlikely but not impossible. This rapid onset of

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1 her symptoms in the absence of fever, in my mind,
2 wasn't strongly suggestive of the diagnosis of a fungal
3 meningitis and of the fungal meningitides. That
4 wouldn't be my first choice.

5 Q. Well, she had a normal temperature or
6 close to normal temperature when she came in?

7 A. Yes.

8 Q. What was her temperature?

9 A. There are several temperatures.

10 Obviously, her one temperature at the time of admission
11 was 99.2, which wouldn't even be abnormal for the
12 evening. And, I think, there were some other
13 temperatures that were in the normal or near-normal
14 range.

15 So that's what I wrote, that in the absence of
16 any significant fever, rapid onset wasn't typical, and
17 that wouldn't have been my first choice for a fungal --
18 anyway, Candida.

19 Q. What kind of fever would you have been
20 looking for?

21 A. There's no specific temperature curve.
22 With fungal meningitides, depending on the individual
23 and a number of factors, the temperature can range from
24 normal to significantly elevated. Frequently they run
25 lower-grade temperatures, 101.

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

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

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

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

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

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

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

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

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

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

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

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

13 Q. How would you have found that out?

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

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

20 A. I didn't have to.

21 Q. Why was that?

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

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1 called if he thought **it was necessary**.

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

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

12 Q. Do you know when you got those charts?

13 A. I cannot tell you.

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

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

25 **Again, we were dealing with a special**

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

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

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

18 Q. So how do you make a --

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

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1 identify.
2 Thrush would be one of ~~the~~ most identifiable.
3 That's ~~one~~ that you can ~~look~~ and ~~see~~ and just from the
4 physical features determine that that's a Candida
5 infection. ~~Then~~ if you saw somebody who was febrile
6 and who was encephalopathic with a stiff ~~neck~~ and who
7 had AIDS and who had ~~thrush~~, you might say I bet that
8 patient has ~~Candida~~ meningitis, and you'd probably be
9 wrong.
10 Q. But you would have investigated the
11 candidal meningitis in that case that you just
12 described?
13 A. Well, you would do nothing different ~~than~~
14 what we did.
15 Q. Which is what?
16 A. An ~~LP~~, spinal tap, and evaluate ~~the fluid~~.
17 And you get a CT scan because that would help in terms
18 of when you're dealing with abscess.
19 Q. How soon do you do the spinal tap after
20 you're presented with those symptoms you just
21 described?
22 A. ~~Soon~~ after.
23 Q. Within hours?
24 A. Within hours. It was not done ~~within~~
25 hours here. I'm aware of that.

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1 Q. Do you know why it wasn't done within
2 hours here?
3 A. ~~No~~, I do not. ~~The~~ house officer was
4 instructed to do so. And I have discovered in
5 reviewing ~~the~~ records and I ~~probably knew it at the~~
6 ~~t h e~~ that -- well, I did know ~~at the time, obviously~~,
7 that it was not done right away.
8 Q. Well, there's a note here on our
9 Exhibit 76, which is indicated as a progress from
10 Mt. Sinai, and it indicates a lumbar puncture. And
11 when was that --
12 A. ~~The t h e~~ is listed ~~as~~, I believe,
13 7:20 p.m.
14 Q. Is that an order there or is that ~~the~~
15 progress note?
16 A. That's ~~the~~ progress note.
17 Q. And 7:20 p.m. on what day; do you know?
18 A. I believe it's 11-4.
19 Q. You can look at the pages before that,
20 Doctor.
21 A. 11-4.
22 Q. Take a look at Exhibits 74 and 75 and tell
23 me if that helps you recall which day.
24 A. I saw ~~the~~ patient listed here as 11-3, and
25 ~~the LP~~ is listed ~~as~~ 7:20. You know, it's interesting

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

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

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1 reason, that's not cost effective.
2 In this case **there are academic** reasons why the
3 **tap should be done very quickly, and** I was bothered by
4 **the fact that I thought the tap** was done on 11-4. In
5 **the expert witness notes I see** a 27-hour delay is
6 mentioned. **But**, obviously, if it was **done on 11-3** and
7 I saw **the patient on 11-3**, it **couldn't have been** 27
8 hours. So that's a mistake.

9 I understand because these records **are** always
10 hard to review for those **kinds of details**. So it would
11 have had to have **been** sometime **within** hours **after** I saw
12 the patient.

13 Q. Why are these records hard to review,
14 Doctor?

15 A. You have a thousand pages of **handwritten**
16 notes, and physicians **don't record** information in
17 charts with **the idea of** them being reviewed legally
18 **three years later**. We're interested in recording
19 information for the ongoing process of **taking care of**
20 **the patient, and recording exact times and dates**
21 **becomes less important**.

22 That's why most notes, **as mine are**, list **the**
23 date but not the time I saw **the patient**. It's just,
24 generally, not that important in **terms** of the care of
25 the case. So when you **go back looking** for things like

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1 **this**, it can be somewhat difficult. Undoubtedly you've
2 had that experience before in reviewing records,

3 Q. Is that to say that doctors don't always
4 have an opportunity to record everything that happens;
5 they record the things which they feel are important
6 for the patient's care at that point?

7 A. Well, of course.

8 Q. So details sometimes are selectively
9 omitted?

10 A. **Part** of any profession, of any endeavor is
11 to select important from the **unimportant, whether**
12 you're a teacher, **a physician, a preacher or a lawyer**.

13 Q. So what you're saying is just because a
14 doctor didn't write something down doesn't mean that
15 something wasn't performed; it's just the doctor chose
16 not to record that particular item?

17 A. What **are** you referring to? **When you say**
18 something is **performed -- When** an operation is
19 performed, that would not be acceptable, of course. If
20 you don't **write down the time** that a blood was drawn,
21 that would be somewhat less important.

22 Q. How about a temperature wrap?

23 A. Well, those **are**, generally, not recorded
24 by physicians. **You see** in the charts the temperature
25 99.6 or whatever the temperature may be **written** down.

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1 **Generally, we don't talk in terms in most progress**
2 **notes of the exact time**.

3 **Sometimes the T max or the maximum temperature**
4 **of the day will be recorded in the progress notes**
5 **because most of that is available from looking at the**
6 **flow charts that are elsewhere in the chart in the**
7 **nurse's notes and so forth if that becomes an issue**.

8 **In certain circumstances it becomes an issue**.
9 **It depends on the case. It's not important to record**
10 **the exact times and temperatures when you're doing a**
11 **foot surgery. It depends on the situation**.

12 Q. In treating Freyda Kaplan and as a
13 physician, do you record all the complaints that a
14 patient makes about their condition **as part of their**
15 history?

16 A. All the **complaints, no**. You would --
17 Again, it depends **what you** mean by complaints.

18 Q. Well, complaints about condition, about
19 health.

20 A. There's **going to be some selectivity in**
21 **going through and looking** when a patient **provides you**
22 information and you make a report from that, certainly.

23 Q. What is it based on, that selectivity?

24 A. **Hopefully on my expertise of what is**
25 **important and what is not important**.

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1 Q. Now, you gave an example a little bit
2 earlier about a patient you would have tapped. You
3 **talked** about **someone** who was perhaps immunosuppressed
4 through AIDS and had confusion?

5 A. Oh, sure. I will say one **thing**. **There's**
6 another concern that hasn't **been** talked much about here
7 **that would have arisen**.

8 This patient had large ventricles **that was shown**
9 on the **CT scan on 11-2**. That was **done in the emergency**
10 room, and that's why she was in **the emergency room on**
11 **11-2** but probably didn't get up to **the floor -- that**
12 would be in the nursing notes -- until sometime in the
13 early morning of 11-3. But she had large ventricles,
14 and a tap in somebody with large ventricles is not
15 something you do lightly.

16 Q. She had large ventricles in the brain?

17 A. Yes.

18 Q. Is that a sign of hydrocephalus? Is it
19 hydrocephalus?

20 A. **Well, that's such a nonspecific term**. But
21 certainly that **term** encompasses large ventricles, many,
22 many causes. But a tap in that particular situation
23 can be lethal.

24 Q. Well, when do you do a tap on someone With
25 enlarged ventricles?

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

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

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

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

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

1 Doctor?
 2 MR. HERBERT objection.
 3 MR. MURPHY: objection.
 4 A. I don't believe I do. And I say it in
 5 that way **because** on a couple of occasions, perhaps **two**
 6 that I can recall in **the** 17 years I've **been here,** I
 7 have **been** invited, if that's **the** right word, to come
 8 down and review cases that **the** lawyers have with a
 9 series of physicians to see if **these are** cases that
 10 should **be** defended or should be settled.
 11 Q. You didn't, by any chance, sit on the
 12 review board for **this** case or --
 13 A. **No.**
 14 Q. -- were asked for an opinion on whether
 15 Freyda Kaplan's case should be settled or paid?
 16 A. My first knowledge of this case even being
 17 a case was --
 18 THE WITNESS: And I asked
 19 you that question, Mr. Murphy.
 20 A. -- I believe June 1.
 21 Q. Have you ever been sued, Doctor?
 22 A. **No.**
 23 MR. HERBERT: objection.
 24 MR. MURPHY: objection.
 25 **///**

