ORIGINAL

IN THE STATE OF OHIO

IN THE COURT OF COMMON PLEAS IN THE COUNTY OF CUYAHOGA

JOANNE JEFFERS,

Plaintiff,

Doc 168

v. CASE NO. 235970

SOUTHWEST GENERAL HOSPITAL, et al.

Defendants.

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The Deposition of FRANCIS ROBERT FEKETY, JR., M.D., taken pursuant to Notice in the above-entitled cause at U of M Hospital, in the city of Ann Arbor, Michigan, on Wednesday, August 18, 1993, commencing at or about 10:00 a.m., before Richard L. Nizza, CSR-2344, a Notary Public, in and for the County of Washtenaw.

APPEARANCES:

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Appearing on behalf of Plaintiff.

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Appearing on behalf of Defendant Southwest General Hospital.

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Appearing on behalf of Defendant Dr. Banaga.

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Appearing on behalf of Defendant Dr. Binder.

I N D E X

E X H I B I T S

None

Ann Arbor, Michigan
Wednesday, August 18, 1993
At or about 10:00 a.m.

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F R A N C I S R O B E R T F E K E T Y, J R., M.D.,
a witness herein, was first duly sworn by the Notary Public to tell the truth, the whole truth and nothing but the truth, testified as follows:

EXAMINATION

BY MR. MELLINO:

Q. Would you state your full name, please, Doctor?
A. I'm Francis Robert Fekety, Junior.
Q. And what's your business address?
A. 3116 Taubman Health Center at the University of Michigan Hospital in Ann Arbor, Michigan 48109-0378.
Q. And what is your current position?
A. I am chief of the Infectious Disease Division in the Department of Medicine, and chief of the Infectious Disease Service of the University of Michigan Hospital, and professor of internal medicine.
Q. How much of your professional time do you spend seeing patients?
A. Probably sixty to seventy percent.
Q. Okay. And do you have a private practice where you see patients in an office setting?

A. I see patients in the clinic, but I don't have a private practice independent of the department of medicine's medical professional service plan.
Q. What hospitals do you have privileges at?
A. University of Michigan Hospital, Ann Arbor Veteran's Hospital.
Q. When you admit patients to the hospital with otitis media, what drugs do you prescribe?
A. There's no simple answer to that. It depends on a whole host of factors.
Q. What is the answer, regardless of whether it's simple or not? What are the drugs that are used to treat otitis?
A. Well, when a patient is admitted to the hospital, if we're assuming the patient is admitted because of the otitis media, we start them on parenteral antibiotics, either intramuscular or intravenous. And we might use Timentin or Unasyn or Ciprofloxacin, Penicillin G, Ampicillin, high doses of those usually. That's the most frequent ones I use, I guess.
Q. Okay. And if you gave those drugs in high doses as you indicated, would those also be effective in treating meningitis if the patient also had that?
A. Let's see. If the patient had meningitis, I might

treat them a little differently.
Q. Maybe you didn't understand my question.
A. Okay.
Q. If you didn't know they had meningitis, you thought they had -- I mean, they had otitis media, and that's all you were treating --
A. Right.
Q. -- would the drugs that you mentioned in your previous answer, would those also be effective in treating meningitis?
A. Some of them would be.
Q. Which ones?
A. Ciprofloxacin specifically, of the ones I mentioned. Probably Unasyn. I can't remember the others. Oh, high dose Ampicillin or Penicillin. It would depend on what you thought was the cause of the meningitis.
Q. What if it was streptococcus pneumonia that was the cause of the meningitis?
A. Then the ones I mentioned are the ones I would use.
Q. Those would be effective?
A. Should be.
Q. So, even if you didn't know there was meningitis and you're just treating the otitis media, those drugs would be effective treatment against the meningitis

also?
A. If it was pneumococcal meningitis.
Q. Okay. Ciprofloxacin is not an appropriate drug to give to treat otitis media, is it?
A. Oh, it can be used to treat otitis media. I don't know whether it's approved for that or not, but it covers some of the organisms that cause otitis media, specifically omphalos, which is one of the most common causes of otitis media.
Q. What about streptococcus pneumonia?
A. It's not considered a good drug for treating pneumococcal meningitis.
Q. Do you feel in the case of Mr. Jeffers that it was appropriate to give Ciprofloxacin to treat otitis media?
A. Well --

MR. MARKWORTH: Objection. Go ahead.

THE WITNESS: It's retrospective. It could be that the doctor was worried about pseudomonas otitis for which it would be the drug of choice.

BY MR. MELLINO, CONTINUING:
Q. What's pseudomonas otitis?
A. Pseudomonas is a fairly uncommon cause of otitis seen particularly in diabetics, and there are a number of antibiotics you could use, but Ciprofloxacin could be

used and is used intravenously to treat pseudomonas otitis.

Q. So, do you feel it was an appropriate -- it would be an appropriate choice of drug to give a patient such as Mr. Jeffers?

A. If he had pseudomonas otitis or --

Q. Well, he --

A. -- omphalos otitis.

Q. Did he have any of those?

A. No, I don't think so.

Q. All right. And he wasn't diabetic, was he?

A. Well, he actually might have been. His blood sugars were elevated.

Q. Do you have an opinion on that?

A. Well, he may well have had diabetes, but I don't think that was known before he came to the hospital.

Q. Did you find any evidence in your review of the materials that anybody thought he had diabetes?

A. Not that I can recall.

Q. Okay. Did you see any evidence in anything you reviewed that anybody thought that he had pseudomonas?

A. Well, I believe Doctor Binder made a diagnosis of malignant otitis externa. And when you make that diagnosis, pseudomonas is the organism to worry about;

not the only one but the most important one to worry about.

Q. Did he have malignant otitis externa?

A. I don't know. He might have, actually. It would be sort of unrelated to the whole sequence of events, but he might have.

Q. What evidence did you see that he might have?

A. Well, you'd have to have a careful examination of the external ear canal, usually in a way that's done by an ear, nose, and throat specialist to pick up that diagnosis, especially early. The findings are very subtle.

