State of Ohio)

County of Cuyahoga) SS:

IN THE COURT OF COMMON PLEAS

ROLAND CUNNINGHAM, SR.,
Administrator of the Estate
of ROLAND CUNNINGHAM, JR.,
Deceased,

Plaintiff,

vs. Case No. CV07639012

Judge Daniel Gaul

MERIDIA HEALTH SYSTEM,
et al.,

Defendants,

_____/

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The Deposition of RICHARD M. NOWAK, M.D.,
Taken at 400 Renaissance Center, Suite 2160,
Detroit, Michigan,
Commencing at 3:01 p.m.,
Monday, November 2, 2009,
Before Jacquelyn S. Fleck, CSR 1352, RPR, CRR, RMR,

APPEARANCES:

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Appearing on behalf of the Defendants Michael A. Billow, M.D., and Emergency Professional Services, Inc.

Detroit, Michigan
Monday, November 2, 2009
About 3:01 p.m.

RICHARD M. NOWAK, M.D.,

having first been duly sworn, was examined and testified on his oath as follows:

EXAMINATION BY MR. LANSDOWNE:

Q. Doctor, for the record, can you give us your full name, please.

A. Richard Michael Nowak.

Q. Dr. Nowak, we met briefly. My name is Dennis Lansdowne, and I'm here to ask you some questions. You've been through this process before; correct?

A. Yes, I have.

Q. All right. I'm going to ask you some questions about your -- the opinions you intend to give in the case of Cunningham versus the Emergency Professional Services, et al. Do you understand that's our purpose in being here today?

A. I do.

Q. And just for the record, I'll remind you of some of the things that you probably have already gone over. But if you don't understand my question, please tell me that rather than answer it. All right?

A. I will.

Q. And you have to answer out loud, as you've been, so that we get an accurate transcript of your testimony. All right?

A. Correct.

Q. If at any time you want to go back to an answer and correct it, amend it, change it in any way, please feel free to do that. We'll stop at whatever point; we'll go back and we'll --

A. Okay.

Q. -- try and make it so that you're comfortable with your testimony by the time we leave here today. All right?

A. Okay.

Q. Same thing if you want to take a break. I don't think we're going to be here terribly long, but if you want to take a break or you have to answer a page or something, just please feel free to do that.

A. All right. Thank you for that.

Q. All right. What's your current position, Doctor?

A. You know, it just occurred to me I didn't bring a current C.V.

Q. I have a C.V.

A. What's the date on it? The date will be on

the back. Yeah, this is 8-'04. So -- well, we have the '07-'09 version.

Q. Okay. Well --

A. Which is --

Q. -- you can maybe give one to --

A. I can e-mail it to her.

Q. That would be great. But this started out with what is your current position?

A. I'm actually past chair of the department of emergency medicine at Henry Ford Health System in Detroit.

Q. You say you're past chair.

A. Yeah.

Q. What are you currently?

A. Well, that's -- I was chair. I'm past chair, and I'm also involved in -- I'm a senior staff and I'm involved in clinical research in the department.

Q. So your title is senior staff, past chair?

A. Well, no. Yeah, they actually refer to me as past chair. That's sort of my title. But my other responsibilities are teaching and education and seeing patients and doing some clinical trials.

Q. Okay. Can you just tell me, tell me what you do.

A. Well, I'm one of the senior staff within our department. So our department is a large department. We see about 95,000 patient visits a year. I work in the department seeing patients, teaching residents and doing clinical trials. We're very much interested in clinical research in emergency medicine as related to acute cardiopulmonary disease for the most part. It's actually reflected in the publications, et cetera, within the C.V.

Q. Okay. So how often are you actually seeing patients?

A. At a -- well, at an absolute minimum, I would say maybe, I don't know, 55, 60 percent of what another staff person like myself would do. The rest of that time is divided for the most part in the clinical trials maybe 30 percent or 25 percent. And then the other 5 or 10 would be education and administrative stuff. The clinical trials are all done within the ER, so I see patients and enroll them and treat them and --

Q. So there's some overlap with the clinical trials and your actual treatment of patients?

A. Yes. Well, yeah, I mean I do both.

Q. All right. When you're seeing these patients are you the actual attending?

A. Yes.

Q. Okay.

A. I am. So I'm responsible for all the patients that are seen in my area, whatever that area may be that I'm assigned to.

Q. Okay. And do you work in a particular shift or --

A. We have rotating shift, so it's days, afternoons, midnights, and seven days a week.

Q. And you can be working any one of those for periods of time?

A. Yes, I can. Well, and I do a little less midnights. I'm a little older, so I get that little break on the midnights, which is harder to do.

Q. Now, you were the chair, so I -- I'm guessing that the chair had a certain amount of administrative responsibility?

A. It was 1988 to 1992. I think that's what it was. You can look back in there. It would be right in the front, under Administrative Posts.

Q. Okay.

A. I can find it for you if you want. So it would be '88 to '92. And then I was vice chair. That's just been changed to past chair. That's reflected on the new C.V.

Q. That's just a change in name?

A. Yeah.

Q. Okay.

A. Yeah. I mean it sort of -- it reflects what I do.

Q. All right. So you're in the ER 40 hours a week?

A. Oh, I'm in the ER many hours a week. It would be more than that. And it's doing clinical trials and seeing patients.

Q. And your particular interest in these clinical trials is the --

A. It's acute cardiopulmonary disease. We're currently doing some biomarker work in identifying patients with acute coronary syndromes. We're interested in novel biomarkers for the diagnosis of congestive heart failure. We are currently doing some asthma trials, looking at novel therapies for acute asthma. So it's an area we've been involved in for some time.

Q. And I noticed that in your C.V. there seemed to be quite a concentration with respect to asthma trials and publications.

A. Yeah. I've been doing that for a while. But if you look at the last few years, there's been a little more biomarker work and cardiac stuff as we've

moved forward. So it's changed a little bit, but we still do asthma work. And a -- it's our area of interest.

Q. And this is all at Henry Ford?

A. Yes.

Q. Okay. Do you work at any other hospital besides --

A. No. I work at the main campus, and I've been working at the main campus since 1975.

Q. And you're still a professor at --

A. Actually Case Western -- are you looking at Case Western?

Q. Yes.

A. Yeah, that relationship changed. It would be on my new C.V. I'm currently a professor at Wayne State University School of Medicine. That -- because we changed the relationship with Case Western I no longer have that appointment.

Q. Okay.

A. I also am an associate professor at the Department of Emergency Medicine at University of Michigan Medical School.

Q. Okay. And you're a clinical associate professor?

A. Yeah.

Q. So that's still --

A. That's -- that's never changed. But the other has.

Q. And do I take it that most of your teaching is teaching residents in the emergency room?

A. Residents and students. The students come from those schools. So we teach students and residents, both within our discipline and outside of our discipline, because we get rotators from other services.

Q. Okay. Is there a pediatric emergency department within the emergency department at Henry Ford?

A. In our department we, as many ERs, we tend to see children in a particular area. They're not mainstreamed with everybody else. So all the children are seen in the pediatric part of our emergency department. That part is staffed by us on a rotating basis.

Q. Okay. So if you're working the emergency room just in the emergency department, you might see patients in the pediatric --

A. If I'm working in the area where we tend to segregate the pediatric patients, because we would -- because we'd rather have them together than mainstream

them with everybody else, then I will see a lot of, you know, kids.

If I'm working in our category 1 area, which is our acute, life-threatening area, I will see more adults. The odd kid, but mostly adults. So it varies depending on what part of the ER I'm assigned to.

Q. Okay. In this case, as you've read, Dr. Billow was working in a -- the pediatric emergency department at Hillcrest Hospital; right?

A. And nationwide some have done what we've done and have emergency physicians see them. Some have used pediatric emergency medicine. Some have used a mixture. So it varies.