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

1 6:50 p.m. on 11-3. So it would have **been done right at**
 2 about that time. I'm pleased to **know that.** **This is my**
 3 **note, yes.**
 4 Q. When did you discuss **this?** What does your
 5 note indicate there, Doctor?
 6 A. **When the fluid came back, there is a**
 7 discussion of **the differential diagnosis of the fluid.**
 8 Q. That's Exhibit 89?
 9 A. Yes, **sir.**
 10 Q. Could you identify Exhibit 90 for us?
 11 A. **Well,** it's a conclusion of my note listing
 12 **recommendations.**
 13 Q. What are your recommendations?
 14 A. That we do an EEG, **an**
 15 electroencephalogram. **I wanted a sedimentation rate**
 16 and ANA, an ACE test. **That's an angio-tensin**
 17 **converting enzyme. I was considering sarcoid. I**
 18 **wanted a repeat lumbar puncture possibly tomorrow.**
 19 **Probably tomorrow I wrote actually. Just the fluid,**
 20 **the spinal fluid results trickle in over a period of**
 21 **days depending** what test it is. And I was particularly
 22 interested in the cytology **looking for an infection of**
 23 **cancer, an infectious disease** consult and temperatures
 24 every four hours.
 25 **The next is a note from infectious disease that**

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

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

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

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

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

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

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

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

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

5 Q. Signs of fungus?

6 A. You can't see signs of fungus.

7 Q. Could you **see** them under microscope?

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

11 Q. The cells?

12 A. -- **the** cells of the budding yeast and
13 other fungi.

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

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

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

20 A. Yes.

21 Q. What are **the** other labs?

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

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

25 **A. Yes. There's the stain for TB of the**

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

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

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

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

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

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

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

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

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

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

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

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1 A. The laboratory would. There's somebody
 2 down there with a computer that receives it. And **they**
 3 punched in **the** date November 4, 1991, 1245 collected
 4 and received at **the same** time. So that's **impossible**.
 5 Q. Right. And the result came back on the
 6 19th of November?
 7 A. I thought it was the -- Didn't I say the
 8 8th? No, that's the date -- See, you're confused.
 9 **These are the dates that the** final laboratory sheets
 10 **are** printed up.
 11 Q. So the result was returned on the 8th?
 12 A. Yes.
 13 Q. Any indications of candidal meningitis
 14 there?
 15 A. It says Candida albicans cultured from
 16 broth only. I presume that cerebral spinal fluid and
 17 that would **then** indicate if you take that at face value
 18 that she has a meningitis of Candida albicans. You
 19 will recall looking at the progress notes it's so
 20 unusual that **the** ID people, **the** infectious disease
 21 people, first considered the possibility of it being a
 22 contaminant, if I remember correctly, which would be
 23 their first thought in a situation like that since it
 24 can be a contaminant since Candida **is everywhere**
 25 This Page 83 doesn't really give you too much

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

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1 A. Well, you have it in my notes from 11-4.
 2 I think that details the thinking that was going on
 3 from the laboratory tests more than looking at the lab
 4 tests.
 5 And my impression in my 11-4 note was that she
 6 **had an inflammatory process involving the cerebral**
 7 **spinal fluid, she had a meningitis, an inflammation of**
 8 the meninges and that **then began our** direction towards
 9 **discovering the cause of her meningitis**.
 10 Q. Well, could you wrap up and just complete
 11 looking at **those** labs there and tell us what **they**
 12 indicate?
 13 A. Well, there are a bunch of cerebral spinal
 14 fluid studies here.
 15 Q. I'm just referring to the lumbar puncture
 16 now, Doctor, the ones that refer to **the** lumbar
 17 puncture.
 18 A. That's what I'm saying. There are about
 19 **50 listed here from the 3rd to the 31st. I don't know**
 20 **how many of those were lumbar punctures and how many of**
 21 those were **fluids** taken from the ventriculostomy. **They**
 22 were all cerebral spinal fluid, but she was having
 23 **fluid taken from several different sources**.
 24 Q. And what do they tell us about this
 25 patient?

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

1 out. But if her cerebral spinal fluid were normal,
 2 **then I** would have gone **the** other route and **started**
 3 **looking** for toxic and metabolic causes for **her**
 4 confusional state.
 5 Q. In her blood or cerebral spinal fluid?
 6 A. All over.
 7 Q. Any other comments on Plaintiffs'
 8 Exhibit 84, Doctor?
 9 A. **No.**
 10 Q. Do you want to turn to Exhibit 85 and tell
 11 me what that tells us about this patient and her
 12 condition?
 13 A. This is a **continuation** of the previous
 14 page looking at **the differential** --
 15 Q. It's a continuation of 84?
 16 A. Yes -- looking at the **differential** of the
 17 white blood cell **counts** for **the** specific spinal fluids
 18 that **are** done **on the** specific dates that **are** given
 19 above **on** Plaintiffs' Exhibit **84**.
 20 Q. Any other information about this patient's
 21 condition and **her** **ultimate** **diagnosis**?
 22 A. Well, **they all** confirm that she has an
 23 inflammatory process in **the** meninges certainly.
 24 Q. Now, anything else on that, Doctor?
 25 A. **No.**

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

1 A. Vasculitis, yes. And vasculitis is a
 2 manifestation virtually of any **meningitis**.
 3 Q. Is that what, ultimately, **happened to**
 4 Freyda Kaplan here, vasculitis leading to stroke?
 5 A. Well, that's **our presumption, yes**.
 6 Q. Is that based upon a **reasonable degree of**
 7 medical certainty that she had vasculitis which led to
 8 a stroke?
 9 A. Yes. Can we prove it? **No**.
 10 Q. Why not?
 11 **A. Well, we'd have to biopsy her brain and**
 12 **look at the blood vessels. Then I would be** in trouble
 13 **with the law**.
 14 Q. **Because** Freyda Kaplan is not dead at this
 15 point?
 16 A. Right.
 17 Q. What's the treatment of choice for
 18 candidal meningitis?
 19 A. Antifungal **agents are used. Probably the**
 20 standard is **Amphotericin B**.
 21 Q. Was that the standard back in November and
 22 December of '91, intravenous?
 23 A. Correct.
 24 Q. Does Amphotericin B treat any other types
 25 of central nervous system infections?

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

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

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

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

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

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1 is.

2 MR. MURPHY. what stage are
3 you talking about?

4 BY MR. ABAKUMOV:

5 Q. Let's look at 11-3 and 11-4 of '91. What
6 were your expectations of Freyda Kaplan at that point?
7 And actually let's look at 11-8-91 when you began the
8 Amphotericin B treatment. What ~~were~~ your expectations?

9 A. My expectations were probably -- Again,
10 I'd have to -- it's always difficult to look back **two**
11 and a half years and know exactly what the state of
12 your mind was at that point.

13 ~~But~~ **Candida** meningitis you know from looking at
14 the literature, which I'm sure you've done, has a very
15 poor prognosis. Patients don't do well. And the
16 fungal meningitides have a high rate of neurologic
17 disturbances, neurological residuals associated with
18 treatment.

19 So it is not an infection in which you approach
20 the family and say, well, we've discovered Candida
21 meningitis and we're **starting** treatment, everything is
22 going to be fine. Everything is very likely not to be
23 fine.

24 Q. You wouldn't say that?

25 A. Absolutely not.

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1 Q. Are you familiar with Gorbach, editor and
2 author of a textbook Infectious Diseases?

3 A. I know the book.

4 Q. Are you familiar with his chapter in that
5 book fungi?

6 A. I've looked at it.

7 Q. I'm going to show you Plaintiffs'
8 Exhibit 41, and just tell me if this Xerox copy of what
9 we represent to be that chapter looks familiar.

10 A. Yes.

11 Q. Now, do you consider Gorbach to be an
12 authoritative text?

13 MR. HERBERT objection.

14 A. Infectious disease is not my area of
15 expertise, but it is.

16 Q. Now, referring to Page 1890 of the
17 exhibit, and there's a section there central nervous
18 system infections and ~~the~~ third paragraph of that,
19 could you take a look at that and indicate to us what
20 it states about prognosis and cure rate and what is
21 required to obtain that type of cure rate stated?

22 A. Increased mortality has **been** associated
23 with a low **glucose** level, longer than a two-week delay
24 in the diagnosis, and signs of increased intracranial
25 pressure.

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1 Let's ~~see~~. This is a combination -- **Well, what**
2 do you want **me** to read **here**?

3 Q. Well, would you agree that a two-week
4 delay in the diagnosis impairs the cure rate?

5 A. Well, it would for any infection. But it
6 **also says in** the same section that ~~the~~ **mean** time from
7 onset until diagnosis is **two months**.

8 Q. **So** then would you agree that Freyda Kaplan
9 had a candidal meningitis two months prior to its
10 diagnosis?

11 A. Absolutely not, absolutely not.

12 Q. That's just a mean time?

13 A. **No**, that's what they say here, that the
14 mean time from onset **until diagnosis is two months**.
15 And **as** you've recognized from all the expert testimony,
16 they give us credit for **making the diagnosis very**
17 rapidly.

18 Q. Well, that's only one expert doctor, and,
19 I believe, that was the expert for Jacobson, Maynard.

20 MR. HERBERT Move to
21 strike.

22 A. That's Dr. **Gardner**. **And he may**
23 be an expert for them but he's also **an**
24 intellectually-competent neurologist who tells **the**
25 truth.

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1 Q. Now, Doctor, would you agree with this
2 statement? **Therapy** is a combination of Amphotericin B,
3 .6 to 1.0 milligrams/kilograms per day, and **5**
4 flucytosine. With this regimen, the cure rate is 75 to
5 100 percent.

6 A. That's what they say **there**.

7 Q. You don't agree with that statement?

8 A. That **wouldn't be my experience**. **And**,
9 again, it has to do **with the fact that some of these**
10 patients **are so** immunologically compromised to **begin**
11 with, they have so many problems. But I'd want to **see**
12 that substantiated in ~~the~~ literature.