Q. Did Doctor Binder make that diagnosis?

A. I don't think he did. He suspected it, I guess, before the patient was admitted to the hospital, but he never established that diagnosis as far as I could tell.

Q. Do you have an opinion based on reasonable medical certainty whether he had malignant external otitis?

A. I do. I don't think he did.

Q. What did you review in this case?

A. All these records, the hospital record, a lot of depositions, some letters from some of the experts. Would you like to see them?

Q. Sure. This is everything you reviewed?

A. As far as I know, yes.
Q. Is this your entire file?
A. Yes.
Q. Has anything been removed from here?
MR. MARKWORTH: Correspondence from counsel.
BY MR. MELLINO, CONTINUING:
Q. Anything else?
A. No.
Q. Is this your note on Jenny Knopf's deposition?
A. Yes, that's my writing.
Q. Okay. Why did you want to know when the Cipro was actually given?
A. Well, I wondered whether it had ever been given.
Q. Why was that important to you?
A. Well, because I wondered whether she'd actually gotten any antibiotics that might have helped her.
MR. MARKWORTH: Him.
BY MR. MELLINO, CONTINUING:
Q. Did the Cipro help him?
A. Doesn't look like it.
Q. Did he get it?
A. Yes.
Q. I just want to put on the record what you reviewed. You have the deposition of Mary Kloetzly, Randolph

Bird, Doctor Prasad, Jenny Knopf, Doctor Jones, Doctor Binder, Joanne Jeffers, Mary Jane Berardi, Doctor Banaga, and the Southwest General chart, the autopsy report, Doctor Craguarilo's report, Doctor Kirkwood's report, Doctor Frank's report. Nurse Reedy's report, Doctor Pasadaro's report. Doctor Conen's report, and the Complaint. That's everything you reviewed in this case?

A. Yes.

Q. Did you review any articles in the medical literature?

A. No.

Q. Have you written any articles which you feel are relevant to this case?

A. It's a broad question. I've written a lot of articles, textbook chapters. I don't think I've ever written an article on pneumococcal meningitis if that's what we'll say is relevant to this case.

Q. What's your experience been in acting as an expert witness in a medical malpractice case?

A. You mean how extensive is it?

Q. Yeah. How many times have you done it.

A. Oh, well, I've testified in court maybe three or four times. I don't know how many depositions I've given. I never kept a record. It seems like it's maybe a

dozen or something like that. I've looked at a lot of cases.

Q. How many have you looked at?

A. Well, again, I don't keep records, but in the past ten years or so maybe fifty or sixty, most of them for defense and a few for plaintiffs.

Q. How many times have you given a deposition on behalf of a plaintiff?

A. I've never been asked to do that after reviewing the records of plaintiff's cases.

Q. Have you ever reviewed a case for a plaintiff and said that there was a case?

A. I don't think so.

Q. I would assume then that all the three of four times you testified in court were for a defendant?

A. Oh, yes.

Q. Okay. Were any of these cases -- did any of them involve meningitis?

A. I don't remember. I suspect some of the cases I reviewed were for -- because of meningitis. I don't think, off the top of my head, that I've ever testified in court in a meningitis case.

Q. Where did you testify in court?

A. Well, let's see. Once in Lansing; I forget the nature of the case. Once in Grand Rapids, and I forget the

nature of the case. And I can't remember any of the others.

Q. Have you ever testified for Mr. Markworth before?

A. Not to my knowledge.

Q. How about any member of his firm?

A. I don't think so.

Q. Do you know how he got your name?

A. No.

Q. Have you ever testified for anybody from the firm of Jacobson, Maynard, Tuschman and Kalur?

A. I haven't paid a lot of attention to the names here. Is that your firm?

Q. No.

A. Jacobson what?

Q. That's the firm that represents Doctor Binder.

A. No, I don't think so.

Q. How about Weston, Hurd?

A. Who?

Q. Weston, Hurd.

A. No.

Q. Have you ever testified in a case where the occurrence happened in Ohio?

A. No. Don't think so. I was involved with a case by the hospital in Columbus, but I don't think I ever had to go testify in court.

Q. Do you know who retained you in that case?
A. No. Not off the top of my head.
Q. How long ago was that?
A. A couple of years ago.
Q. Were you reviewing it for the hospital or for a doctor?
A. Actually, for a doctor, and then -- then I've subsequently been asked to review it for the hospital.
Q. Is this a case that is currently pending?
A. Yes.
Q. Have you had your dep -- you haven't had your deposition taken in that case?
A. Not on the one for the hospital. It was taken for the one for the doctor. It's the same case.
Q. I see. Do you know who the attorney was that took your deposition?
A. No.
Q. How long ago was your deposition taken?
A. A couple of years ago.
Q. Do you know the name of the case?
A. I can't remember the name of the plaintiff, but I do remember the name of the defendant. And I think that's privileged information, which I'd rather not give up if I don't have to.
Q. Why do you feel that's privileged?

A. Because I don't want to do anything that might harm the reputation of a physician.
Q. All right. Well, you have -- obviously you have cases currently pending, and somewhere you have the name of this case.
A. Oh, yes.
Q. So, you could produce it if you were ordered to by a court?
A. Oh, yes.
Q. What do you feel your role is as someone who is reviewing records and to act as an expert witness?
A. What do I feel my role is?
Q. Right.
A. Well, to look at it from my particular area of experience and decide whether any kind of actions were taken that were beneath the standard of care for the physician and hospitals involved or not, to give an honest opinion to the person who asked me to review the case about my findings.
Q. How do you define the standard of care?
A. It seems to be a matter of judgment and experience, I guess. I can't find a book where you look it up. It's what the average physician of that type in a similar community would probably do.
Q. And what were you asked to specifically do in this

case?

A. Well, I was asked to review all these records with particular emphasis upon the -- Doctor Banaga's involvement in this case.

MR. MARKWORTH: Banaga.

THE WITNESS: Excuse me, it's written wrong on this report. I apologize for that. That's how I've gotten that. Banaga.