Q. Okay.

A. It just -- the structure varies. The kids are usually kept apart. Who actually manages them can vary.

Q. Okay. And that's what I was -- in your hospital it's the emergency room physicians seeing the pediatric patients in a segregated area?

A. Yes. And actually, that's the model for the vast majority of emergency departments in the United States.

Q. Okay.

A. It's just not generally cost efficient to have pediatric people see them, because there aren't as many kids as there are other patients. So -- and we train people to take care of kids. So --

Q. Right.

A. -- the primary model is emergency docs take care of everybody. There are some places that will use pediatric emergency medicine people, pediatricians, pediatric critical care people. It varies.

Q. What's your understanding of Dr. Billow's training?

A. I understand that he's a pediatrician who also was trained in pediatric critical care. That's my understanding.

Q. All right. In terms of -- if a doctor such as Dr. Billow works in an emergency department, do you agree that they're held to the standard of care of an emergency physician?

A. Yes.

Q. And that's the standard of care, you're looking at Dr. Billow's care in this case; correct?

A. Yes.

Q. Now, how much of your work is related to medical-legal cases such as this?

A. Well, I guess the best way to explain it is

probably just in terms of income. It's always been in the single digits as a percent of my income.

Q. And so --

A. It varies year to year depending on how many --

Q. Sure. Just roughly, how many cases do you get involved in in a year?

A. It varies. But I mean some -- some years maybe one every couple of months. Some years a little more than that. Maybe the odd year one every month, but it varies. In that neighborhood.

Q. All right. Do you have your whole file with you here today, Doctor?

A. Yes, I do. I do.

Q. All that highlighting is making me nervous now.

A. It's a carry-over from medical school. God only knows why I do it, but I do it.

Q. Yeah. It's a little crutch or something, I know. I understand.

A. Want to know what I have?

Q. Yeah. Would you just tell me.

A. Okay. I have the records from Meridia Hillcrest Hospital, the Cuyahoga County coroner's office. I have the expert report of Dr. Khandelwal.

My expert report that I authored. The expert report by Brian Erling, M.D., the -- actually have two of those. I don't know why. And then I have the expert report that's authored by Jonathan Zenilman, M.D. I have two -- I have the deposition transcript of Michael Billow, of Dr. David Talan, and of Karen Durham, R.N. And I have the deposition transcripts of Brian Erling, M.D., Jonathan Zenilman, M.D., Mr. Ronald Cunningham.

Q. I think that's Roland.

A. I'm sorry, Roland. Yeah, it is.

Of Ms. Candace Nunn, Debra Cunningham, Latasha Cunningham and Latoya Cunningham. And then just a notification about the trial date.

Q. Okay. Which records from Meridia Hillcrest do you have?

A. I can tell you. I have the 10-12-06 emergency visit. I have the 10-23 5:55 emergency visit. And I have the 10-23 emergency visit at 17:33.

Q. Okay. And did those medical records and the autopsy report all come together?

A. Yes. It's in the same binder.

Q. Okay. All right. Anything else you've reviewed for this case?

A. No.

Q. Okay.

A. Oh, I've seen the pictures --

Q. Okay.

A. -- of the deceased. I actually had them and I lost them. And I looked at them again today. I asked the attorney to look at them.

Q. Okay. You're talking about the post mortem pictures?

A. Yes.

Q. And how about any literature; look at any medical literature?

A. No.

Q. All right. Do you know any of the doctors who are either involved in the care of Mr. Cunningham or are involved as expert witnesses?

A. I only know David Talan. And I know him from meetings and presentations, et cetera, at our meetings. So I've known him actually for a number of years.

Q. Have you ever been involved in a medical-legal case where Dr. Talan was also involved as an expert, as you are in this case?

A. Yes. As a matter of fact, I don't remember the case, but he was involved in another case that I was involved in.

Q. Is that a case that's still going on or --

A. No. You know, he does a lot of infectious disease work because he -- that's his area of special interest. So it was some other infectious disease case. But he and I have been involved in another case. Or two maybe. I can't remember, actually.

Q. Were you both acting as witnesses for the defense in those cases?

A. One he was a witness for the plaintiff, one I think for the defense. But -- I think.

Q. And were you -- in all the cases were you on the same side or were you --

A. No, we were on opposite sides one time.

Q. Okay. So you had different opinions --

A. Yeah.

Q. -- about the standard of care?

A. It gets a little technical, because on the one case where he was on the plaintiff, he was more testifying, at least the way I understand it, to the actual mechanism of the injury or death. So it was more of a causation witness. And he did not testify as to the standard of care. Why, I don't know.

Q. Okay. But it was an emergency room case?

A. Yes, it was.

Q. And you were testifying about the standard of care, correct, in that case?

A. Correct.
Q. On behalf of the defense?
A. Correct.
Q. And -- okay. Were any of those cases with Dr. Talan cases out of the state of Ohio?
A. You know, I don't remember. I just don't.
Q. Have you testified in Ohio before?
A. Yes.
Q. In -- have you testified in Cleveland before?
A. Yes.
Q. I would think so.
MS. HESS: What was your question? I didn't hear you.
BY MR. LANSDOWNE:
Q. I just said I would think so, your connection to the case and everything. And --
MS. HESS: Oh.
BY MR. LANSDOWNE:
Q. When's the last time you testified in court in Cleveland?
A. I'm really not good with these dates, because when these cases are done, they're gone. I don't remember them and I don't want to remember them.
I think it would have been within

the last couple of years, I'm thinking. Or two to three years. And it may not have been right in Cleveland. It may have been the proximity of the Cleveland area.

Q. Okay. Have you been involved in a case that involved Hillcrest, the emergency room or the emergency department at Hillcrest Hospital before?

A. You know, I don't know. I may have.

Q. Okay. How about a case involving the entity Emergency Professional Services, Inc.?

A. That I don't know.

Q. Okay. How about Team Health?

A. That I don't know either.

Q. You've heard of Team Health, I assume?

A. Yes.

Q. Okay. And what's your familiarity with that corporation?

A. Well, it would be a large corporation that contracts out with emergency departments, I guess throughout the United States, providing emergency services for their institution.

Q. Does Team Health have anything to do with your hospital?

A. No. No. Not at all.

Q. Are the emergency department physicians at

Henry Ford employees of the hospital?

A. Yes. All the physicians of the System are employees.

I shouldn't say all. The vast majority. There may be some in some of the satellites that are contracted private docs, but the vast majority are employees of the Henry -- we're actually part of the Henry Ford Medical Group, which is part of Henry Ford Health System.

Q. Okay. So if a -- from our area we're familiar with the Cleveland Clinic style of -- of practice, where the physicians are employees of the Cleveland Clinic. Is that the way Henry Ford --

A. Yes, we would be similar.

Q. Okay.

A. I don't know all the details --

Q. Sure.

A. -- but similar.

Q. Okay. All right. Let me ask you a little bit about your experience with meningitis, meningococcemia. Have you ever diagnosed this disease in the emergency department?

MS. HESS: Which one are you talking about?

BY MR. LANSDOWNE:

Q. Meningococcemia.

A. Yes. It has occurred -- I was trying to think of how many times -- but at least a few. And the reason we made the diagnosis is the patient had a petechial rash. And we actually Gram stained the contents of the little petechial area and were able to show gram-negative Diplococci. Some of those were actually gonococcemia and some were meningococcemia, because the organisms look the same.

But it was based -- the reason we knew it was that, because we had actual Gram stain. Other than that, there are patients that have had rashes or been admitted with suspected meningococcemia because of a rash, and some of those have also turned out to be meningococcemia.

Q. And were these cases in which you've -- that you've just described, were they, the majority of them, earlier in your career?