13 Q. Well, there's a further statement here in
14 Gorbach's book in the fungi chapter that single-agent
15 Amphotericin B therapy has a cure rate of 87 percent.
16 Would you agree with that statement?

17 A. For fungal meningitides ~~or~~ for Candida?

18 Q. This is for -- Why don't you take a look
19 at that chapter. Why don't you look at Footnote 34,
20 Doctor.

21 A. I know the article. I'd have to look at
22 **the** -- I haven't looked at it in preparation for this
23 deposition though. But **the point is still that it**
24 **comes down to the** individual case by your own reference
25 and at least by one of the expert witnesses, whatever

1 side he's on.

2 This was a diagnosis that was made quickly and
3 treatment was **begun quickly. Every evidence by which**
4 you have come to learn is **that the infection began a**
5 week or so before her **hospitalization, the second**
6 hospitalization. So instead of being a two-month
7 **course, this woman had probably a two-week course**
8 **before treatment was begun.**

9 Q. Well, to what do you attribute your
10 conclusion that this occurred two weeks before?

11 A. The history.

12 Q. And what specifically about the history?

13 A. She had a change in mental status.

14 Q. On the 22nd or 23rd of --

15 A. About a week prior to **the admission.**

16 Q. Concurrent with taking of Cipro?

17 A. Yes. That's in retrospect.

18 Q. As a neurologist, Doctor, if you had seen
19 her on the 22nd or 23rd, if you were brought in as a
20 consulting physician and the doctor who called you in
21 said this lady, Freyda Kaplan, says she's having
22 confusion associated with Cipro, what would you do at
23 that point, Doctor?

24 MR. HERBERT objection.

25 MR. GROEDEL objection.

1 A. Well, **she** wasn't **seen** on the 22nd. Cipro
2 was started on the 22nd. She was **seen** on the 30th.

3 Q. She was **Seen** on the 22nd also, Doctor.

4 A. Yes. But **then** she wasn't confused and she
5 was placed on Cipro at that time for a cloudy **urine,**
6 and there **was** no evidence of any confusion at that
7 point, at least in **the** notes. She didn't really
8 demonstrate confusion until thereafter.

9 So let's keep **the** times correct here because
10 **that seems** to be an important **part of** this **whole issue.**
11 **And the times are that on 10-30-91, several days before**
12 **admission, she was developing confusion at that point.**
13 it **was** recognized by **the** physicians that she **was**
14 **confused. She was not recognized to be confused prior**
15 to that by anyone. Even her family told me that she
16 was not confused.

17 Q. Do you remember that?

18 A. It's in **my** note, change in mental status
19 times one week.

20 Q. Do you remember who you talked to in the
21 family?

22 A. I probably tried to get some information
23 from **the** daughter. I doubt that we had Russian
24 interpreters available at that point. I can't tell you
25 **the** exact source of **the** information.

1 Q. Now, could you refer to that note, change
2 in mental status one week?

3 A. **Times one week, yes. Problem, change in**
4 **mental status times one week.**

5 Q. One week in relationship to what, Doctor?

6 A. For **admission. For the week prior to**
7 **admission, there had been a change in mental status.**

8 Q. Now, the October 30, 1991 note of the GU
9 clinic, do you recall reading that note?

10 MR. HERBERT: The October 30
11 note?

12 MR. ABAKmov of the Russian
13 Clinic.

14 A. Yes, I looked at **that note.**

15 Q. Now, that says confusion reported with
16 Cipro?

17 MR. HERBERT objection.

18 Are you going to let him look at **the** note?

19 MR. ABAKmov Sure.

20 A. If I recall **correctly, she was noted to be**
21 **confused, and the deduction was that this might be due**
22 **to the Cipro. And so what the physician did was**
23 **stopped the Cipro and started her on Keflex.**

24 Q. Now, if a patient presented to you with --
25 if you were called in to consult -- You were here at

1 the hospital on the 30th?

2 A. Yes.

3 Q. If you were called in as a neurologist,
4 would you do a mental status exam as a neurologist,
5 would you do a mental status exam at that point?

6 MR. HERBERT objection.

7 A. **On this patient probably not effectively.**

8 Q. Why not?

9 A. Because **the mental status means that I**
10 **have to know and be able to speak her language. Even**
11 **through an interpreter, a mental status exam is**
12 **difficult.**

13 Q. Well, how do you determine mental status
14 in your Russian patients?

15 A. With an **interpreter as best** we can or from
16 **observations. If she gives me the answer, that doesn't**
17 **mean she's** confused. Confusion is a -- **The mental**
18 **status examination is the longest single part of the**
19 **neurologic examination. It's done during the course of**
20 **the history taking on the quality of the information I**
21 **receive and it often takes ten minutes or more as part**
22 **of the general neurological examination.**

23 Q. So you wouldn't do that for Freyda Kaplan
24 **because** she spoke Russian or because the **exam** takes **ten**
25 **minutes or more?**

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

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

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

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

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

19 A. **Sure.**

20 Q. But if you didn't --

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

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

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

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1 that.

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

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

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

13 MR. HERBERT objection.

14 BY MR. ABAKUMOV

15 Q. -- and neurological examination?

16 MR. HERBERT objection.

17 Move to strike.

18 A. That really is kind of a ridiculous
19 question.

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

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

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

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

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

13 A. Thank you.

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

20 MR. HERBERT: objection.

21 Move to strike.

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

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

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

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

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

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

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

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

22 A. They do, indeed.

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

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

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1 inappropriate SIADH syndrome.
 2 Q. So something that should be looked into
 3 but not a serious concern?
 4 A. At that point **sodium** of 128 was not that
 5 much **of** a concern.
 6 Q. How long with a sodium existing at a 128
 7 level would be of concern to you?
 8 A. **The shorter the** duration of low **sodium**,
 9 **the greater the** concern.
 10 Q. So it had been up to 132 and dropped down
 11 to 128?
 12 A. It's not much of an issue.
 13 Q. Is that your note or someone else's?
 14 A. This is **the** house officer that got back
 15 **the** initial results. Again, we had trouble with his
 16 **name**, if you'll recall. This is his survey of **the**
 17 initial results. He notes **the sodium** to be below **the**
 18 lower limits of accepted normal, which is 135, and
 19 makes, again, an observation, which is what I want the
 20 house officers to do.
 21 Q. Was that sodium ever worked up?
 22 A. I'd have to check later **on**. We checked
 23 her and, I believe, her serum osmolalities. I'm not
 24 sure.
 25 **///**

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

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1 **120s** because then with a rapid drop in **sodium, you'll**
 2 **face the** issue of seizures and so forth
 3 Q. What does this low sodium level indicate
 4 in terms of any nervous system process?
 5 A. **Inappropriate ADH is caused by everything,**
 6 **anything and nothing. It's a sign of chronic illness,**
 7 **primary CNS infection, central nervous system tumors,**
 8 **lung cancers, COPD, essentially chronic illness. It's**
 9 **a very lengthy list. It's a very nonspecific problem.**
 10 **We see it after patients have strokes. It's a very**
 11 **nonspecific phenomenon. The most important thing to do**
 12 **is to treat it.**
 13 **I mean, our ultimate deduction here would be and**
 14 **why we weren't terribly concerned about it is when we**
 15 **discovered she had a meningeal process, no matter what**
 16 **the cause, it would have been a safe deduction that if**
 17 **she had inappropriate ADH, it was due to that. So it**
 18 **really wasn't a major issue. It's something I see all**
 19 **the time.**
 20 Q. Now, does this **rule** out central nervous
 21 system involvement if you have a normal test?
 22 A. Oh, of course not.
 23 Q. And this test doesn't rule out central
 24 nervous system involvement; in fact, it indicates that
 25 it should be examined further?

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

1 the spinal tap.
2 Q. Yes. And you did the spinal tap for
3 reasons you say that weren't related to the results in
4 this test?
5 A. Absolutely. We didn't know it.
6 Q. At the time you did this test you didn't
7 know the --
8 A. No, at the time I did the spinal tap I
9 didn't know her serum osmolality. That would have been
10 a later result.
11 Q. But this test indicates a possibility of
12 central nervous system involvement, which indicates
13 other tests? I mean, do you stop with this test?
14 A. No, it's a cul-de-sac in this particular
15 case. It might in other circumstances. Remember what
16 I told you before. You don't practice medicine by an
17 algorithm. This particular test was probably ordered
18 by the house officer when he noted the low sodium.
19 That's an important piece of information. But for the
20 treatment of the patient, I don't care a wit about it
21 in terms of the diagnosis.
22 If her sodium had been 150, my workup would have
23 been the same. It would have only meant that she was
24 dehydrated, which is seen in meningitis. It doesn't
25 mean anything.