BY MR. MELLINO, CONTINUING:

Q. Were you able to form an opinion as to whether or not Doctor Banaga met the standard of care?

A. Yes, I was.

Q. How were you able to formulate what the standard of care of a house physician was in this case?

A. Well, I've talked to a lot of house physicians, and I think I have a feel for it.

Q. Did you talk to him in connection with this case?

A. Oh, no.

Q. Have you yourself ever been a house physician?

A. Well, it depends how you define house physician.

Q. I mean somebody who's had a position at a hospital such as Doctor Banaga.

A. Well, you haven't defined what her position was. But as I understand her position, I have never been in that same position.

Q. Have you ever trained somebody in that position?
A. I don't train house physicians. I've trained a lot of people who've become house physicians.
Q. So, your understanding of the standard of care then is based on your conversations you've had with other house physicians, your standard of care as it relates to a house physician?
A. Based upon house physicians that I've been with as a visiting professor at their hospitals and talked to them about their cases and how they managed them, yes. That in addition to the other things you said.
Q. What other things?
A. You said have I ever been in -- well, you have to read it back to me, I guess. About how I got my feeling for what a house physician does. It was in the first part of your question. Something about in addition to speaking to them.

MR. MELLINO: Why don't you read back the question because I'm lost.

THE WITNESS: Yeah, I forgot it too. I'm sorry.

(Whereupon the last question is read back.)

BY MR. MELLINO, CONTINUING:
Q. So, are we saying the same thing; it's based on conversations you've had with house physicians?

A. I'm not sure that I consider a teaching interaction just a conversation. I guess I wanted to make it a little stronger than a conversation.

Q. Well, when you say teaching interactions, you don't -- do you teach house physicians? I thought you just said you don't train house physicians.

A. Well, I train house officers here at the University of Michigan.

Q. Those are residents you're talking about?

A. Right, interns and residents. And we don't have any house physicians at the University Hospital that have completed their training and work solely at night to cover attending physicians who are out of the hospital. We don't have any such persons here, but certainly I've trained thousands of house officers here at the University of Michigan.

Q. Do you consider those house officers or residents in training to be the same as Doctor Banaga's position at Southwest General Hospital as you understand it?

A. No, it's different. It's clearly different.

Q. Okay. And you don't even have physicians such as Doctor Banaga, house physicians, at University of Michigan Hospital where you practice?

A. As far as I know, that's correct.

Q. Okay. Did you come to any conclusions about whether

any of the other -- any other physicians -- well, let me be more specific.

Did you come to any conclusions after reviewing material as to whether Doctor Jones adhered to the standard of care required of him?

A. I'm sorry. The name Doctor Jones doesn't --

Q. Doctor Jones was the emergency room physician that saw him the second time in the emergency room.

A. Yes, I did. I believe he acted within the standard for his position.

Q. How about Doctor Binder?

A. Well, I don't know what the standard is for an ear, nose, and throat specialist. I'm not an ear, nose and throat specialist. I don't know that I have the right to comment on his performance.

Q. Well, you're not a house physician either?

A. That's correct.

Q. Why is it you can comment on the conduct of a house physician and not on an ear, nose, and throat doctor?

A. Because an ear, nose, and throat doctor is trained in a specialty that I've not been trained in extensively, whereas house physicians have been trained to do the same kinds of things that I have done many times in my own training.

Q. Have you been taught how to treat meningitis and

otitis media?
A. Yes.
Q. So, as far as the care that was given in this case, you had the same training to treat Mr. Jeffers as Doctor Binder; would that be true?
A. I would have been comfortable treating this patient, yes.
Q. And do you still feel, even though you would feel comfortable treating Mr. Jeffers, that you can't comment on Doctor Binder one way or the other as to whether he met the standard of care?
A. Well, if you want to ask me something specific, I guess I can answer that. But I don't know what the standard of care is for an ear, nose, and throat specialist.
Q. How about --
A. I don't have a good feeling for that.
Q. Well, is there a standard of care for any physician that's treating a patient with the same presentation as Mr. Jeffers?
A. Well, different physicians, first of all, might treat this patient differently. But I think the standards are higher for one type of physician as compared to another. I think -- well --
Q. Do you think there's a different standard of care in

this case for Doctor Jones and for Doctor Banaga and for Doctor Binder, each of them have a separate standard of care?

A. Well, it's my understanding that's the way the law looks at it. They're different.

Q. Well, what about a physician?

A. Pardon?

Q. What about from a medical standpoint? You're not going to be giving legal opinions in this case, I assume.

A. Well, I thought you wanted my opinions.

Q. I'd like them from a medical standpoint, though, as opposed to a legal standpoint.

A. Okay. What was the question now?

Q. Was there a different duty for each physician involved in this case?

A. I assume so, yes.

Q. And why is that?

A. That's a legal question. I don't know the answer to that. I think we generally demand more of people who are well trained in a certain area than we do of people who are more general. I certainly would think that the standards for an emergency room physician might very well be higher than they would be for a house physician in handling this kind of a case. I'm

not sure, but that's my opinion.
Q. Is it fairly common knowledge in the medical field that otitis media can turn in to meningitis?
A. Yes.
Q. What stage of your medical training would you learn that?
A. Well, in the United States you learn that when you are a medical student in the third and fourth years and as an intern.
Q. What are the clinical signs and symptoms of meningitis?
A. Fever, headache, disorientation, stiff neck, confusion, malaise, perhaps chills.
Q. Nausea and vomiting?
A. Yes.
Q. Photosensitivity?
A. That's sometimes seen in meningitis. It's not specific for it.
Q. Would you consider an unrelenting headache --
A. Well, I mentioned headache.
Q. You would consider that a sign of meningitis?
A. That's one of the things you see in meningitis. It's certainly not specific for meningitis.
Q. If a person had an unrelenting headache, nausea, vomiting, photosensitivity, and a glucose cytosis and

an inability to put his chin to his chest due to pain in his spine, would you consider that clinical evidence for meningitis?