A. Boy, you know -- well, I think they've been sporadic. You know, I'm not -- it's hard, because I've been doing this a long time. So within that time period they've occurred. Exactly when I don't know. Not within the last six months, I can tell you that. But if you get beyond that, it becomes a little more difficult.

Q. All right. So, what, you've been doing this for 25 years, 30 years?

A. 34.

Q. 34. Sorry.

Ten cases?

A. Yeah. Well, certainly not much more than that. It would be under that, I think. Where, I don't know. It's not -- it's a very uncommon disease.

Q. How about meningitis?

A. See more of meningitis. Do a lot of lumbar punctures to rule out meningitis. Some of them have it, some of them don't.

You know, you have a headache and a fever and any kind of neck pain, you -- you get an LP and worked up.

Q. Right. If I heard in your previous answer, I think what I was hearing is that you've had cases where you've suspected it in the emergency department, and then it goes on to be diagnosed by somebody else in the -- on admission; is that correct?

A. Yeah, we've diagnosed that and we've suspected it based on the presentation and rash.

Q. Okay.

A. Now, there may have been people that came and they got admitted with some septic thing that had

no rash, for example. We would have not known what that was. It may have turned out later that they had that. I -- I don't know.

Q. Right. So it's possible that there's a few more that you just don't know about that you -- the patient got admitted, and what happened to them you don't know?

A. Don't know. But for us clearly the thing that would make us think of that is this typical rash in the right clinical circumstance.

Q. All right. You've got a pretty thick C.V. here, Doctor, so I'm not sure I got every single presentation and publication. Any of your presentations or publications have anything to do with meningococcemia, meningitis?

A. No.

Q. Any of your clinical trials have anything to do with it?

A. No. No. We've not been involved in that.

Q. Tell me, would you, what is academic emergency medicine? I know it's been something that you focused a lot on your career. And when you say academic emergency medicine, what do you mean?

A. It's -- it's in a facility that is interested in teaching and research, in addition to

clinical care.

Q. Are you a member of the -- oh, you are a member of the American College of Emergency Physicians; correct?

A. I'm a member of the American College of Emergency Physicians, the American Academy of Emergency Physicians, the Society for Academic Emergency Medicine. Those are the main three U.S. emergency medicine organizations.

Q. And you've held positions with I'll call it ACEP; is that --

A. I was president of the Michigan chapter. I was president of the National Academic Emergency Medicine Society.

Q. What were your duties and responsibilities in those positions?

A. To lead the organization in its mission.

Q. That's the boilerplate. What does that mean?

A. Well, you know, those -- for example, in the academic emergency medicine organizations, their mission is to improve the care of the emergency patient, to improve the education of trainees, to improve research as related to emergency room medicine. And those are very broad, and there's broad things that

we did.

In ACEP it -- it was more focused on clinical care, not as much on research and education, because that was more the practicing doc. And the practicing doc would be educated, and we would discuss many issues relative to billing, to staffing, to patient flow. It was more clinically oriented things that we did.

Q. Were you involved at all in putting together policy statements for ACEP?

A. No. No. I may have reviewed some. I mean I did get a lot of things sent to me. But, no, I was never on the committees that actually developed them. But I may have reviewed some of them for commentary.

Q. Are you generally familiar with ACEP's policy statements?

A. Not in detail. I know of some of them, but not in much detail.

Q. Are those policy statements things that you try to follow at your institution?

A. It's just another piece of information that, you know, there's a lot of things you would -- you would follow relative -- you're talking about relative to patient care?

Q. Right.

A. No. It's another piece of information.

Q. And I -- I suppose, you know, in patient care there's policy statements on staffing, there's policy statements on shifts. Are those things you're aware of?

A. Yeah. And that's what they are. They're policy statements. And some might be used, some might not. Depends on the institution. It's another piece of information.

Q. So tell me, what is the role of the emergency physician? You've been asked that question before and --

A. It's to see emergency patients.

Q. I mean within the -- within the continuum of the medical practice, how do you describe that role to your -- those physicians in training in emergency medicine?

A. We see everyone that comes to the emergency department with a complaint, whatever it is, day or night, and we evaluate them.

Q. Is one of the roles of the emergency doctor to rule out life-threatening conditions?

A. I would think that would be the role of any physician anywhere.

Q. Okay. And tell me about your teaching

responsibilities right now, if you would.

A. Well, I have online teaching responsibilities, and I work in a shift. We will work with our own residents and rotating residents. And I supervise them and see their patients and go over the cases and help them manage the patient. I see my own patients, in addition. I speak at our grand rounds, as the other staff do.

I'm involved in some resident research projects, although that's a pretty small amount of what we do. And we also teach medical students that are on the shift with us. And I have two residents that are my advisees. And they're -- I meet with them at least once every six months, and we go over their progress and any issues that we need to deal with and see how they were doing in their training.

Q. I just want to look at something relative to training on here. This is Dr. Erling's report, and he has a sentence, first sentence of the second paragraph with respect to training. Do you see that?

A. You're talking about: It is the cornerstone of emergency medicine training that every patient presenting to an emergency department is assumed to have the worst possible disease process.

Q. So what -- what do you think about that?

A. I don't know what he means. We evaluate, we see, for example, chest pain patients. All those patients could have ACS, pulmonary emboli, aortic dissection, bad pneumonias, tension pneumothoraces.

We think of all of those. We actually then clinically, by history and physical, start to rule them out. And then depending on what we think, we may move on to some other diagnostic tests, whether they're blood tests or radiographic tests, and continue to work up. I don't know what he means by this, to tell you the truth.

Q. Okay.

A. The worst possible disease process?

Q. I -- it's not my statement.

A. Well, we try to diagnose as accurately as we can what your problem is.

Q. Mm-hmm. Well, I think that what you were saying is somebody with chest pain, you would have to consider the most dire thing that might be related to chest pain, and then rule that out and move on to something else?

A. No. You would think of about six or seven of all the things I mentioned, and they'd all be coming into your mind. And then as you talk to the patient, you'd start ruling some out just based on history and

physical; doesn't sound like, is not. And then you would come down with a few more and you'd say, Well, we need to do some biomarker work here, or we need to do some imaging or whatever based on the clinical evaluation of the patient.

You don't do the same imaging and biologic testing on every patient that comes in with chest pain. It varies. You couldn't do it all.

Q. When you're doing -- as part of your teaching do you ever go back and look at charts that a resident has seen a patient on?

A. Oh, yeah.

Q. And --

A. We read them and sign off on them.

Q. Do you ever go back and review, do random reviews of charts in the emergency room as part of quality assurance?

A. I don't. There are quality initiatives that we do. We also have, you know, morbidity and mortality rounds of cases that are of interest as part of the educational process.

Q. In those cases in which you're going back and looking at a chart, you may know what the result of the patient's course has been by the time you go back and look at the chart; correct?

A. Yeah, you could. Sure.

Q. And so to evaluate the doctor's thought process during the encounter with the patient, you have to kind of put yourself back at the time that the doctor was seeing the patient; correct?

A. Yes, you try to.

Q. I mean even though you -- you may know the result, you have to put that aside; right?

A. Well, yeah. I mean you -- you try to go back and look at the case as if it was presenting to you and what you would have done.

Q. That's a fair way to do it, isn't it, even though you know the result?

A. Well, nothing is as accurate as the retrospectoscope. Once you know what it is, I mean that's there. You can't deny it. I mean you know. And that would be a very different process than having a patient come in and not knowing what the final result was. I mean it's a different -- little bit of a different thinking.

If you come in, you have a complaint, I have no idea what it is, that's a different process than you come in, you've been worked up, I know the diagnosis and now I'm going back to look at you. It's very different thinking. You try not to

be affected by that, but guess what, you know what the final outcome was.