1 Q. Does this type of result tell you to stop
2 doing further tests and start treating the patient?
3 A. Absolutely not. I've already told you
4 that.
5 Q. I just wanted to get that clear. Doctor,
6 I'm going to ask you to identify a couple signatures at
7 the bottom of Plaintiffs' Exhibit 86. There seems to
8 be two doctors there.
9 A. There is a Dr. Gardner. And is that
10 Kovozev?
11 Q. I don't know.
12 A. Yes.
13 Q. No recollection of those doctors?
14 A. No.
15 Q. Doctor, are you aware that -- how did
16 Freyda Kaplan do after treatment was commenced?
17 A. Poorly. I mean, she had her ups and she
18 had her downs. But the obvious answer to that question
19 is in the pudding, and --
20 Q. Well, she had her ups and downs and
21 eventually she had a down; is that what you're saying?
22 A. Yes, and she did very poorly and was
23 discharged to a chronic care facility. If she did
24 well, we wouldn't be here.
25 Q. Are you aware that a ventricular shunt was

1 placed into her cranium?
2 A. Yes.
3 Q. What was the purpose of that?
4 A. Enlarged ventricles to see if she was
5 obstructed and needed to be decompressed.
6 Q. Did she have a hydrocephalus, continuing
7 hydrocephalus at that time?
8 A. Yes.
9 Q. Was it to relieve the hydrocephalus?
10 A. Well, it was part diagnostic, and if the
11 diagnosis was correct, it would have been therapeutic
12 as well. As it turns out, her pressures were not that
13 elevated, her ventricular pressures. So she had
14 probably a communicating hydrocephalus secondary to the
15 meningitis.
16 Q. Communicating between the --
17 A. Ventricles and the subarachnoid space.
18 Q. And the spinal fluid?
19 A. Well, the spinal fluid is everywhere.
20 Communicating means that there's no obstruction within
21 the ventricular system that prevents the egress of
22 spinal fluid outside the ventricular system where it's
23 absorbed over the top of the head in the subarachnoid
24 villi of the superior sagittal sinus.
25 So basically anywhere along -- the fluid is

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

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

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

22 A. Yes.

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

25 A. Absolutely, unequivocally, emphatically,

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1 **no**.

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

4 A. Absolutely, yes.

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

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

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

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

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

21 A. Spinal tap.

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

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

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

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

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

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

8 A. Yes.

9 Q. Doyouhave those notes available to you?

10 A. It didn't **become dislodged**.

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

12 A. Possibly **so**. **But it became disconnected**.

13 Q. what's **the** difference?

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

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

22 A. **Well, they always are**. You **always sew**
 23 **them in**.

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

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

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

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

6 A. Right. So it **probably should have been**
 7 **disconnected**. That's **the best we can say**.

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

11 BY MR. ABAKUMOV:

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

15 A. Yes.

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

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

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

24 A. Yes, it's **my note**.

25 MR. GROEDEL: what's the

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

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

1 **anymore**.
2 Q. That didn't have anything to do with it
3 becoming dislodged?
4 A. **No. One of the main problems with an**
5 **external shunt is the separation of the tube**.
6 Q. And that's what happened here?
7 A. **That's what we think happened here**.
8 That's what I **think** happened. **An internal shunt -- It**
9 **depends what shunt you're talking about**.
10 Q. Let's talk about the internal shunt that
11 Freyda Kaplan had.
12 A. **What about them?**
13 Q. **So** you went to **an** internal shunt after
14 that shunt was dislodged?
15 MR. GROEDEL: Objection.
16 A. **I'm trying to remember without going**
17 **through the notes what the exact course of her shunt**
18 **was**. I believe it was, ultimately, if my memory serves
19 **me correctly, that we never, ultimately, shunted her**
20 **into her abdomen, if my memory serves me correctly;**
21 **that she was -- obviously, an external shunt is a**
22 **short-term phenomenon -- that she was removed from the**
23 external shunt. But I cannot remember **specifically** if
24 she had a VG or a VA shunt into the abdomen **or** if we
25 **just closed it off. I honestly can't remember that**.

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

1 disconnected, Colombi; that there was evidence of
2 cultures of CSF from the collection bag, presumably
3 from the external shunt bag; that it grew out
4 gram-positive cocci, probably **strep**, and, I think, she
5 was finally determined to have a strep.
6 Q. Is that confirmed in Plaintiffs'
7 Exhibit 96, which is a microbiology routine lab?
8 A. Let's see. Yes. But this is from a --
9 Well, the final **report** is November 15. Fluid collected
10 November 13, **right**
11 Q. So it was following the date of
12 dislodgement or disconnection as you've indicated?
13 A. Yes.
14 Q. Did that Streptococcus virus --
15 A. Bacteria.
16 Q. -- bacteria enter as a consequence of the
17 dislodgement or disconnection of the shunt?
18 A. I can't tell you for sure, but it's
19 certainly a possibility.
20 Q. Is it a probability given the fact that
21 she didn't have it before and it appeared on a lab
22 approximately one day after the --
23 A. Again, I honestly can't say that, can I?
24 Q. Well, I don't know. I'm asking you.
25 A. Well, I can't. It's certainly a

1 possibility.
2 Q. What are some of the other possibilities?
3 A. That it's a superinfection because she's
4 so immunologically compromised that she could get
5 infections, fungal meningitides from other
6 superinfections.
7 Q. What is immunocompromised?
8 A. Chronic use of antibiotics. That's
9 probably why she got it in the first place. But what
10 happens in a situation like this is you develop
11 bacterial strains that don't react to antibiotics
12 anymore and they go beyond -- you develop what we
13 sometimes call a superinfection or nosocomial infection
14 because of lack of response to antibiotics. That's
15 very much in the news today. It's a very real problem.
16 And this woman was on multiple antibiotics for a period
17 of months.
18 Q. Well, that's something that was known in
19 '91 also? We knew this in '91 also?
20 A. We knew this in '81. We've known this for
21 a long time. The race is going on to come up with
22 different antibiotics.
23 So she had a strep infection. There is no
24 question about that. The cultures grew out several
25 days after the disruption, whatever it might have been

1 in the ventricular system, the drainage system, and
2 very possibly there's a connection, of course.
3 Q. You used the term immunocompromised. Is
4 that the same as immunosuppressed?
5 A. Yes. In her case those terms are used,
6 admittedly, somewhat cavalierly because how much of
7 this is -- she's been chronically ill, she's on a
8 number of antibiotics. There probably is some
9 immunosuppression. People like this are more
10 susceptible to serious infections.
11 Part of that is probably also that she's growing
12 new and wonderful bacteria in a medium that's had four
13 or five months of different antibiotic use.
14 Q. And that's what made her subject to
15 picking up an infection like -- more susceptible to
16 picking up an infection like Streptococcus during the
17 second admission?
18 A. Well, to be completely honest, how much
19 would be due to that, how much would have been due to
20 the possible contamination of her spinal fluid through
21 a disrupted ventricular system is difficult to know.
22 One could certainly develop a meningitis from a
23 disrupted ventricular system. It's a common
24 complication of an external shunting process, as you no
25 doubt have come to know.

1 So you don't have to be immunologically
2 compromised. Perhaps 15 percent of the patients
3 develop meningitis from an external shunt.
4 Q. Are you more susceptible to infection when
5 you're immunologically compromised?
6 A. Absolutely. That's what AIDS is.
7 Q. This vasculitis which she developed, was
8 that caused by Streptococcus, was it caused by Candida
9 albicans, was it caused by something else?
10 A. Who knows? Again, vasculitis is a
11 deduction. We never proved it. Then to go one step
12 further and say something that we haven't proved, is it
13 due to this or that or the other thing is folly.
14 Q. So all you know, Doctor, is that she had a
15 stroke and you don't know if it was caused by
16 vasculitis?
17 A. Sure. I mean, it could have been long
18 term and we may have never found a cause for it. It's
19 probably a vertebral basilar distribution stroke.
20 Since it's the vertebral basilar system that has input
21 into the thalamic structures, she could have embolized
22 from somewhere else in her body, from her heart. I
23 don't know. We don't know. You frequently cannot
24 prove the etiologic mechanism in a stroke.
25 Q. Well, do you think it's probable that she

1 had the stroke as a result of the hypothalamic
2 infarcts, I guess would be more precise, as a result of
3 the vasculitis?
4 A. Well, I think that's a reasonable
5 deduction **because** we **know** it happens. But what I'm
6 telling you is here is a woman who has **been infirmed**
7 for months and she's also 69. I've **had 69-year-old**
8 people who have had thalamic infarcts and no preceding
9 illness.
10 So the first question is is it connected to her
11 illness at all. If it's connected to her illness, what
12 is **the** exact etiologic mechanism? **We suspected that it**
13 might be a vasculitis, but **there is no proof. In fact,**
14 you'll never know. Even an **autopsy couldn't prove it**
15 at this late date. It could **prove another cause. She**
16 might have advanced atherosclerosis, which we never
17 really ruled out in the **type** of workup that we did.
18 Q. Do you **think** it's more probable that the
19 vasculitis was caused by the Candida albicans
20 meningitis or the Streptococcus?
21 A. I just told you that's folly. I don't
22 know.
23 Q. I just had to ask you that question,
24 Doctor. You've only treated one patient with a
25 candidal meningitis that you can recall?