A. Are you talking about this patient or hypothetically here?

Q. Well, what difference would it make?

A. Well, I'm not sure this patient had all those things.

Q. I see. Okay. Well, then hypothetically assume that a patient had those symptoms.

A. All right. What was the question?

Q. Would you consider that clinical evidence for meningitis?

A. It would suggest the possibility of meningitis. It certainly would not make the diagnosis. It's insufficient evidence for the diagnosis of meningitis.

Q. Which one of those symptoms aren't you sure that he had?

A. His inability to put his chin to his chest.

Q. And what makes you unsure about whether he had that or not?

A. Well, because the only thing that's in the records that suggest that was present was a nurse's observation, and two or three doctors had examined the patient and hadn't found that.

Q. And do you find the doctors -- well, I assume then you do find the doctors' findings inconsistent with the nurse's finding of the inability to put the chin to the chest?

A. No, I don't, because -- I don't find them inconsistent because I don't know exactly what the nurse asked the patient and exactly what the patient said when he replied. It's too subjective. It's not objective enough.

Q. So, what do you do with that information as you review it?

A. You examine the patient to see whether the neck is supple, whether they can touch their chin to their chest.

Q. And you're assuming that that was done in this case in order to give your opinion?

A. It was so recorded as having been done.

Q. Where was that recorded, sir?

A. In Doctor Banaga's note.

Q. Could you show it to me, please, where she recorded that she put his chin to his chest?

MR. MARKWORTH: The question was neck supple.

THE WITNESS: Right.

MR. MELLINO: That wasn't the question.

MR. MARKWORTH: Yes, it was.

BY MR. MELLINO, CONTINUING:

Q. Did she record that she put his chin to his chest, sir?

A. The way you determine whether the neck is supple is you put the chin to the chest. So, I believe that she did that.

Q. If she didn't do that, did she fall below the standard of care required of her?

A. She did it. It's right here in the notes she dictated. She said the neck was supple.

Q. So, if she didn't do it -- the question was, if she didn't do it, did she fall below the standard of care required of her?

A. You mean if she put down something that was a lie, is that below the standard of care?

Q. No. If she didn't put Mr. Jeffers' chin to his chest?

A. Then she wouldn't be able to say it was supple.

Q. Can you answer my question, sir?

A. Well, if I don't -- I don't exactly understand it, but please say it again.

Q. Sure. If Doctor Banaga did not put Mr. Jeffers' chin to his chest, was she below the standard of care? Was she negligent in this case?

A. If we assume that your hypothetical is true, then she would be below the standard of care.
Q. Okay. How do you make the diagnosis of meningitis?
A. Lumbar puncture is the usual way. Spinal tap.
Q. And would a patient who had unrelenting headache, nausea and vomiting, photo sensitivity, a leukocytosis, and an inability to put his chin to his chest need a lumbar puncture?
A. Is this another hypothetical because you said he couldn't put his chin to his chest. I would probably do a lumbar puncture.
Q. So, if he had all these symptoms at the time that Doctor Banaga examined him, then she should have done a lumbar puncture?
A. Well, she probably wouldn't have wanted to do it right away. She probably would have wanted to do a CAT scan first.
Q. I didn't ask about specific time frame in the question.
A. Okay. If all those things are true, and I don't think they were, then she should have done a lumbar puncture or gotten somebody else to do it. Somebody should have done it.
Q. Okay. And the standard of care would have required that?

A. Yes.
Q. And you -- I think you were about to tell me that she may have wanted to get a CT scan before she did a lumbar puncture? Was that the point you were going to make?
A. Yes.
Q. And if she were going to do that, should she have covered him with antibiotics pending the CT scan?
A. Not necessarily.
Q. The standard of care wouldn't have required that?
A. No, I don't think so. First of all, it all depends on how long it's going to take to get the CT scan. There is the factor that the patient was -- had already been prescribed antibiotics so she would have had to change the antibiotics if she was going to do something different. And it also depends on how the general appearance of the patient is to whether you feel it's urgent to give antibiotics or whether you want to wait.
Q. If you were going to wait to do a lumbar puncture and do a CT scan first, should you do the CT scan on a stat basis?
A. It all depends on the patient's clinical condition. It's not mandatory to do the CT scan on a stat basis. The patient was getting some antibiotic.

Q. I thought you said before the antibiotics weren't doing him any good?
A. Well, we didn't know that this was pneumococcal meningitis at this point. It's retrospective. This probably would have been good therapy for meningococcal meningitis, maybe omphalos meningitis. So, given the hypothetical that we have information that we don't have when she did this.
Q. Well, isn't that one of the reasons you do a lumbar puncture so you can determine what kind of meningitis it is?
A. Only if you think the patient has meningitis.
Q. How much do you charge for reviewing records?
A. I charge four hundred dollars an hour for everything I do record, record reviews, depositions, testifying in court. Actually, I charge more than that now because I'm trying to get out of this business, but I think that's what I agreed to charge you.
Q. What do you charge currently?
A. Five hundred dollars an hour.
Q. And you charge five hundred dollars an hour because you're trying to get out of the business?
A. Right. There's a lot of people who don't want my services when they hear that.
Q. Do you think Mr. Jeffers was critically ill at the

time Doctor Banaga examined him?
A. No.
Q. Do you agree that he had an unrelenting headache that was unrelieved with narcotics at the time she examined him?
A. Let me look at what she wrote, okay? Well, certainly nowhere does it he say had an unrelenting headache, and she doesn't indicate that he had a headache when she saw him because he was asleep and when she aroused him, he was in no distress.
Q. So, you don't agree with that then?
A. I think he had a headache as part of his illness, but I think it's exaggerating it to say that it was an unrelenting headache.
Q. I see. How about -- well, when she saw him, did he have a history of having an unrelenting headache?
A. I never saw the word unrelenting anywhere in the records. He'd had headache intermittently.
Q. What about severe headache? Would you agree with that characterization of it?
A. I don't see the word severe anywhere. Would you want to define it?
Q. No.
A. Okay.
Q. Do you use that word?