Q. Well, you've -- you've been an expert witness on behalf of a patient in an emergency room case, haven't you?

A. Yes.

Q. And that -- those cases you've had to look back at the chart knowing what the result was; right?

A. Yeah.

Q. And still you've come up with a conclusion that the emergency room physician failed to meet the standard of care?

A. Yes.

Q. And you're able to do that even though you know the result; correct?

A. Well, we do do that, yeah. And I'm just saying it's different, though, when you know the final result. I mean you try not to be encumbered by that, but you do know it. You even try harder to be fair.

Q. Right. And you -- you've been able to do that in the cases that you testified to on behalf of the patient; I assume you feel you have?

A. Yeah.

Q. All right. I want to talk with you for a few minutes about the evening visit of October 23rd.

A. The evening, not the morning?
Q. Right. You did review that; correct?
A. Yeah. It was not the primary focus of my review. I was asked to review the morning visit in particular, the care provided by Dr. Billow.
Q. Okay. Well, that's a good point. When you were contacted about this case -- and who contacted you, by the way? Ms. Hess?
A. Ms. Hess' office, yes.
Q. Was it Ms. Hess or somebody --
A. I don't know. I don't know.
Q. Okay. Had you worked with that office before?
A. Yeah.
Q. Okay. On how many occasions?
A. A few.
Q. Okay.
A. I just don't think I remember. It's not 20. It's a few. It may be ten, somewhere -- six, somewhere in there.
Q. Do you have any other cases besides this one going on with that office?
A. I don't believe so.
Q. Okay.
A. Although, some -- the reason I say that is

some of these take a life of their own, and you forget about them because they -- the time process. So I don't believe so for that reason.

Q. Okay. So what is it you were asked to do?

A. To review the care that was provided by Michael Billow to the patient in the emergency department on the date that he saw the patient, which would have been 10-23-06, in the morning visit.

Q. Right. So -- but you were given the 10-23-06 evening visit, as you said; correct?

A. Yeah.

Q. And you looked at it --

A. Yeah.

Q. -- reviewed it; right?

A. Mm-hmm.

Q. It's better if you say yes.

A. Yes. Yes.

Q. Now, Roland was critically ill when he presented on the evening of October 23rd, 2006; would you agree?

A. He was ill. Well, yes, he was ill.

Q. And let's just look at this for a second here. Look at the triage, the nurse's triage.

A. On the evening visit?

Q. On the evening visit.

A. Yes. Yes. I have it.
Q. Now, with respect to vital signs --
A. Yes.
Q. -- you've got a lot of highlighting up there, too.
A. I have highlighting everywhere.
MS. HESS: It's all highlighted.
BY MR. LANSDOWNE:
Q. And no blood pressure was obtained; is that right?
A. It appears so, yes. I don't see one written.
Q. I mean blood pressure is a -- it's a vital -- one of the vital signs; correct?
A. Correct.
Q. It's important to obtain a blood pressure, isn't it, on a patient?
A. If possible, yes.
Q. Well, what -- what are the reasons it would not be possible to obtain a blood pressure?
A. You know, I mean, again, I -- I don't know if there was one done later. I mean I didn't spend a lot of detail on this particular visit. I mean I read it, but if you're asking me a specific thing about vitals or if there were more, I just don't know. I'd

have to read through. Did they -- I don't know if they did anymore. I don't know what the situation here was. I mean I don't feel comfortable.

I mean I've read it, but it was not the focus of my review. Do you understand? I spent a lot more time on the first visit.

Q. Okay. Well, let me ask you this.

A. Sure.

Q. Do you know whether the emergency care that Mr. Cunningham received on the evening of the 23rd met the standard of care?

A. I wasn't asked to review that, so I -- I haven't reviewed it with that -- with that philosophy in mind. I just haven't. I wasn't asked to do that.

Q. You don't have an opinion one way or the other?

A. Well, I'd have to go through and reread it and --

Q. But I mean as --

A. -- spend some time on it and see if I thought it did or not.

Q. But as you sit here today, you don't have an opinion one way or the other?

A. As I'm explaining to you, that was -- it's hard for me to answer that because I didn't review the

chart for that purpose.

Q. Well, really it's not that hard, because either you have an opinion today or you don't.

A. No, that's not true, sir. I mean when I review these, I take them very seriously. So I read the entire thing and I spend a lot of time on it and I think about it.

Q. And you haven't done that?

A. Not in particular, no. That wasn't the focus of my review.

Q. I understand that. So that's why --

A. It's kind of hard to ask me about standard of care of something that I wasn't asked to review to determine the standard of care.

Q. Right. And so as you sit here today, you just don't have an opinion on that; correct?

A. I honestly don't know. I mean if you look at it from an overview standpoint, I mean it seems that they got fluids, they addressed the patient's needs, and it seemed reasonable to me. I mean I -- but I -- you know, you need to go through and read it all.

Q. Okay. And you -- you're not planning on coming into Cleveland next week, or the week after next maybe, and tell the jury that the care that Mr. Cunningham received the evening of October 23rd met

the standard of care?

A. I was never asked to do that.

Q. Okay. So you're not planning to do that?

A. No.

Q. Okay. Now, if we turn to the -- again in the evening --

A. The evening, okay.

Q. -- still in the evening --

A. Okay.

Q. -- the physician's check sheet, I guess. That's the one in front of you right there.

Do you use at Henry Ford, in your emergency department, charts like this?

A. We have used the T-System. We currently have an electronic version of this called PHYSDOC. So it's a computer-generated report. It gives you the ability to use checked boxes, to actually type in your own edited evaluations. So it becomes a combination. But it's -- it's all electronic today.

Q. What's the program?

A. It's called PHYSDOC. P H Y, phys, S D O C, PHYSDOC.

It's a commercially available recording system that's computer-generated, and there's all different kinds out there. Like the T-System, I

don't know who this is -- this is -- this is copyright by Lakeland Emergency Associates. So this is one of a number of them that are out there.

Q. Does PHYSDOCs, is that one of the systems that will give you pop-ups of -- you know, prompt the doctor to do -- take certain actions based upon what has been entered?

A. No. No. It's strictly recording.

Q. Okay. Are you familiar with what I'm talking about, the prompts?

A. Not really, because the only -- the only things that this will prompt is if you don't fill out relevant fields or something, it won't let you go on.

Q. Oh, okay.

A. But it doesn't tell you what to do.

Q. Okay. All right. Back to this T sheet for the evening. You see again that Dr. -- this is Dr. Wong, by the way, we know that, has filled in the vital signs and there's no blood pressure there. Do you see that?

A. I do.

Q. And do you see the pulse is 116?

A. I do.

Q. Which would be tachycardic?

A. Well, we would say up to a hundred. Above a

hundred we would define it as tach. And then there's grades of tachycardia above that.

Q. Well, what grade would this be?

A. Well, I'd say this is mild.

Q. Okay. You see that the doctor has -- on the T sheet has, in the section for heart, has checked regular rate and rhythm. Do you see that?

A. Hold on. Again, I wasn't asked to review this, so I -- okay. Regular rate and rhythm.

Q. You've got them highlighted.

A. Yeah, I briefly went over, but it was not the focus of my review.

So heart. Regular rate and rhythm, yes. Pulse is normal, no loud murmurs it says.

Q. You wouldn't consider 116 to be a regular rate, would you?

A. Well, regular rate means just that it's not irregular. That the heart rate is regular, meaning not irregular, not with dysrhythmia. That's what we would generally call rate and rhythm, I think.

Q. And pulse would be elevated, not normal?

A. Well, it would be a sinus -- mild sinus tachycardia -- or mild tachycardia. If it's regular, it would most likely be sinus tachycardia.

Q. And of course tachycardia is not checked

under this box, is it?

A. No, looking at this chart, no, doesn't appear to be.

Q. Do you know why that is?

A. Well, when you have these numerous things to check, I mean there is some redundancy. I mean if you see the vital signs and see the heart rate, I mean I wouldn't necessarily repeat it. I mean it becomes redundant. You would be reworking it. You know, you've clearly established what the pulse is. It speaks for itself.