1 A. I haven't treated very many. I don't
2 **know.** I've **seen a fair number of** cases with fungal
3 meningitis because I trained in Los Angeles, and that's
4 where--
5 Q. A lot of AIDS patients?
6 A. **No,** I trained in the '60s before **the AIDS.**
7 But that's where coccidioidomycosis comes from. And
8 so I have probably treated more cases of
9 coccidioidomycosis meningitis than anybody certainly in
10 Cleveland. But the specific fungal agent, whether -- I
11 just can't tell you how many cases of Candida
12 meningitis.
13 Q. Did any of **those** patients stroke?
14 A. With cocci?
15 Q. Yes.
16 A. **Sure.**
17 Q. Was that related to the cocci?
18 A. Vasculitis means inflammation of **the** blood
19 vessels, and you can determine indirectly by
20 observation, by angiography that may show
21 characteristic pictures. You can do biopsies of muscle
22 and **skin** if it's a systemic illness that's associated
23 with vasculitis such **as** lupus. But in a situation like
24 this it becomes conjecture.
25 Q. How about postmortem studies, Doctor,

1 would **those** reveal the vasculitis?
2 A. Probably not. You might -- It would
3 **depend on the nature of the problem. You might,**
4 conceivably, find some evidence, but I **doubt it because**
5 the **inflammatory process, I suspect, would have been**
6 **self-limited and long since gone away. But I would --**
7 I mean, if it's important **for you to know that, it**
8 would be something that **we probably should ask a**
9 **neuropathologist.**
10 Q. Well, you treated Freyda Kaplan throughout
11 this second admission as her neurologist?
12 A. **Not throughout. I followed her case, but**
13 **I was the teaching attending for the month of November**
14 **She was seen by Dr. Riley, one of my associates, in the**
15 **month of December, and you'll note that her discharge**
16 **summary was signed out by Dr. Chandar who covered the**
17 **month of January. But, obviously, most of the interest**
18 **in her case was in the month of November, and then I**
19 **continued to follow her along.**
20 Q. Do you know what her status is today?
21 A. **At this particular moment, no.**
22 Q. Do you know what it was when she left?
23 A. **Yes. She was significantly impaired,**
24 **markedly encephalopathic and --**
25 Q. Would you use the **terms** comatose,

1 semicomatose?
2 A. I don't **think she was comatose. She was**
3 **probably at that point probably more in a vegetative**
4 **state. But I'd have to look at the records.**
5 Q. How is that different from comatose?
6 A. Well, it's an interesting **question.**
7 Patients who **are** vegetative usually pass **through a**
8 state of coma where there's **absolutely no evidence of**
9 **any kind of consciousness, no sleep/wake cycle, no eye**
10 **following. Individuals who move into a vegetative**
11 **state have often preservation of the sleep/wake cycle,**
12 **the brain stem is functioning, may show some evidence**
13 **of eye following, may even occasionally take food,**
14 **although often they won't. But the main difference is**
15 **that there's preservation of the sleep/wake cycle.**
16 Q. These people can speak?
17 A. **No,** no. From the standpoint of **neurologic**
18 **function, it doesn't mean much. You're non-functioning**
19 **in both states.**
20 Q. What's the life expectancy for a
21 69-year-old woman in **the** kind of condition that you
22 last saw her? Is it a normal life expectancy?
23 MR. GROEDEL: objection.
24 A. Well, the only answer I would give to you
25 is that if she remains **as** neurologically impaired now

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1 as she was ~~then~~, I hope not.
 2 Q. But you have no idea if her normal life
 3 expectancy is 13 years, she would live ~~those~~ 13 years
 4 out?
 5 MR. GROEDEL: objection.
 6 A. Of ~~course~~ I don't. If I did, you should
 7 pray to me.
 8 Q. I guess I'll have to pray to the
 9 statisticians ~~then~~, Doctor.
 10 A. We all do.
 11 Q. The number crunchers.
 12 Are you aware that Ampho B irrigations were --
 13 A. Amphotericin B?
 14 Q. Yes -- were prescribed or ordered on
 15 October 13, 1991?
 16 MR. MURPHY: October 13?
 17 MR. ABAKMOV: November 13.
 18 I thank my colleagues.
 19 A. Oh, you're not talking about the first
 20 admission; you're ~~talking~~ about the second admission.
 21 Q. I'm talking about November 13.
 22 A. I can't specifically recall it. If she
 23 had Candida in her urine, that would be a reasonable
 24 thing to do. It's something that's not uncommonly
 25 done.

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

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

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1 A. There were some comments made about it.
 2 Yes, he did. But, frankly, it was more a chitchat. It
 3 really didn't have too much to do with what I was doing
 4 here.
 5 Q. Do you remember the chitchat?
 6 THE WITNESS: YOU told me
 7 you had come from his deposition.
 8 A. I can't recall too much else. I guess
 9 something--
 10 THE WITNESS: And, again, if
 11 I misspeak, correct me.
 12 A. -- something to the effect that he didn't
 13 have much argument about the patient's hospitalization
 14 in November through January, if I'm remembering
 15 correctly.
 16 Also, what he is mentioning in his letter, which
 17 was merely just confirmation of a letter, that he is
 18 making the assertion that this patient had meningitis
 19 that was missed, Candida meningitis that was missed
 20 during the first hospitalization.
 21 Q. Anything else? Anything critical about
 22 you that was discussed?
 23 A. No.
 24 Q. So that was pretty much the entire
 25 20-minute conversation?

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

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

12 A. No.

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

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

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

1 A. Patrick Murphy.
2 THE WITNESS: I believe it
3 was one of the letters you or somebody in
4 your office sent me, very possibly your
5 secretary.

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

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

10 A. Absolutely.

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

13 MR. MURPHY: objection.

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

25 Q. Well, do you feel that if you had

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

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

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

25 A. On what date?

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

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

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

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

8 Q. It's called a hypothesis.

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

14 Q. On October 22?

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

20 Q. You never use hypothesis in your training?

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

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1 **you on Amphotericin B, you will do better than if I**
 2 **diagnose it two months from now when you become**
 3 **symptomatic.**

4 Q. And I'm less probable to have a stroke
 5 than if you diagnose it two weeks later?

6 MR. HERBERT objection.

7 MR. GROEDEL: objection.

8 You're asking a lot of expert opinion
 9 questions here even though you've called
 10 him **as a fact witness. I assume** then it's
 11 okay by you that all the other attorneys
 12 here have the opportunity to ask expert
 13 opinion questions, too.

14 MR. ABAKUMOV I feel this is
 15 his question **as a treating physician of**
 16 this patient. I'm asking him a specific
 17 question about this patient.

18 MR. GROEDEL You're asking
 19 him questions beyond what he did from a
 20 factual standpoint. You've been doing it
 21 all day. You've opened the door to use
 22 him **as an expert witness, which we intend**
 23 to do. But go ahead.

24 BY MR. ABAKUMOV

25 Q. Answer the question, Doctor.

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1 A. **The question is?**

2 Q. Would it have made a difference?

3 A. **If she had Candida meningitis at that**
 4 **time? Of course. The earlier you make a diagnosis in**
 5 **almost any condition, the better it is for the patient.**

6 Q. Where did the Candida meningitis come from
 7 in this patient **as her treating physician?**

8 A. **Probably her urine.**

9 Q. And how did it get into the cerebral
 10 spinal fluid?

11 A. **Probably through hematologic spread.**

12 Q. Through the blood?

13 A. **Probably.**

14 Q. How do you detect it in the blood?

15 A. **Blood cultures. They were negative.**

16 Q. Which blood cultures?

17 A. **I think the blood cultures we drew**
 18 **initially on 11-3, 11-4 were negative.**

19 Q. **Is that because it was already in the**
 20 **cerebral spinal fluid?**

21 A. **No, that's because it's hard to grow and**
 22 **you don't always get it.**

23 Q. But not impossible to grow?

24 A. **No. But with blood-borne infections, you**
 25 **can't have negative cultures as can the CSF if you have**

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1 **meningitis.**

2 MR. ABAKUMOV okay. Thank
 3 you very much, Doctor.

4 MR. GROEDEL I have no
 5 questions.

6 MR. MURPHY: I've got a few
 7 questions. We've been here a long time,
 8 but --

9 MR. **ABAKWOV:** Doctor, before
 10 **Pat asks --**

11 THE WITNESS: I can talk
 12 forever.

13 MR. ABAKUMOV: -- before Pat
 14 Murphy starts speaking here, I would just
 15 like to object for the record **as to your**
 16 **being an expert in this case, and all the**
 17 **questions I directed to you here today**
 18 **were as a treating physician of Freyda**
 19 **Kaplan during her second admission and**
 20 **whatever part thereof you treated her.**

21 MR. HERBERT The record
 22 speaks for itself.

23 CROSS-EXAMINATION

24 BY MR. MURPHY:

25 Q. You indicated you reviewed the record from

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1 the first admission, too, earlier this morning?

2 A. **Yes, sir.**

3 Q. Mr. Abakumov asked you questions about **the**
 4 low sodium level on the second admission. I'm going to
 5 hand you **the** blood chemistry sheet where I highlighted
 6 the low sodium readings from the first admission and
 7 just have you look at that for a minute, please.

8 A. **Yes.**

9 Q. Dr. Tucker has testified to the effect
 10 that those low sodium levels had to be worked up more
 11 thoroughly before the patient was discharged on
 12 October 10 to ~~see~~ what their etiology was, presumably
 13 that it might just be meningitis. Do you agree or
 14 disagree with that assessment?