A. Severe?
Q. Yes.
A. Yeah, but I'm not necessarily using it the way you do.

Q. I see. So, you wouldn't agree that he had a severe headache?
A. No. I would say he had a significant headache as part of his illness.
Q. How about a history of nausea and vomiting?
A. Yes, he did. He had that over several days.
Q. How about photosensitivity?
A. A few people have mentioned that. Photophobia.
Q. Over what period of days did he have nausea and vomiting?
A. Well, I think he had it -- I noticed somewhere that he had it on the 2nd of May. He may have had it earlier than that. He had it off and on for a couple days. It might have been a side effect from Erythromycin. That's another antibiotic that he got.
Q. And he did have an elevated white blood count?
A. Twenty-seven thousand two hundred as I recall, yes.
Q. Is that pretty high?
A. It's what you see with a bacterial infection very commonly.
Q. But you wouldn't characterize it as critically ill?

A. No. His blood pressure is normal, his pulse is normal, he is oriented, easy arousable, able to sleep, and in no distress --

Q. According to Doctor Banaga?

A. -- according to Doctor Banaga's note.

Q. All right. What about Nurse Knopf's note?

A. Well, you'll have to either show me what you're talking about specifically or --

Q. Well, she did an assessment of him; do you recall that?

A. Right, I did, but I can't remember exactly what she said in terms of the wording. I don't remember that she said he was critically ill.

Q. Based on her assessment of him, would you characterize him as critically ill?

A. I did not get the impression from reading her notes that he was critically ill, but maybe I didn't -- maybe I don't have a good memory on that.

Q. Well, you can refer to it, it's not a memory test, if you want to look at the nursing assessment.

A. I was hoping you would tell me what she said so I wouldn't have to hunt for it.

I'm looking over the systems assessment. I would say that this is not a patient who is critically ill.

Q. If you had a hypothetical patient that had an unrelenting headache and nausea and vomiting and photophobia and an inability to put his chin to his chest and an elevated white blood count, twenty-two thousand, would you consider that patient to be critically ill?

A. Not necessarily. No, not at all. I've seen a lot of patients like that that are not what I would call critically ill.

Q. Did Mr. Jeffers have meningitis at the time Doctor Banaga saw him?

A. That's a good question.

Q. Do you have an opinion based on a reasonable medical probability whether he did or not?

A. I do.

Q. What is your opinion?

A. I believe he did not. More likely than not did not have meningitis at that moment.

Q. And what is that based on?

A. Just on my gut reaction. He was easily aroused, he was able to sleep. His CAT scan was -- in terms of the central nervous system obtained some hours later after Doctor Banaga saw him, was not alarming. You don't make a diagnosis of meningitis on a CAT scan. But there was nothing alarming on that x-ray, whereas

the one done on the next day was very, very much different. And I suspect that some time after she saw him his otitis media progressed to meningitis, but I can't be sure about that. I'd say more likely than not, however, that's the way it happened.

Q. If he was receiving the appropriate antibiotic for otitis media, would that -- that would have prevented the otitis from progressing into meningitis, wouldn't it?

A. Probably.

Q. What is your expertise in radiology or neuroradiology?

A. I'm real good at reading their reports.

Q. Not too good at reading the films though?

A. No.

Q. Okay.

A. I might read the films, but I don't call myself an expert.

Q. Well, do you know what the time lag is for any brain injury to show up on a CT scan?

A. I don't know how to answer that question. You mean like if you got hit on the head, how long would it take to --

Q. No. Like if you had meningitis and then you had a CAT scan taken later on, how long would it take to show up

on a CT scan?

A. You have to go on my experience now, please. I don't know of any patient I've ever seen with meningitis who had a negative CAT scan and then later had an abnormal one as the meningitis progressed. I think that every patient I've seen with meningitis -- and my experience is sort of limited, not because of numbers but, you know, we've only had CAT scans for, I don't know, eight years or something. Every patient I've seen with meningitis who had a CAT scan, they had some evidence of cerebral abnormalities when I first saw them, first saw the CAT scan.

Q. How many of those patients died?

A. I don't know. A lot of them. Meningitis is a very serious disease. Even when treated correctly, there's a mortality rate of between ten and forty percent.

Q. Do you have an opinion on what Mr. Jeffers' mortality rate was?

A. Well, he died. What are you asking me?

Q. If it had been properly treated?

A. I don't know. I hadn't really thought about that. He might very well have gone on and died anyway.

Q. Really?

A. Yep.

Q. What's the mortality rate for otitis media?

A. It should be zero.
Q. So, if he had gotten the proper treatment by Doctor Banaga, he wouldn't -- his mortality rate was zero then?
MR. MARKWORTH: Objection. There's never been any statement by this witness that Doctor Banaga gave improper treatment. The question assumes that there was improper treatment. The question assumes that the proper treatment was something other than this witness has ever testified to.
BY MR. MELLINO, CONTINUING:
Q. If Doctor Banaga had properly treated his otitis media, his mortality rate was zero, correct --
MR. MARKWORTH: Objection.
BY MR. MELLINO, CONTINUING:
Q. -- in your opinion?
A. Well, I'm having trouble answering that because he got treatment with good antibiotics before he came to the hospital. He had Erythromycin and then Augmentin. Both of those are respectable treatments for otitis media. Doctor Banaga did not write any orders for treating this man's otitis media.
Q. At the time Doctor Banaga saw him he was not getting respectable treatment for otitis media, was he?
A. Oh, I didn't say that Cipro wasn't good for otitis

media. It's not good for meningitis.
Q. Well, it's contra-indicated for meningitis, isn't it?
A. I don't know that it's contra-indicated.
Q. You don't?
A. It just doesn't -- doesn't work very well in meningitis. It doesn't get over in to the spinal fluid.
Q. Well, doesn't it cause central nervous system depression, Doctor?
A. Oh, well, it does have CNS side effects.
Q. That wouldn't be good to give somebody that had meningitis, would it?
A. If you knew they had meningitis.
Q. Or if you should know they had meningitis?
A. I don't know how you would know they should know.
Q. Well, we -- can we agree that his otitis media was not properly treated in Southwest Hospital?