Q. What -- the respiration rate of 32, how would you describe that?

A. Elevated.

Q. Are there grades of elevation like there are for tachycardia?

A. Well, we would -- yeah. I mean I would say this is moderate to severe. I mean they come in higher, but this is significantly elevated respiratory rate.

Q. Do you take into account the age of the patient when you're considering that?

A. Well, when you're talking children, yeah. When you get up into teenagers and adults, it's pretty much, you know, I mean pretty standard adult rates.

Q. Okay. So what would be a normal rate?

A. I don't know. 14 to 18, in that neighborhood.

Q. Can you tell me what should have been in Dr. Wong's differential diagnosis?

MS. HESS: Objection, because I think he already said he doesn't have an opinion about this right now. Go ahead if you can.

A. Well, I wasn't prepared to go through a detailed discussion of a visit that --

BY MR. LANSDOWNE:

Q. I understand that.

A. -- I wasn't asked to review for standard of care. So --

Q. If you can't -- if you can't answer, then you can just tell me that, you know, you can't answer. That's fine.

A. Well, I mean I guess I can look at it and give you a general overview. I mean the patient came in, you know, had abnormal vital signs, which could be compatible with sepsis, compatible with trauma, compatible with cardiogenic shock, compatible with volume loss. It's compatible with a lot of things. But significantly abnormal vital signs, so serious disease of some sort.

Q. Just follow this time line through. Looks like the patient came in at around 17:32 in the evening?

A. Yes, on the triage short form that's what it says.

Q. And was seen by Dr. Wong, at least her note is dated -- or is timed 6 p.m.?

A. If you say so. Where is that?

Q. You were just looking at it.

MS. HESS: I think that's the triage.

A. 6 p.m.

BY MR. LANSDOWNE:

Q. Is that the time that the doctor saw the patient or the time the doctor was finished with the patient?

A. I don't know, because I wasn't prepared to spend time on this particular visit.

Q. Okay. I just thought --

A. This is not the point of my review.

Q. Okay. I understand.

After the doctor made orders, Dr. Wong made orders, it looks like then that 20 minutes later two attempts were made to start an I.V. Do you see that?

A. No. Where are you looking?
Q. Right where you're looking. (Indicating.)
A. I.V. attempts times two without success at 18:20, I think. Is that what you have?
Q. That's what I'm reading it as.
A. Yep, I think that's what it is.
Q. And then?
A. Then it says: At 18:45 I.V. placed per -- and there's a name.
Q. Right.
A. And then labs sent, and it has increased. I.V. fluids were increased.
Q. So at 18:45 is when the I.V. is placed?
A. That's what it looks like in review here, yeah.
Q. And then the labs actually -- look at the lab sheet. Labs actually are at 18:35?
A. Yes. Collected at 18:35.
Q. Do you know when they were reported?
A. Well, they were printed at 19:23. I don't know how their ER works relative to reporting of labs, whether it's electronic, whether it's paper. You know, I don't know. Different places do it differently.
Q. So you don't know when those labs were reported back to the -- to the emergency room?

A. Not without spending a lot more time to figure it out.

Q. The labs, I take it you would agree, are significantly abnormal?

A. Yeah. We could go through the individual ones. Do you want a sort of blanket statement? I mean the BUN, creatinine, carbon dioxide, anion gap, the differential on the white count.

Q. So what -- what would be the significance of those lab reports to you as an emergency room physician?

A. Sick patient.

Q. Anything other than sick patient?

A. Well, they'd have to go through what the possibilities are. Is he infected, is it a cardiac problem, is it a renal problem? What's the problem? I mean I didn't --

Q. Is this a patient that you would call for a -- a consult for on immediately or admit immediately with those lab results?

A. Well, you'd work them up. You'd need to find out what the problem was, what you thought was the thing causing them. Start, initiate therapy, resuscitate the patient, give them I.V. fluids and do your job.

Q. How would you work the patient up?

A. Okay. So now we've got to go back to -- I guess I've got to reread -- I was not prepared to discuss this visit. That was not the focus of my review.

Q. I understand.

A. The focus was --

Q. Yeah, I understand.

A. So now you're asking me what would I do -- what would I do with this case that I don't know as much as I should about. It's not such an easy thing.

Q. Well, you've got the lab results.

A. Well, no. The lab results you've got to interpret based on the history, the physical exam, what the patient presented with, what his past history was, et cetera.

Q. Well, you know what he presented with the morning because you've thoroughly reviewed that. Right?

A. Yeah.

Q. So I mean you've already said --

A. Well, I mean this guy presented with what appeared to be a viral infection and came back sick, so the question is why did he come back sick. And that clearly needs to be worked up.

Q. Okay. So one of the things you said was I.V. fluids to resuscitate the patient?

A. Mm-hmm.

Q. It's better if you say yes, Doctor.

A. Yes.

Q. And by resuscitate what do you mean?

A. Address abnormal vital signs, address abnormal labs. Try to fix them, understand them, correct them.

Q. All right. What's HUS?

A. Where is that written?

Q. In the -- concerned about HUS.

A. HUS.

MS. HESS: I'm going to object, because I'm not sure why we're spending so much time on this visit. Go ahead.

BY MR. LANSDOWNE:

Q. The attending's note.

A. What page; page 1?

Q. Page 2 of the attending's notes.

A. Page 2 of the notes. What line? Oh.

Q. Fourth line.

A. I don't know. Some sort of syndrome. Hemolytic uremic syndrome? I don't know.

Q. I think that's what it is, hemolytic uremic,

because she refers to the "crit," called it --

A. Right. So they're not thinking that he's actually hemolyzing.

Q. Do you see that the doctor ordered Lasix for this patient, a thousand milligrams I.V.?

A. It's not a thousand milligrams. It's a hundred milligrams.

Q. Did I say a thousand?

A. Yes, you did.

Q. A hundred. I'm sorry.

A. Mm-hmm.

Q. You did see that?

A. Yes, I did. Right here.

Q. This patient had a significantly elevated creatinine; correct?

A. Yes. The creatinine was -- yeah, it was elevated. I didn't look at the number, but it was.

Q. And as you've already said, the patient was in need of resuscitation by fluids; correct?

A. Apparently. I mean I'm just telling you, I'm feeling uncomfortable about commenting about a case that I've not reviewed in detail. I mean you're asking me all these details about what I would have done, when I would have done it, and I don't feel that I know this visit very well.

Q. Okay.

A. And I'm trying to understand why we're doing this.

Q. Okay. Well, I'll short-circuit this if you want. Doctor, you're not going to -- as long as I know that you're not going to come in and say that Dr. Wong and the emergency room physicians in the evening met the standard of care.

A. I've not been asked to look at the standard of care.

Q. Okay. I just want to make sure.

A. I haven't been asked. I mean I guess someone could ask me. They haven't as of yet.

Q. I know. That's why I'm asking you this.

A. Well, no one has asked me to do it. So at this point in time, because no one has asked me to do it, I'm not planning to do it.

Q. Okay. All right.

All right. That cuts down on time there significantly.

A. Okay by me.

Q. You can keep highlighting if you want. That's all right. But --

A. It's an obsession.

Q. Let me just do some housekeeping, then,

before I ask you about the morning.

A. Okay.

Q. What are your charges for your expert review and testimony?

A. It's $300 an hour for review, $600 an hour with a three-hour minimum for depositions, and $4,000 a day for trial testimony.

Q. So it's $600 an hour, three hours minimum for a deposition?

A. Correct.

Q. So even if we're done in two hours, you're going to charge me 1800?

A. That's what the math says, yes.

Q. Then there's really no incentive for me to get done earlier than three hours.

A. That's fine with me. As long as you want to stay.

Q. Well, I thought maybe you'd be interested and you'd say I'm really only going to charge you for the actual time that I'm sitting here.