15 MR. ABAKUMOV objection.

16 A. **I disagree.**

17 Q. Why so, Doctor?

18 MR. ABAKUMOV: Note a
 19 continuing objection.

20 A. **Because probably half of the patients on**
 21 **the T8 unit have sodiums of this level, 132, which is 3**
 22 **milli-equivalents below the lower limits of normal,**
 23 **which really doesn't mean that much. Plus her sodium**
 24 **was going up. At the time of discharge her BUN was 15.**
 25 **And, if anything, I would suspect that that very low**

1 sodium with a rapid drop in BUN from October 2 to
2 October 9 or October 4 with a rapid climb to October 6
3 is more a result of hemodilution and fluid overload.
4 To me, it's just not an issue. Too much has
5 been made out of this issue of whether or not she has
6 an appropriate ADH. And I wouldn't keep a patient in
7 the hospital any longer than that.
8 Q. You were discussing with Mr. Abakumov
9 various etiologies for her bilateral thalamic infarcts
10 or stroke?
11 A. Yes.
12 Q. You talked about vasculitis as one
13 possibility, embolization as another?
14 A. Yes.
15 Q. Her age as one?
16 A. Well, the age just makes her more
17 susceptible to stroke.
18 Q. Would that tie in with atherosclerosis?
19 A. Sure, at that time. You can have about
20 one percent per year.
21 Q. Are there any other etiologies you can
22 think of, giving what you know for Freyda Kaplan, other
23 than those that we've just mentioned?
24 A. No, not off the top of my head.
25 Q. As a doctor who followed Freyda Kaplan

1 during her second admission at Mt. Sinai Hospital,
2 given what you know about her and given what you know
3 about strokes, do you believe anybody can truly state
4 an opinion with reasonable medical probability as to
5 what the etiology of her stroke was?
6 MR. ABAKUMOV objection.
7 A. No. I certainly can't. I could--
8 Q. Can you render such an opinion as to the
9 etiology of her stroke?
10 A. For sure?
11 Q. No, with reasonable medical probability or
12 certainty.
13 A. I understand the meaning of that term, and
14 you're asking me to a 51 percent certainty to tell you
15 what the etiology of what her diagnosis is. I put it
16 in this chart as vasculitis, and, I think, others felt
17 that possibility. And that's conjecture. And to try
18 to fit that into a legal definition of probability I
19 think loses meaning. I think it's a reasonable
20 deduction. It certainly happens. Whether it's right
21 or not is another issue.
22 MR. ABAKUMOV Move to
23 strike.
24 BY MR. MURPHY.
25 Q. Is it your opinion with reasonable medical

1 probability that as a physician you don't really have
2 enough data or information to make a call as to her
3 etiology for her stroke --
4 MR. ABAKUMOV. objection.
5 BY MR. MURPHY:
6 Q. -- to a 51 percent certainty?
7 A. Correct. We would have had to do
8 angiography and so forth. And to take a woman this
9 neurologically impaired, to make an academic diagnosis
10 would have been a moral outrage.
11 MR. ABAKUMOV Move to Strike
12 that opinion.
13 Q. When Mr. Abakumov was showing you that
14 article from Gorbach's text, you made a statement to
15 the effect that you reviewed the article but you don't
16 believe the meningitis was present back at the time of
17 the first admission; is that true?
18 A. That is correct.
19 Q. Is that your opinion to a reasonable
20 degree of medical probability based upon what you know
21 about this first admission?
22 A. Yes.
23 MR. ABAKUMOV. objection.
24 Move to strike.
25 Q. Can you explain why you state that

1 opinion?
2 A. Because there's no evidence that she had
3 meningitis at that time.
4 Q. Do you recall seeing her fluctuating
5 temperature during the first admission?
6 A. Well, it was a low-grade temperature. By
7 fluctuating it wasn't wide peaks and valleys but it was
8 mainly in the 99 to 100 and a fraction range. So it
9 was what I would call a low-grade temperature.
10 Q. Given Freyda Kaplan's presentation at that
11 time with that low-grade temperature, in your opinion,
12 to a reasonable degree of medical probability, was such
13 low-grade temperature an indication to tap her at that
14 time?
15 A. No.
16 Q. Why not?
17 MR. ABAKUMOV objection.
18 A. If I were to tap everybody in this
19 hospital that had that temperature curve, I wouldn't be
20 guilty of malpractice; I would be guilty of a criminal
21 act. The basis for a tap is not a fever. Every mother
22 would have her child tapped ten times by the time he
23 was twenty years of age. You don't tap people because
24 they have a fever. You tap them if there is reason to
25 tap them based on the history, the physical examination

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1 and the information on hand at that time. You do not
2 do spinal taps cavalierly.

3 MR. ABAKUMOV objection.

4 Move to strike.

5 A. It's expensive, it causes discomfort and
6 it is not something that you do. You don't do any test
7 unless it needs to be done.

8 Q. You're aware that one of the urine
9 cultures during that first admission grew out Candida
10 tropicalis, or are you aware of that?

11 A. Yes, I am.

12 Q. Given your background as a neurologist and
13 your understanding of Candida infections and Candida
14 central nervous system infections, in your opinion, to
15 a reasonable degree of probability, is the finding of
16 candiduria in this first admission something that
17 should cause the physicians watching her and taking
18 care of her at that time to have a heightened suspicion
19 of her developing a systemic Candida infection and
20 subsequently Candida meningitis?

21 A. No, I don't think so. But I do think that
22 it's fair to say --

23 MR. ABAKUMOV. objection.

24 A. -- that this is a patient who had a
25 history of chronic recurrent infections throughout her

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1 hospitalization in Russia and was known to already be
2 having infections in the United States and was,
3 obviously, going to be a patient to be followed up and
4 observed. She's a candidate for infection, sure.
5 That's why she was followed.

6 Q. Is it your opinion that the diagnosis of
7 Candida meningitis was made in a timely manner in the
8 second admission and treatment started --

9 MR. ABAKUMOV objection.

10 BY MR. MURPHY:

11 Q. -- started in a timely manner?

12 A. I, obviously, have a bias. And all I can
13 say is, I think, it was made in a timely manner. If I
14 had it to do all over again, obviously, I would have
15 done the -- knowing the information that I know, I
16 would have done the LP myself.

17 Q. The first time you saw her?

18 A. Sure.

19 Q. But that's retrospective, true?

20 A. I'm much better retrospectively than I am
21 prospectively.

22 Q. In your opinion was the appropriate
23 workup done in the second admission to lead to the
24 diagnosis of Candida meningitis, the tap and the
25 culture and so forth and so on?

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1 A. To quote you, the act speaks for itself.

2 Yes, we made the diagnosis.

3 Q. Was it the nuchal rigidity that led you to
4 request the tap be done?

5 A. Yes. Well, maybe it's a little better to
6 say the nuchal rigidity suggested to me the possibility
7 of a meningeal inflammation and that possibility led me
8 to do the tap. Again, lots of people have stiff necks,
9 and I don't tap them just for a stiff neck alone.

10 THE WITNESS: Could I make a
11 phone call?

12 (Thereupon, there was a brief recess.)

13 BY MR. MURPHY:

14 Q. Dr. Devereaux, given your knowledge of
15 Candida meningitis, can the patient's presentation, the
16 signs and symptoms that she would exhibit, change
17 rather dramatically in a period of days such as
18 comparing Dr. Baron's October 30 note with your note
19 when you saw her on the first day of admission?

20 A. Yes.

21 Q. Why is that?

22 A. Well, she has an evolving process, and, of
23 course, different people are going to react differently
24 to it. That's where you get into a problem answering a
25 question like this. We know one thing that's a

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1 certainty; that there was a major change in a week. We
2 know that. That's beyond question.

3 So what you're asking me then is could there
4 have been a significant change in the last four or so
5 of those seven days, and the answer is yes. I mean,
6 this patient when she came into -- you just look at the
7 record -- when she came into the hospital here, she was
8 on a gurney. I mean, this patient couldn't walk as
9 near as I can tell. She was obtunded. This was a
10 patient who came into a clinic three or four days
11 before

12 So forgetting about all the legal stuff, there
13 was, obviously, a change, whatever the cause may be.
14 If it wasn't the meningitis, then it was something
15 else.

16 Q. In response to one of Mr. Abakumov's
17 questions, you said you couldn't really conjecture what
18 you would have done on November 30 had you seen the
19 patient on that day?

20 A. You mean October 30?

21 Q. October 30 I meant to say, yes. And then
22 you went on to say that you didn't think that would
23 affect the outcome, anyway?

24 A. I don't believe so.

25 Q. Why do you state that, that you don't

1 believe the outcome would have changed?
2 A. Well, **again**, we're dealing **with the type**
3 of infectious process that usually **doesn't do dramatic**
4 **damage** over hours, where I said literally **minutes can**
5 **make a** difference in the quality of survival. You're;
6 **dealing** with an infectious process which is somewhat
7 more indolent and usually doesn't produce dramatic
8 change that fast.

9 Again, **the** biggest delay is not between
10 Dr. Baron **and** my **seeing** the patient which was three
11 days, **four** days. **The biggest delay was between my**
12 **seeing the patient and starting treatment. So if we**
13 **use that time** line, I'm more guilty than she is, if
14 **we're talking** strictly about time. The patient waited
15 **five days in the** hospital before we started
16 **Amphotericin B.**

17 Q. Your opinion though, if I understand it,
18 is even had you started it --

19 MR. ABAKUMOV objection.

20 BY MR. MURPHY:

21 Q. -- on November 3, the Amphotericin B, in
22 all probability, her condition would not have changed?

23 A. Probably. Again, **the** obvious answer that
24 we would all agree with is that --

25 Q. Well, probability is all I'm asking.

1 A. -- it's always better **to** treat **something**
2 **as fast as** you can. **No** one is going to dispute that.
3 **But in reality**, had she **been** started **on** October 30
4 **versus or had the** diagnosis been made on October 30
5 versus November 8, and that's really when **the** diagnosis
6 was made, you have some argument for **saying** that it
7 would have made a difference. However, the diagnosis
8 wouldn't have been made on October 30 even if I, for
9 some reason, would have **seen** her and suspected it. It
10 would have been made on November 4. So we're talking
11 about a **three-** or four-day delay versus an eight-day
12 delay. And my suspicion is that it wouldn't have made
13 a lot of difference.

14 Q. I'm just asking in the scheme of
15 responsibilities, in your opinion, would it make a
16 difference in her outcome?

17 MR. ABAKUMOV objection.

18 A. I suspect not.

19 MR. MURPHY: That's all I
20 have.

21 MR. SUMNER Let me **ask** a
22 couple questions.

23 CROSS-EXAMINATION

24 BY MR. SUMNER:

25 Q. Doctor, I'm Dave Sumner, and I represent

1 Mira Baron in this case.

2 I **take** it from what you've already said that you
3 don't believe medical standards of care as might apply
4 to my client Mira Baron when she evaluated this patient
5 on October 30 given the presentation that you see
6 documented in the Russian Clinic record mandated that
7 she refer this patient on that date for a neurologic
8 workup to include a spinal tap?