MR. MARKWORTH: Objection.

MR. SWITZER: Objection.

BY MR. MELLINO, CONTINUING:
Q. I mean, the antibiotic -- you already said the antibiotic he was given for his otitis media was no good to him; it didn't do him any good?
A. Well, that's because we know the diagnosis of pneumococcal meningitis here. They didn't know that.

Q. Why even for otitis media? They knew he had otitis media, correct? It wasn't doing his otitis media any good either, was it?

A. Well, they didn't know that it was pneumococcal otitis media. It would have been fine if it had been omphalos otitis, and omphalos is probably the most common cause of otitis media, and at any rate it was prescribed under -- by Doctor Binder for treatment of malignant otitis externa, I believe, and for that it is a very good treatment.

Q. Yeah, for something he didn't have?

A. Well, what do you want me to say to that? In retrospect, yes.

Q. Well, even at the time. I mean, is it your understanding in this case that the Cipro was given because of an external malignant, that being a possible diagnosis?

A. It was my understanding from reading the records that that was Doctor Binder's working diagnosis.

Q. And do you think that that -- do you think under those circumstances it's reasonable to give Ciprofloxacin?

A. For malignant otitis externa, yes. Yes.

Q. If there was no -- if the patient didn't have external otitis and that wasn't the differential

diagnosis, would Ciprofloxacin be the appropriate drug to give this patient?

A. I think I've already said no.

Q. Okay. Now, let's get back to my original question. If Mr. Jeffers had received antibiotics that were appropriate for the otitis media that he did have, he had a zero mortality rate in your opinion?

A. I never said that. I think he could have died anyway. Pneumococcal meningitis --

Q. Well, I thought you said he didn't have it at the time Doctor Banaga saw him.

A. I thought you were posing a hypothetical to me.

Q. Drug treatment is hypothetical.

A. You asked me if I thought he would have survived if he had gotten appropriate therapy, and I said not necessarily. People die with pneumococcal meningitis, even though you give them the right therapy, a lot.

Q. And then we progressed from that point, and I asked you if he had meningitis at the time Doctor Banaga saw him, and you said no. I asked you if he had received -- if he had given -- been given drugs for otitis media, that would have prevented the otitis media from turning in to meningitis?

A. No, not necessarily.

Q. That's not what you said the last time I asked you, but that's all right. That's why we take everything down.
A. Well, I think you asked me the first time about pneumococcal infection, and I got confused by your last question. People get meningitis occasionally while on appropriate therapy for otitis media.
Q. Well, the same organism was causing both the otitis and meningitis, correct?
A. Presumably. We don't have cultures from the ears as far as I know.
Q. Well, what's your opinion in this case based on a reasonable medical certainty?
A. I believe he had pneumococcal otitis media and pneumococcal meningitis.
Q. All right. So, if they had treated the organism, the pneumococcal organism causing the otitis media, it would have prevented the otitis from spreading into meningitis?
A. Not necessarily, but probably.
Q. Fine. Should a physician -- should a physician prescribe antibiotics over the phone without having examined the patient?
A. I don't believe they should, but it's done often. Common practice.

Q. And Doctor Banaga didn't think that he had external otitis, did she?
A. She diagnosed bilateral acute otitis media.
Q. Right.
A. Media, not external. So, she made the correct diagnosis based on her exam.
Q. And based on her examination and diagnosis -- well, what is your understanding of what her obligation was to contact the attending after she did an examination and diagnosis?
A. Well, I'm trying to read her mind and that's difficult to do. The attending had already prescribed antibiotics that are useful in some forms of otitis media, and I guess she felt the patient was not critically ill based on her exam, and I assumed she didn't feel any need to contact Doctor Binder.
Q. Well, I'm not really interested in what she felt. I want to know your opinion is as to what the standard of care required of her to the extent you can give an opinion on that.
A. I've already given an opinion. I think she acted within the standard of care for a house physician.
Q. Well, I'm trying to test that opinion a little bit.
A. Okay.
Q. That's my job here. So, I want to know what you feel

the standard of care required of her in terms of after she did the examination and she comes up with a diagnosis. Should she have contacted Doctor Binder?

A. Well, I said I didn't feel it was necessary that she contact Doctor Binder. I think that unless she felt the patient was clearly on a wrong antibiotic regimen, her duty would be to see how that antibiotic therapy worked.

Q. Okay. So, if she thought that the antibiotic was incorrect for his condition, then she should have contacted Doctor Binder?

A. If she thought that. I don't think she thought that because she didn't call him.

Q. All right. If she should have known that it was the wrong antibiotic for his condition, she should have called him also then too?

MR. MARKWORTH: Objection to form; assumption.

THE WITNESS: She did not know that this was pneumococcal at the time so she didn't know that it was the wrong antibiotic.

BY MR. MELLINO, CONTINUING:

Q. All right. The question really was, if she should have known that the antibiotic was wrong, then should she have called Doctor Binder?

A. Hypothetically, I think I've said this, if she knew that the patient is getting the wrong antibiotic, then she should have called him.

Q. What about if she came up with a different diagnosis than Doctor Binder's working diagnosis? Doesn't she have an obligation to call the attending at that point?

A. My reaction is that it's not the function of the house physician to call up the attending senior staff person and tell them they're wrong unless she feels that the patient's life or well-being was suffered by not doing that. So the answer is not necessarily should she have called him.

Q. Do you think that Mr. Jeffers' life or well-being suffered by her failure to call Doctor Binder in this case?

A. It's hypothetical, I guess. My opinion is that Doctor Binder might have said, well, we'll wait and see or he might have come in and decided that things were okay or he might have changed something. I don't know what he would have done, so I don't know how to answer that question.

Q. Your opinion that he didn't have meningitis, is that based on the assumption that -- I'm talking about at the time Doctor Banaga examined him now, your opinion

that he didn't have meningitis at that time, is that based on you're assuming that he didn't have an inability to put his chin to his chest?

A. It's based upon my -- in part upon my reading the finding of Doctor Banaga that his neck was supple, which is a different way of saying the chin to chest test, yes.