A. No. Those are the charges.

Q. Okay. All right, then. Forgive me if I've asked you this before. But have any of the cases in which you've appeared as an expert been involving meningococcemia?

A. I don't remember meningococcemia. I do remember meningitis.

Q. You have been involved in cases involving --

A. I believe so.

Q. Okay. And was the issue in that case claimed failure to work up for meningitis?

A. I don't remember the details, but I assume so, yeah.

Q. Has it been a significant time since that case? Is it just one case?

A. It may have been -- you know, I've been doing this since the early 1980s, so within that time period there's been a number of cases. And I do recall that there's been some meningitis cases. And usually that would have been the failure -- or at least the allegation would have been to have failed to diagnose.

Q. Okay. Do you remember if in those cases you were testifying on behalf of the patient or the doctor?

A. I don't remember.

Q. Have you done any -- back to your C.V. a minute -- any publications or presentations on staffing in the emergency department or length of shifts?

A. No. No.

Q. Are you aware of any literature, medical literature about the relationship between patient

safety and length of physician shifts in the emergency department?

A. Well, first of all, it wouldn't be that simple. If you look at staffing in emergency departments throughout the country, in smaller ERs, or I suppose in areas of ERs like pediatric ERs, where volumes aren't so big, because people can sleep it's not uncommon that shifts can be 24 or even 48 hours. So it's not simply the length of the shift, it's that the context within that shift is organized.

Q. I think my question was, are you aware of any literature?

A. Not specifically. But, you know, you talked about length of shifts, and there are different lengths of shift. So I don't know exactly what you mean. You're talking about -- I'm sorry, if you could ask the question again.

Q. Sure. Sure. My question was, are you aware of any literature about the relationship between patient safety and length of physician shifts in the emergency department?

A. Specifically emergency department, not resident hours on a week? Specifically emergency department, no.

Q. Okay. Are you aware of what ACEP's position

statement says about physician shifts --

A. No.

Q. -- in the emergency room?

A. No, I don't recall exactly what it would be. No.

Q. What are the shifts at Henry Ford?

A. They work -- they can be 8, 9 or 10 hours.

Q. You don't have any 24-hour shifts in the emergency department?

A. No. Our -- our ER is very busy, so it would be very difficult to do a 24-hour shift.

Q. What's -- what's busy?

A. 95,000 people a year.

Q. Per shift?

A. Well, we -- you know, you -- in the department you can have at any one time up to 130 people in the department, but you've got multiple providers, and multiple residents and rotators. That can go down to 60, can go back up. It varies, depending on patient volume.

Q. What do you know about the patient volume at the Hillcrest emergency department, and specifically the pediatric?

A. Not a lot. Although, my understanding is, is that the pediatric volume was not a great deal, and

that because of that staffing could be on a 24-hour basis because people would actually have time to rest.

Q. Now, where'd you get that understanding?

A. Actually, I -- I discussed that with Erin Hess about that, and I asked specifically.

Q. Today?

A. I don't remember when we talked about that.

Q. Well, what is your understanding of the volume of patients?

A. I don't know the exact numbers.

Q. Well, how do you know if it was such that physicians could sleep?

A. Well, A, that's why they would schedule it that way. That's why they would do that. They wouldn't do that for any other reason.

Q. Do what?

A. They wouldn't schedule someone a 24-hour shift in a busy ER where there was no opportunity to rest. It would not happen. People know you can't do that. That's why you schedule those.

Q. So if it's a busy emergency department, you don't schedule somebody for 24 hours; is that what you're saying?

A. Well, that's a decision that's made by the staffing and the -- the ER physicians as to what they

need based on the volume of patients and how often they need to staff someone for that. That's how you staff.

Q. Okay. But you don't really specifically have the knowledge, as you sit here today, of the patient volume at the emergency department at Hillcrest, so you can't really say whether 24-hour shifts were appropriate or not, can you?

A. No. No. But I can tell you that having been involved in this, especially for the longest time, in smaller volume ERs it's not uncommon that people will have shifts that can be 24 or even 48 hours, because they have time to rest within that shift. So that happens.

Q. Well, what's considered a small volume?

A. I don't know the exact numbers because I don't do staffing. It's not my area of interest. But I can tell you this happens. And it's not uncommon.

Q. What do you mean? You mean 24-hour shifts happen?

A. Yes.

Q. Okay.

A. Yes.

Q. And --

A. And it can be a 48-hour shift if it's a small hospital.

Q. Okay.

A. Someone can stay for two days.

Q. Have you ever worked at a hospital like that?

A. No, I have not.

Q. Do you know the factors that ACEP recommends be taken into account with respect to shifts and length of shift?

A. No, not specifically.

Q. Night shift and Circadian rhythm and things like that?

MS. HESS: Objection.

A. I don't know specifically. You know, there may be recommendations. You know, in our own shop we've decided to go to single midnights rather than a whole bunch in a row because the theory is that the recovery is easier. So there's various theories. Other places may say no, if you work midnights, for example, if you do a series and you now shift your Circadian rhythm, you should stay doing midnights for a while, and then not do midnights for a length of time and then go back. So there's different philosophies on how best to staff the midnight shift. There's no one answer that I know of to that.

BY MR. LANSDOWNE:

Q. Okay. Just let me be clear about this, Doctor. And it may be similar to the evening visit. But you're not going to be offering an opinion in this case that it was appropriate for Dr. Billow to be working a 24-hour shift on the specific October 22nd and 23rd date, are you?

A. No.

Q. Okay.

A. Understanding that if he did do it, there's -- that -- I believe that's probably the reason, that this is a lower volume place. This is -- this happens.

Q. Okay. Well, I mean that's a belief you have, but --

A. No, I know it happens. I mean I know in smaller places that that's the way they work. I know that.

Q. Let me just ask you this. In your experience at Henry Ford in an eight-hour shift, how many, you know, patients on average do you see?

A. Depends where you work. Depends on the shift. In category 1, which is our acute life threat, you may at any one time have up to 20 people, but it varies. Depending on availability of critical care beds, some move out, some don't, so the actual volume

really depends on the egress from that area as from the rest of the E.R.

In the category 2 area, there's two of them, you could have, you know, 7 or 8 to 22 or 23 in your area.

In our peds. and our non-acute area, because they're very close together, we staff those together, you could have anywhere from three or four people to 27 or 30 people. It varies. The volume varies depending on the time of day and depending on the individual day.

Q. Mm-hmm.

A. If there's a lot of flu around or not. It just varies.

Q. Mm-hmm. This is a standard question we always have to ask.

A. Sure.

Q. In your work as a medical -- in your medical-legal work as an expert witness, do you have a breakdown of how many times plaintiff versus defense?

A. I would estimate it's always single digits for the plaintiff, and that varies now. So down to 2 or 3 percent or 7 percent, but it's low.

Q. Why is that?

A. I review what people send me.

Q. You're not on any services, are you, that advertise?

A. No. Never have been.

Q. Okay. You mentioned before that you'd seen the post mortem pictures of Roland, Jr.; correct?

A. Correct.

Q. And was there a specific reason that you looked at that, at those?

A. It was part of everything that was sent to me.

Q. Anything that you noted about those pictures?

A. Not -- no, not particularly.

Q. Have you seen any pictures of Roland prior to October 23rd?

A. No, I have not.

Q. So you have no way to know whether what you saw on the photographs is how he looked prior to 10-23-06; correct?

A. I have no -- I have seen no prior pictures of the patient other than post mortem.

Q. I get myself in trouble assuming things, Doctor, so I'm just going to ask you some basic definitions, if you don't mind.