9 MR. ABAKUMOV: objection.

10 A. Your question is **then do I agree with that**
11 **she didn't need to?**

12 Q. Do you --

13 A. I think the case was handled
14 **appropriately. I would not have -- Looking over the**
15 **records, there doesn't appear to be enough evidence to**
16 **make an immediate referral to a neurologist or admit**
17 **the patient. I think the case was handled**
18 **appropriately.**

19 Q. You, I think, have made an assumption from
20 reading the record from that date that Dr. Baron
21 actually determined upon interaction with the patient
22 or observations of the patient that there may have been
23 some mental status changes or slight confusion. Is
24 that how you read the record?

25 A. That was my interpretation from **what she**

1 said.

2 Q. So is it your opinion that you believe she
3 met reasonable standards of care in how she handled
4 this visit even if she determined upon interacting and
5 observing the patient that there were, indeed, mental
6 status changes by that patient on that visit?

7 A. **Yes. You certainly don't** refer everybody
8 **to a neurologist who might have some confusion.**

9 MR. ABAKUMOV Objection.

10 A. **Goodness, no. It would be wonderful for**
11 **my business if they did.**

12 Q. Would you agree that given the Vital signs
13 that were taken **and** the accompanying laboratory workup
14 for that visit that there were no signs on this visit
15 that this patient had an acute infection or an acute
16 systemic infection or **chronic systemic infection?**

17 A. **No. The temperature was 98.2. There were**
18 reports of fever but, again, no determination **that she**
19 was febrile at **the time of that evaluation. And she**
20 talked about hematuria, **weakness**, confusion, and **then**
21 we made a deduction that perhaps it's **the Cipro that's**
22 producing the problem and switched her to another
23 antibiotic.

24 Q. It seemed to be a very reasonable judgment
25 and decision?

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

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

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

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1 revealed that **her temperature was normal. So sure.**
 2 MR. SUMNER Okay. I don't
 3 have anything else.
 4 MR. ABAKUMOV: I have a few
 5 questions.
 6 FURTHER CROSS-EXAMINATION
 7 BY MR. ABAKUMOV
 8 Q. Doctor, does a patient running a febrile
 9 course always have the same temperature?
 10 A. Well, **no,** it fluctuates.
 11 Q. It goes up and down?
 12 A. **Sure.**
 13 Q. So the fact that she had a temperature of
 14 98.9 or whatever it was --
 15 A. 98.2, which is lower **than our 98.6**
 16 **legendary normal.**
 17 Q. Does that mean she had 98.2 the entire
 18 month of October and --
 19 A. No. It's just **that every time we have it**
 20 **checked that it was normal.**
 21 Q. How many times was it checked in October
 22 after the first discharge?
 23 A. Let's see. In the urology clinic 10-22 it
 24 was 98.6.
 25 Q. What time of day was that taken?

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

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

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1 Q. Well, you don't know that; you're
 2 presuming?
 3 A. **Well**, I'm presuming because most of **the**
 4 **time they are.**
 5 Q. What if I told you that the records didn't
 6 indicate; would you still presume it was oral?
 7 A. I would presume it until otherwise. I'd
 8 **ask the doctor. If it's important, let's go back and**
 9 **ask how they checked the temperature, Hampel's office,**
 10 **how they checked the temperature in the Russian Clinic**
 11 **and how they checked the temperature in the urology**
 12 **clinic, three different temperatures. There's not much**
 13 **bias here.**
 14 Q. What time of day were those temperatures
 15 taken?
 16 A. I don't know.
 17 Q. Well, look at the October 30 note and tell
 18 me what time of day the temperature was taken because
 19 you're basing your conclusions on the note here.
 20 A. **No, I'm basing it on the temperature. The**
 21 **temperature is 98.2. I don't know what time of day**
 22 **that was taken.**
 23 Q. Because it's not indicated there?
 24 A. **No.**
 25 Q. And the temperature route is not indicated

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

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1 discharge for the family to take her temperature chart?
 2 A. ~~She's~~ a physicist and ~~she should know~~
 3 better. You made the point ~~that she's intelligent and~~
 4 the temperature is more reliable at home than in the
 5 hospital --

6 Q. Are you telling me ~~that~~ you're
 7 disregarding her complaints of a fever?

8 A. I am not. I'm telling you ~~the~~ job of a
 9 physician is to evaluate the nature of the complaints
 10 and what they mean. We are told here that the patient
 11 has a fever. The doctor recognizes that. The doctor
 12 even writes it down. The doctor is not denying it.
 13 The doctor writes down that ~~the~~ temperature is 98.2.
 14 ~~She~~ is not febrile at that time.

15 You're right, I can't tell you that she wasn't
 16 febrile ~~two~~ hours before that. I can tell you it's not
 17 particularly likely. But I can tell you that ~~she's~~ had
 18 ~~three or four temperatures scattered over the course of~~
 19 a month ~~within~~ a normal range, and you can ~~try~~ to
 20 challenge that.

21 Q. How about a temperature of 99.4 taken by
 22 the VNA on the 25th of October?

23 A. What ~~time~~ of day?

24 Q. Why don't you look in the notes and tell
 25 me if it's indicated what time of day.

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1 A. 99.4 versus 98.6 is a marginal
 2 temperature. But, I ~~think~~, the problem that we have
 3 here is that ~~the~~ doctors -- it's not terrifically
 4 important and I'll tell you why it's not terrifically
 5 important -- the doctors are recognizing -- they're not
 6 denying that she had an infection; they're treating her
 7 for an infection.

8 Q. Are they treating her fever?

9 A. You never treat ~~the~~ fever; you treat ~~the~~
 10 cause of the fever.

11 Q. Do they determine the source of the fever?

12 A. The presumption is that they thought that
 13 the source was ~~the~~ bladder.

14 Q. Based on what, Doctor?

15 A. Based on a history of repeated urinary
 16 tract infections, based on a history of a
 17 hospitalization in early October for a urinary tract
 18 infection, based on a deduction on what was going on,
 19 based on the fact that her urines have grown out some
 20 stuff at different times.

21 I mean, if you're going to challenge their
 22 treatment, ~~then~~ you have caused -- in that approach,
 23 ~~then~~ you're going to destroy the American medical
 24 system. That means you're saying that everybody has a
 25 fever, why not only --

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1 Q. We're talking about Freyda Kaplan here,
 2 Doctor.

3 A. All right. Should she get blood cultures
 4 every day along with urine cultures? I mean, where do
 5 you stop? You make rationale judgments. That's what
 6 we do; we make rationale judgments.

7 Q. Assume that she had a temperature of 99.4
 8 on October 25, not an evening temperature, but perhaps
 9 a late morning, midday temperature.

10 A. Let's not worry about that because it
 11 depends on the environment which you're not
 12 controlling, everything else, not just the time of day.
 13 The fact is that when she was seen in the Russian
 14 Clinic, her temperature was 98.2, and that makes a
 15 temperature of 99.4 five days before less important.

16 Q. Okay. Doctor, did you ~~see~~ Freyda Kaplan's
 17 temperature chart from the first admission, did you
 18 review that?

19 A. Yes.

20 Q. Do you want to pull that out?

21 A. Well, I could.

22 Q. Here, we have it right here. Would you
 23 agree that that's her temperature route between
 24 September 30 and October 6?

25 A. Yes, it appears to be so.

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1 Q. Now, is she running a febrile course
 2 during this admission?

3 A. Yes, low-grade fevers.

4 Q. And to what do you attribute these fevers?

5 A. Her urinary tract infection. At least
 6 that's what they attributed it to at that point.
 7 That's why she was in the hospital being treated.

8 Q. Well, do you know what she was being
 9 treated with?

10 A. Oh, goodness. What her antibiotic course
 11 was, let's ~~see~~ if I wrote that down. She was on
 12 Bactrim initially and she was switched to
 13 Ciprofloxacin, Cipro, after the cultures because the
 14 agents that they cultured were evidently more sensitive
 15 to the Cipro.

16 Q. Was ~~the~~ Cipro effective in treating her
 17 urinary tract infection?

18 A. Yes, I presume it was effective.

19 Q. Why do you presume that?

20 A. Well, because at least for the three weeks
 21 after her hospitalization where she was evaluated, she
 22 was not running temperatures and it continued and they
 23 continued her on treatment.

24 Q. So the treatment ~~was~~ effective because
 25 after 10-7-91 she had no temperatures?

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1 A. Oh, I think her temperature at the time of
2 discharge was 98.9.

3 Q. And then you're presuming because of the
4 four or five temperatures we have during the month of
5 October that you're aware of that she was not running
6 temperatures?

7 A. Would you do me a favor? On every case
8 like this would you call up Blue Cross/Blue Shield and
9 ask them if we can keep the patients longer? You can't
10 do it. You can't do it. You don't look at a case like
11 this and necessarily keep them in the hospital until
12 every electrolyte and everything else is
13 hemodynamically perfect. You can't do that.

14 Q. They won't let you do that, Doctor?

15 A. Oh, absolutely not.

16 Q. Why not?

17 A. Because it's not necessary and they won't
18 pay for it. That's what they're trying to do. That's
19 what you're reading about in Congress. They won't
20 allow that.