Q. What else is it based on?

A. Well, people with otitis media, they usually go on to get meningitis fairly late, after awhile, and when those patients get meningitis, it usually escalates very rapidly unless they're treated. So, reading the note of Doctor Banaga on the 4th, I think it is, this sounds to me like a patient who didn't -- who -- it sounds like a patient who could have had meningitis, but the evidence that's strong that this is meningitis was certainly not there.

Q. What would --

A. And so, I would say maybe if the patient had meningitis, it was early and not really diagnosable by clinical signs. You might suspect it, but this is not the usual findings of a patient with pneumococcal meningitis.

Q. This, you're pointing to Doctor Banaga's --

A. I'm pointing to Doctor Banaga's note on the 4th of

May.

Q. Do you think that Doctor Banaga was required to do a more thorough examination than the emergency room physician?

A. I guess I'd have to say not necessarily. Not necessarily. I don't know off the top of my head what exam the emergency room physician did. We don't do a complete exam on everybody. You can't.

Q. You don't do a complete exam on someone that's being admitted to the hospital?

A. We do. We do things, but we don't necessarily record them if they're negative so I --

Q. So, was she -- go ahead.

A. I would say that this exam as stated is within the standard for a house physician.

Q. As stated by who?

A. Me.

Q. Is that based on the -- her -- the chart alone?

A. That's the only thing I have to go on. I have all the notes.

Q. So, based on your review of her notes in the chart, you believe that that exam meets the standard of care?

A. Yes.

MR. MELLINO: I don't have any other

question for you, Doctor.

EXAMINATION

BY MR. HUPP:

Q. Doctor, my name is Steve Hupp. I represent Doctor Binder in this case.

Just so we're clear, you don't have any opinions on Doctor Binder's care in this case?

A. I wasn't specifically asked to render an opinion on his care.

Q. And the only opinions you have of Doctor Jones' care, the emergency room doctor, is that Doctor Jones met the standard of care in treating this patient?

A. Yes.

MR. HUPP: I don't have any further questions.

EXAMINATION

BY MR. SWITZER:

Q. Just a few questions, Doctor.

Is a supple neck finding inconsistent with a stiff neck?

A. Yes.

Q. And I take it that would also be inconsistent with a rigid neck?

A. Yes.

Q. Okay. Are rigid and stiff neck the same?

A. Not exactly.
Q. What's the difference, and simple?
A. It's a matter of personal usage, I guess. To me a rigid neck is one that's as stiff as a board, and not all meningitis necks are that stiff. Supple -- shouldn't get too involved with. Supple is the common jargon used by physicians to describe a neck that when looked at specifically for evidence of meningitis is negative for that evidence. It may be jargon but we all understand it.
Q. In your experience, Doctor, would a patient who is presenting as Mr. Jeffers presented on May 4, 1992 -- let's talk about in the morning -- know whether or not he had a stiff neck?
A. Would you repeat that again?
Q. I'll repeat it. I was going to ask him to read it, but I'll just repeat it.

Would a patient presenting as Mr. Jeffers presented in the early morning hours of May 4, 1992, would he know whether or not he had a stiff neck?

A. Mr. Jeffers?
Q. Yes.
A. Would he know, no, not in the medical sense, like a meningitic stiff neck.

Q. Okay. How about in the lay person sense?
A. Well, a lay person having --
Q. When he's exercising a lot or --
A. -- a stiff neck from osteoarthritis of the bones of the spine. He could have it from tensing of the muscles, the strap muscles of the neck. Because the patient has otitis his muscles tense and it's stiff and it hurts. There's a whole host of causes.
Q. Would any of the medications that Mr. Jeffers received from the time he was admitted to the hospital until approximately 4:30 p.m., okay, that's about --
A. The following afternoon.
Q. Yes. A sixteen hour time period, would any of those medications make him lethargic?
A. My recollection is that he got some Demerol.
Q. He had some morphine in the emergency room?
A. Right. That could make him lethargic, yeah. And then he got some --
Q. Compazine?
A. Yeah. Not Demerol. Anyway I was coming to the Compazine. Compazine could make him lethargic. And I think he got some Tylenol with codeine in it perhaps. That might contribute to it a little bit.
Q. Is one of the side effects of Cipro nausea and vomiting?

A. Definitely.
Q. That's also a side -- you mentioned --
A. Augmentin and Erythromycin can cause nausea and vomiting.
Q. How about Demerol?
A. Yes.
Q. We're talking about bacterial meningitis in this case, but let's assume that -- well, let's not assume anything. Are there different signs and symptoms if a patient had viral spinal meningitis as opposed to bacterial meningitis?
A. Basically they're very similar. Although patients with viral meningitis and, in fact, viral respiratory infections, in general, including viral otitis, commonly get photophobia, but really the only standard between distinguishing between them is the lumbar puncture.
Q. Would any of the antibiotics that you listed earlier as being appropriate to treat pneumococcal meningitis have had any effect on viral meningitis?
A. No.
Q. I take it the same would be true if it was a viral -- a virus that was causing the otitis media?
A. Correct.
Q. None of those antibiotics would have had any effect on

that?
A. Yes.
Q. The only way, I take it, that a physician would know one way or the other whether antibiotics would have any beneficial effect on a patient that he suspects has meningitis would be to perform a lumbar puncture and then determine what type of organism is causing the meningitis; is that correct?
A. I think -- yes.
Q. Are you going to offer an opinion in this case as to when it became apparent from Mr. Jeffers' clinical course at Southwest General Hospital that he did have meningitis based on probability?
A. Well, it sounds like he definitely had it in the afternoon around 4:30.
Q. Based on your review of the records, would that have been the appropriate time for a physician to diagnose meningitis in Mr. Jeffers without performing a lumbar puncture?
A. I think you still need to do a lumbar puncture. He could have had a brain hemorrhage or something that would have produced similar findings.
Q. Let's assume that antibiotics appropriate to cover the pneumococcal -- I guess it's what typically, streptococcus?