A. Sure.

Q. First of all, we've mentioned it already, but differential diagnosis, can you tell us what that is?

A. Well, it's a series of diagnoses that you would entertain as you start to work up the patient. And then what you do is as you talk to them and examine them and order tests, you try to define that to the more working diagnosis or the initial diagnosis that you have. And then you try to move to a final diagnosis.

Q. Is there a prioritization in the differential diagnosis in terms of severity of the potential illnesses that we talked about before?

A. Virtually everything we see, whether it's headache, neck pain, chest pain, abdominal pain, all can be potentially serious diseases, all of them. Within that there's certain catastrophic diseases that can occur. So you're always thinking a variety of diagnoses, and having that in mind, you work the patient up and try to come to the right diagnosis at that time.

Q. All right. Standard of care, what is that?

A. What a reasonably trained physician would do in a like circumstance.

Q. And in this instance we're talking about a

reasonably trained emergency physician?

A. Well, as we mentioned earlier, there are places throughout the United States that use emergency docs. They use, for example, in this care, pediatricians or other health care providers.

There are actually individuals in the United States who are not trained who are practicing emergency medicine, because there's no way that there would be the -- there's no way that there's enough graduates that could fill every position in every ER. So there's a whole bunch of people out there who aren't trained in the specialty to work in emergency departments.

The goal is to eventually have everybody residency trained and board certified. That isn't where we're at yet.

Q. The goal is to have everybody in every department, in every emergency department, residency trained in emergency medicine?

A. And board certified, yeah. That would be the goal. That will take a while.

Q. But as far as -- as far as the standard of care, it's a reasonably trained --

A. Physician.

Q. -- physician?

A. That's what --

Q. Or is it reasonably trained emergency physician?

A. Reasonably trained physician. Well, you have a standard of care that's an emergency medicine standard. That is provided by emergency docs, and other people who are not emergency docs, and pediatric docs, because there's no way you could have a residency trained emergency physician in every ER. There's just not enough of them. We've gotten more and more and we're moving in that direction. This field started with nobody trained in the specialty.

Q. All right.

A. And we're moving forward to try to make it better.

But so I mean there is a standard of emergency care. Anyone who works in the ER is held up to that standard of emergency care.

Q. And that's been a big part of your career, is the academic part of --

A. Well, we've been trying to develop it, yes.

Q. So let me ask you this, then. With respect to the morning visit --

A. Yeah.

Q. You knew eventually I was going to ask you

something about the morning visit.

A. I was hoping.

Q. Well, I've got three hours, so I might as well kill some time.

A. Take as long as you like. Take four if you like.

Q. But if you told me you were going to not charge me, I'd probably be done in sooner than three hours.

A. Your call. Your call, sir.

Q. But if you want the money, you've got to stay here.

So at what point in the morning visit would the emergency physician have a differential diagnosis for this patient?

A. When they pick up the chart they'd be starting to think of what this patient could have.

Q. Okay. And so what would the -- you've got the chart. And you've tried to review it like that, as if you were picking up this chart yourself, haven't you?

A. Mm-hmm.

Q. Better if you say yes.

A. Yes. Yes.

Q. And so you pick up the chart, and what's the

differential diagnoses that are going through your mind?

A. Well, you've got to read the chart first. So I mean you start thinking, here's a 19-year-old patient that comes in that actually is complaining of vomiting, cold, sore, felt warm, achy, and that the emergency doc describes as having nausea, vomiting, aches, low grade fever, positive sore throat. I mean you're totally thinking this is some sort of viral syndrome. And there wouldn't be much else in my differential at that point.

Q. So nothing beyond viral syndrome initially?

A. With this presentation, that's what would be the first thing. I don't even know what else I would be thinking of. It certainly sounds like a viral syndrome.

Q. Okay. And then obviously the physician, Dr. Billow, sees the patient.

A. Correct.

Q. And we have his note from that; correct?

A. Yes.

Q. All right. We've got his T sheet; correct?

A. Right. Yes, we do.

Q. All highlighted?

A. Correct.

Q. Again we've got tachycardia?

A. 116, mild tachycardia, as we said earlier.

Q. And blood pressure, what's your -- what's your thought about --

A. For a 19-year-old male, not remarkable.

Q. Okay. Would you, if you're the emergency room physician, do anything to find out what his -- what the patient's baseline blood pressure would be?

A. 19-year-old kid, no.

Q. Okay.

A. Unless he said he had a history of hypertension or there was another reason to do that.

Q. Let me ask you this. If a patient presents to the emergency room with abnormal vital signs, is it your practice to recheck the vital signs before the patient's discharged?

A. Not always, no.

Q. Not always?

A. No.

Q. Why not?

A. Well, it's a clinical evaluation of the patient. If the patient's improving, looking better, you briefly examine them, they're better, I don't repeat them always. Some cases, if I'm concerned, I might. But it's a clinical decision that drives that.

Q. How long does it take to get a set of vital signs?

A. Depends how busy the ER is. Depends who's available.

Q. I mean once you've --

A. Once you've actually got someone there? Doesn't take long to get a blood pressure, a pulse, a temperature.

Q. A couple minutes?

A. Well, probably longer. Probably five, ten minutes.

Q. Is it costly to get a set of vital signs?

A. Well, it takes somebody's time. It takes them away from somebody else. It may be a --

Q. Is that the only cost, time?

A. Well, you'd need the equipment. You need the person to do it.

Q. Okay. If -- do you do vital signs yourself on all your patients?

A. I can -- no. I mean I can. I mean the odd time I might, but most of the time we have nursing staff or the technical staff to do it.

Q. So the -- if the nurse does the vital signs, don't need to do it; is that your --

A. I am free to do them if I feel there's some

reason I need to repeat them; they've changed, they're different, whatever. I mean I can if I want.

Q. Okay. What's your understanding of why Dr. Billow ordered a bolus of fluids?

A. Well, the patient had been nauseous, vomiting. He felt he was dehydrated and they wanted to rehydrate him.

Q. Was it partially, that order, based upon his elevated heart rate?

A. I believe so. That would be a reasonable assumption.

Q. That dehydration was causing the elevated heart rate?

A. That would be one of the possibilities, yeah. I mean people come into ER, sometimes they get anxious. There's a number of reasons why a heart rate could go up. But in the context of nausea, vomiting, you know, most people would say, well, probably is a little dry.

Q. One of the things you talk about in your report is -- one of the categories you list is you talk about history, physical examination, laboratory investigations, therapeutic interventions and follow-up recommendations; right?

A. Correct.

Q. And the fluids would be a therapeutic intervention; correct?

A. In addition to the medications, yes.

Q. If possible, should an ER doctor evaluate whether therapeutic intervention has had the desired effect?

A. Well, he did, according to his deposition. He went back and re-evaluated the patient.

Q. And my question is just should an ER physician attempt to determine whether therapeutic intervention has had any effect?

A. Most of the time, yeah. I mean I would go back to see if -- and I think most docs would, to see if they did -- most of the time you would, to see if the patient's better, same or worse.

Q. Do you agree with Dr. Billow -- you read his deposition -- that you would expect that if the heart rate was from dehy- -- the elevated heart rate was from dehydration, that the bolus of fluids would reduce it?

A. It's possible, yeah. I mean if you felt it was strictly dehydration, you should see some improvement. You'd think you would, unless the patient was anxious or there was something else going on. But, yeah, you would.

Q. And I think Dr. Billow said if the heart

rate didn't come down, the patient would have to be re-evaluated. Do you agree with that? After the fluids.

A. It's a clinical evaluation. I mean it's not just the heart rate. It's how is the patient doing.

Q. Well, I'm just referring to his statement in his deposition that if the heart rate didn't come down after the fluids, you'd have to --

A. Re-evaluate them, make a decision as to what you want to do.

Q. Okay.

A. And that would be a clinical decision.

Q. Now, is it your understanding that Dr. Billow did not recheck Roland's heart rate after the fluids?

A. It was my understanding that he re-evaluated him and listened to him and felt that the patient was better. So he would have heard what the heart rate was and felt that it was reasonable, whatever it was. And that was a response to therapy.