21 In fact, the real question here is today could
22 you admit this patient. Probably not. You'd probably
23 have to treat this patient as an outpatient. We treat
24 lots of urinary tract infections as outpatients. The
25 main reason she was admitted was she was new to the

1 A. Yes.

2 Q. Do you feel that the Ciprofloxacin cleared
3 up her problem during the first admission?

4 A. In a situation like this, and, again, I'd
5 want ID people to talk about this and a urologist, the
6 best you're going to do in a person like this is
7 control the bacteria. You're not going to cure this
8 patient. This is a damaged bladder. You're going to
9 continue to have a chronic recurrent infectious
10 process, which has been her course before she came here
11 and continued to be her course. That's just the
12 problem that you have. This was a sick lady. She was
13 run over in Russia four months before, and it's a
14 shame.

15 Q. Did the Ciprofloxacin treat her Urinary
16 tract infection? Did it treat her Urinary tract
17 infection problem on the first admission?

18 A. I think that it seemed to work reasonably
19 well given the follow-up. This is a woman that had
20 culture stuff out of her urine probably all the time.
21 I think other people more expert in that area that have
22 been called into this case would agree with that.

23 The situation is that -- I mean, there's
24 bacteria in the urine even in a normal bladder. But in
25 a situation like this, it's going to be an ongoing

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1 country, she had mechanical problems with the bladder.

2 So if this was a woman coming in with this fever
3 curve and no bladder problems, she would be treated as
4 outpatient. In Minnesota she would tell them her
5 temperature curve, speak to the nurse, the nurse would
6 speak to them over the phone and treat her with an
7 antibiotic after talking to the doctor.

8 Q. And that's what you view as the problem
9 with the health system today?

10 A. Well, that's one of the problems. The
11 other problem is that it costs \$900 billion a year and
12 the system can't afford it because of the kind of thing
13 that we're getting into here. And you can't keep this
14 patient in the hospital. There's no reason to keep
15 this patient in the hospital, and, believe me, they
16 wouldn't pay for it.

17 Q. Well, would you have liked to follow her
18 temperatures for another day if Blue Cross/Blue Shield
19 had permitted or would you want to follow it on an
20 out-patient basis?

21 A. I leave that up to the decision of her
22 interns. I am a neurologist. My view of the case as a
23 neurologist looking at this discharge is that there was
24 nothing inappropriate about this discharge, nothing.

25 Q. Well, she was treated With Ciprofloxacin?

1 problem and you're probably fighting a maintaining
2 battle, hopefully, until you can get the catheters out
3 of her and, hopefully, until that fistula closed up.

4 Then once you establish normal anatomic integrity in
5 the bladder, you might have a chance to stop the
6 recurrent infections.

7 Q. So you're saying she had a temperature of
8 99.9 on discharge?

9 A. Yes.

10 Q. And that's an indication to you that Cipro
11 had --

12 A. It appears to have worked. Plus I have
13 added proof in the fact that she had subsequent visits
14 in October to different clinics seeing different
15 physicians and has normal temperatures.

16 Q. And the fact that Ciprofloxacin brought
17 her temperature down to 98.9 and brought it under
18 control throughout the following period until things
19 got bad again in the month of October indicates that
20 Cipro had worked during this first admission?

21 A. Either that or she got better in spite of
22 it. They did what was appropriate. They cultured her
23 Urine. It was sensitive, the agents that grew out.
24 They made a change from Bactrim, which she was on
25 before, to Cipro because that was the right thing to do

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

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

9 BY MR. ABAKUMOV

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

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

17 Q. What's the count on that one?

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

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

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

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

1 A. It doesn't make a difference.

2 Q. Well, you're making the distinction.

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

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

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

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

16 A. Yes.

17 Q. Actually it's from the Foley catheter?

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

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

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

25 Q. Is that what it was on the first

1 admission?

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

9 Q. Well, this was in her bladder.

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

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

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

23 A. Evidently.

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

25 A. **Sure**.

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

3 A. Yes.

4 Q. The fact that she had a **urinary** tract
5 infection?

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

8 Q. Elderly?

9 A. Elderly, yes, all **those things**.

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

15 A. I don't believe so.

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

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

20 Q. If I represent that to you, you wouldn't
21 disagree with that?

22 A. No.

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

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

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

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1 you do what **needs to be done and try not to do any**
 2 more.
 3 Q. And not any **less**?
 4 A. **No**, of course not any less.
 5 Q. Doctor, if Freyda Kaplan came -- well, she
 6 **did come** to you **and** she complained of confusion, fever,
 7 headaches. Would you send **her** to the urology clinic at
 8 that point or -
 9 A. **When I saw her in the hospital?**
 10 Q. Yes. Would you send **her** to urology?
 11 A. Of course not.
 12 Q. What if you saw her **as** an outpatient in
 13 your office here?
 14 A. **Well, if she came** in my office **as an**
 15 **outpatient on a gurney, no.** I would immediately **admit**
 16 **her to the hospital.**
 17 Q. What if she walked in with the assistance
 18 of her daughters holding her up and complained of that,
 19 would you send her to the urology clinic?
 20 A. It would depend **on the circumstances.** **As**
 21 a neurologist, it isn't **very often that we refer to**
 22 urologists **on outpatients.**
 23 Q. If you had seen Freyda Kaplan on
 24 October 30, would you have sent **her** to urology **if** she
 25 came up to you through the Russian Clinic complaining

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1 of fevers and headaches; would you have sent **her** to
 2 urology?
 3 A. **No. If Mira** Baron had asked **me to see**
 4 her, I would **have not** referred **her** to urology. **I would**
 5 have either referred her **back** to **Mira** Baron, which is
 6 probably what I would have done. Again, I can only
 7 speculate what I would have told her to **do or suggested**
 8 that she do, and that would have **been her decision as**
 9 **the** primary care physician.
 10 Q. Did you train --
 11 A. In fact, it would be inappropriate to
 12 refer **her** to a urologist if she's referred **to me as a**
 13 consult from another physician.
 14 Q. Did you train Dr. Mira Baron?
 15 A. Yes.
 16 Q. For how long?
 17 A. **Three years I was involved**
 18 Q. Take a look at your October 30 --
 19 A. That's why **she checked the neck.**
 20 Q. Take a look at your October 30 note, Mira
 21 Baron's October 30 note. Where does it say mild
 22 confusion there?
 23 A. It doesn't.
 24 Q. Did you put that word in on your own?
 25 A. **No.** I said -- **What it says is -- Well,**

1 maybe I misspoke. I was talking in the examination.
 2 She lists hematuria, fever, weakness, confusion started
 3 after patient was prescribed Cipro by her urologist I
 4 suspect.
 5 Q. Where did the word mild come from? I
 6 wrote that down when you said it.
 7 A. I don't know that I said mild. Did I? It
 8 doesn't say mild here. It just says confusion.
 9 Q. Now, Doctor, do you put or did you put
 10 into Freyda Kaplan's notes conjecture or information
 11 that you found and was somehow established to you
 12 scientifically or through history?
 13 A. I'm not sure of your question.
 14 Q. Do you often put things into the medical
 15 records which are conjecture in your practice as a
 16 physician?
 17 MR. MURPHY: objection.
 18 A. You mean do I conjecture in medical
 19 records?
 20 Q. Yes.
 21 A. Oh, of course.
 22 Q. Given the fact that you trained Mira Baron
 23 and, I guess, you associate with her here regularly at
 24 Mt. Sinai Medical Center, do you feel you can be fair
 25 in this case in stating what happened here?

1 further.
 2 MR. ABAKUMOV I'll object to
 3 that last statement. We'll move to strike
 4 any of your expert opinions.
 5 ---
 6 (DEPOSITION CONCLUDED AT 2:15 P.M.)
 7 ---
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1 A. Sure, absolutely. There's no question
 2 about it.
 3 Q. And you have no doubt in your mind that if
 4 you felt that she or anyone else here that we've
 5 mentioned did anything wrong, you wouldn't have any
 6 problem saying that they operated below the standard of
 7 care?
 8 A. The only thing that I would do is, as any
 9 physician would do, if I felt that I was going to be
 10 biased because of personal reasons, I would excuse
 11 myself from the case. I wouldn't lie for another
 12 doctor. I don't get paid to lie.
 13 MR. ABAKUMOV: okay. I don't
 14 have any further questions, Doctor.
 15 FURTHER CROSS-EXAMINATION
 16 BY MR. SUMNER:
 17 Q. Doctor, you're licensed in the State of
 18 Ohio?
 19 A. Yes.
 20 Q. And you spend greater than 50 percent of
 21 your professional time in the active clinical practice
 22 of medicine or the teaching of medicine in an
 23 accredited institution?
 24 A. Correct.
 25 MR. SUMNER I have nothing

1 STATE OF OHIO } ss:
 COUNTY OF CUYAHOGA
 2 CERTIFICATE
 3 I, BARBARA A. OSER, a Registered
 4 Professional Reporter and Notary Public within and for
 5 the State of Ohio, duly commissioned and qualified, do
 6 hereby certify that the within-named witness, MICHAEL
 7 W. DEVEREAUX, M.D. was by me first duly sworn to tell
 8 the truth, the whole truth and nothing but the truth in
 9 the cause aforesaid; that the testimony then given by
 10 him was reduced to stenotypy in the presence of said
 11 witness, and afterwards transcribed by me through the
 12 process of computer-aided transcription, and that the
 13 foregoing is a true and correct transcript of the
 14 testimony so given by him as aforesaid.
 15 I do further certify that this deposition was
 16 taken at the time and place in the foregoing caption
 17 specified.
 18 I do further certify that I am not a relative,
 19 employee or attorney of either party, or otherwise
 20 interested in the event of this action.
 21 IN WITNESS WHEREOF, I have hereunto set my hand
 22 and affixed my seal of office at Cleveland, Ohio, on
 23 this 18th day of July, 1994.
 24 Barbara A. Oser, RPR, Notary Public in
 25 and for the State of Ohio.

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