A. Streptococcus pneumonia, yeah.
Q. -- pneumonia organism that was causing Mr. Jeffers' meningitis, let's assume that he did receive appropriate antibiotics.
A. When?
Q. Let's make it one a.m.
A. Okay. When Doctor Banaga saw him?
Q. Yes. What is the time period or is there a range for when a patient receives the appropriate antibiotics intravenously and the time when those antibiotics would have a beneficial effect on the organism so that it would make it more likely or not that a patient would survive?
A. Well, it's highly variable and in part for two reasons. First, the pneumococcus -- which is what I call it because when I started out they didn't call it strep pneumonia -- the pneumococcus produces toxins that elicit some of the damage that you see in meningitis. And so, if you kill the pneumococcus right there quickly with antibiotics, those toxins are still there and producing damage. That's why some patients may go ahead and die even though you kill all the bugs.

And the second thing is the toxins and the presence of the organism cause the host -- cause

the host defense mechanisms to be turned on to fight that, and these host defense mechanisms, white blood cells and antibodies and products of lymphocytes and monocytes, they're marshalled to the site of the infection. Those defensive entities are like medicines that the body produces, and like any other medicine they have side effects, and, in fact, they may be why the patient dies. The over production of the these cyctocones results in the patient's death even though you -- you killed the pneumococcus.

I'm sorry for that being so long winded, but I think it's important to know that in this patient that the patient can go ahead and die even though you get the right antibiotics early.

Now, the pneumococcus is very susceptible to Augmentin, which this patient got, although vomited it up. The pneumococcus is usually very susceptible to Erythromycin, which this patient got on the outside. Now, you wouldn't want to treat meningitis with those oral antibiotics, but the pneumococcus is stopped in its tracks by them, and this patient went ahead and died anyway.

Q. How does a physician test for photosensitivity?

A. You don't test for it. I guess maybe you'd shine a light in the patient's eyes, but the patient says the

lights are hurting my eyes.

Q. The physician using a pen light to examine the eyes --

A. They might squint and say that bothers them. I'm not sure that's what you're asking.

Q. I think you probably answered my question.

What are the causes of photosensitivity? And let's just take a patient such as Mr. Jeffers.

A. There's a whole lot of them. I'd hate to try to elicit them, but --

Q. Maybe five or six of them?

A. Five or six. Probably the most common cause is viral infection of the respiratory tract, then maybe certain medications. In fact, I wondered if the morphine didn't have something to do with this man having photosensitivity. I meant to look to see whether he had that before or after he got the morphine.

Certainly bacterial infections of the head and neck including otitis and sinusitis, which this man had, can produce photosensitivity. Intrinsic diseases of the eye, paralysis of the pupil so it dilates widely or something can produce photosensitivity.

Q. How about a severe headache?

A. Well, it's commonly found with severe headache. I'm

not sure the headache is what causes it. It's just whatever causes the headache also can cause photosensitivity. It's a very common and non-specific finding and in my opinion in no way points to the diagnosis of bacterial meningitis in this or any other case.

MR. SWITZER: I have no other questions. Thank you, Doctor.

RE-EXAMINATION

BY MR. MELLINO:

Q. Doctor, you gave us a definition before of what supple -- of what you said it universally means.

A. I'm not sure I defined it, but I'm saying that supple is a commonly used word to put in physical exams because it's a brief way to say that you examined the patient's neck to see if it was stiff or rigid and whether there were signs of meningitis or not. And there were no such signs so you write down the neck is supple.

Q. Well, it's not only -- it's not used only in examinations that are done to rule out meningitis, is it?

A. Correct. You can get stiff neck from a major bleed inside the head, you can get stiff neck from bone disease, tenseness of the muscles of the strap muscles

in the neck because of an ear infection.

Q. So, it's used in any examination of the neck regardless of whether a physician is suspicious of meningitis or not?

A. When you say supple, you're implying to the reader, in my judgement, that there's no evidence that the patient has meningitis based on the physical exam of the neck.

Q. Well, if you were just examining somebody that you didn't even -- didn't have any signs or symptoms of meningitis and there's no reason for you to believe they had meningitis, are you saying you would never use the word supple?

A. Oh, no, I use the word supple a lot, you know. But when I say it, it means that there's no evidence that the patient has meningitis clinically on physical exam.

Q. That's the only reason that you ever use the word supple in your practice?

A. No, but that's what it always means when I use it.

Q. Well, if you were just examining somebody that you didn't think that they had menin -- there's no reason to suspect they had meningitis, say you're just doing a general physical examination --

A. Right.

Q. -- why would you use the word supple?
A. Because that's the word I commonly use to say that I flexed the neck and there was no pain when I did that, no evidence of bone disease, et cetera.
Q. So, it can mean other things?
A. Oh, absolutely. It doesn't mean the patient doesn't have meningitis.

MR. MELLINO: Okay. That's all the questions I have.

MR. HUPP: No questions.

MR. MARKWORTH: Thank you.

(Deposition Concluded at 11:28 a.m.)

STATE OF MICHIGAN)
COUNTY OF WASHTENAW)

CERTIFICATE OF NOTARY PUBLIC

I, Richard L. Nizza, of the firm of HURON REPORTING SERVICE, a Notary public within and for the County of Washtenaw, State of Michigan, duly commissioned and qualified, do hereby certify that the witness whose attached deposition was taken before me in the before entitled cause on Wednesday, August 18, 1993, was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony contained in said deposition was by me reduced to writing in the presence of said witness by means of Stenography; afterwards transcribed upon a computer under my personal supervision; and that the said deposition is a true and correct transcript of the whole of the testimony then given by the witness to the best of my ability.

I do further certify that I am not connected by blood or marriage with any of the parties, or their attorneys or agents; that I am not an employee of either of them, nor interested, directly or indirectly, in the matter in controversy, either as counsel, agent, attorney, or otherwise.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal in Ann Arbor, County of Washtenaw, State of Michigan, this 23rd day of August, 1993, A.D.

Richard L. Nizza, CSR-2344
Notary Public, Washtenaw County
State of Michigan
Commission Expires: 9/1/93