Q. What do you mean listen to the heart rate?

A. I believe he said he examined him.

Q. You're saying that it's your understanding that he listened to the heart rate?

A. Or he went back and re-evaluated the

patient. And I can't remember exactly. I thought he actually listened to the chest. But I'm not sure. I'd have to look at it.

Q. Well, please do, because I think this is kind of important.

A. I mean I would have to readdress and reassess the whole clinical situation at that time.

He says: You didn't recheck his heart rate.

The answer was: No.

Q. Okay. Was that your understanding then?

A. Well, that's what it says here, yeah.

Q. So he didn't recheck the heart rate; correct?

A. Well, I mean I don't know if he felt the pulse rate or listened. I mean that's what I've got to find out here. Because if you listen, you can actually listen to the heart rate rather than checking the pulse. Maybe that's what he was talking about. Let me -- just give me one moment.

Q. Take as much time as you would like. We've got three hours. That's fine.

A. I will. Thank you.

Q. Yeah. Why don't you.

I tell you what, I'm going to go to

the rest room. All right?

A. All right.

(A short recess was taken.)

BY MR. LANSDOWNE:

Q. Doctor, have you had a chance to --

A. Yes. No, I reviewed this. It does not appear that he reexamined him. He said that he reassessed him, and the reassessment was how he felt, his mentation, et cetera, and from that he felt he was better.

Q. So you --

A. So I was in error.

Q. Okay. That's all right.

So -- and he said he didn't -- I think he, specifically Dr. Billow, said he didn't need to know his heart rate. Did you read that?

MS. HESS: Objection. Go ahead.

A. I'm reading that he felt that based on his improvement and everything else that, yeah, he didn't specifically check it for that reason. The patient said he was feeling better, and so that that was good.

BY MR. LANSDOWNE:

Q. All right. Well, don't you think it would have been a good idea for him to recheck his heart rate?

A. No. If a patient -- I mean 19-year-old kid comes in with a viral syndrome, he's got a mild tachycardia, receives some fluids, is feeling a lot better, no.

Q. Would there be anything wrong with checking his heart rate?

A. Well, I guess I could recheck all the vital signs of every single patient in the ER every five minutes. I'm not sure what value it would be.

Q. I didn't really ask you to recheck every patient.

A. No. But I'm saying you're saying, well, would there be any harm in it. Well, the counter is obviously that you could check the vitals on everybody. There wouldn't be any harm in it. It's just for what purpose?

Q. I am specifically asking about Roland.

A. And I'm -- and that's what I said. That, you know, the patient was better, the patient said they felt better, he had gotten adequate fluids, he had kept down Gatorade. I wouldn't have.

Q. I mean --

A. Would not have.

Q. -- wouldn't it be kind of a logical thing? You've given this bolus of fluids

because you're thinking he's dehydrated and that the heart rate is related to -- let me finish -- is related to the dehydration, and then you check the heart rate and see what it -- what it's doing?

A. It's a mild tachycardia. Mild tachycardia in a young man who's otherwise healthy, who's received fluids and who's feeling better. The answer would be no, I don't think it's logical.

Q. Okay. What do you think was causing him the tachycardia?

A. At the time that -- well, at the time --

Q. Now that you -- that you have seen the whole case now, so now --

MS. HESS: I object to the retrospective, but go ahead.

A. It may have been the nausea and vomiting. He may have been dehydrated. That clearly may have been why he was tachycardic at the time. It may have been in part because he was in initial phases of this meningococcemia. I don't know for sure really. It may have been a combination of things.

BY MR. LANSDOWNE:

Q. You don't have an opinion one way or the other?

A. Well, I just said it could be a number of

things. So I'm saying my opinion is it could be a number of things, which is different.

Q. Okay. And you don't know which one?

A. No. He was throwing up and vomited and -- you know, he could be dry from that easily.

Q. Now, your report also talks about the laboratory investigations.

A. Yes.

Q. And let's see, Strep test was one of these laboratory investigations I guess; right?

A. Yes, negative.

Q. Obviously done to rule out Strep, I suppose?

A. Strep throat.

Q. And basic metabolic panel; right?

A. Correct.

Q. What was that done for?

A. To assess his volume status, to assess his hydration status.

Q. And what were the results?

A. He had a minimally elevated creatinine of 1.5, the range being .8 to 1.3. A minimally elevated glucose at 111, range being 70 to 100. And a minimally decreased potassium at 3.4, with a range of 3.5 to 5.1 being normal.

Q. So what did those tell you about -- or tell

the doctor about the volume status and hydration status?

A. Probably dry.

Q. Based on the -- the abnormal findings that you just told me?

A. The creatinine. The sugar is -- I don't know when he last ate. It would be hard to comment on that. Potassium at 3.4 may have been from his GI upset. But the creatinine would have been the thing that, you know, would have pointed to that.

Q. Complete blood count was done. What was the purpose of that?

A. The complete blood count, to evaluate this patient, who had a history of some fever and nausea and vomiting.

Q. And what were the results and what were the significance of those results?

A. Well, the white count was 15.3, which is elevated. Upper range of normal, 10.5. The hemoglobin, hematocrit and platelets were normal, and there was on the differential 94.4 percent neutrophils, with an upper limit of 78 percent as the reference. Pretty non-specific results.

Q. I think Dr. Billow acknowledged that these results would represent a left shift?

A. Yes, the 94.4 would be.

Q. And what's the significance of that?

A. Non-specific has been seen with bacterial infections, viral infections.

Q. How does a viral infection produce a left shift?

A. Don't know, but we see them. And if it's the stress, I don't know. I don't know, but we see them. It's non-specific.

Q. What percentage of patients with viral syndrome do you see a left shift?

A. Some.

Q. What percent?

A. I don't know. I mean that's -- I have no idea, but you see it. And it would be not rare, but not common, but you see it.

Q. Not rare, but not common, and you can't tell me what percent; right?

A. Well, I mean I don't know the literature well on this area, but you see it.

Q. And why it happens you just don't know?

A. Demargination, don't know.

Q. Demargination, what are you talking about?

A. Yeah, when cells come out of the spleen and you see more of an increase in white count.

Q. Dr. Billow testified that with the left shift one thing you'd have to consider was a bacterial infection.

A. In the differential with this, yes. But this must be interpreted in light of the clinical picture. All these lab tests must be interpreted in light of the clinical picture. You don't treat a lab test, you treat the patient.

Q. Right. Is there anything inconsistent in the clinical picture with a bacterial infection?

A. Inconsistent with a bacterial? I don't think there's anything consistent with bacterial infection.

Q. Yeah. My question is, is there anything inconsistent? If you say it's -- what is it about this presentation that is not consistent with a bacterial infection?

A. Some -- young men or women that come in with nausea and vomiting, felt warm, aches, the complaints that he had, I mean I don't see bacterial infections in those. Bacterial infections in those younger people tend to be UTIs, they tend to be pneumonias, they tend to be cellulitis, abscess, things of that nature. You don't see this presentation with bacterial infections in young people.

Q. Isn't that a common presentation for a bacterial meningitis?

A. Not at all. A meningitis is a headache and neck pain. You have headache and neck pain.

Q. What about meningococcemia?

A. Don't know. Extremely rare disease. As we've mentioned, in my entire 34 years maybe seen it, maybe seen it, you know, under ten times. Would certainly not be something I would be thinking of, nor I believe the vast majority of emergency physicians that you talk to.

Q. Is that presentation that Mr. Cunningham had consistent with that disease process?

A. The early stages of meningococcemia can. And it's been known to be notoriously different, to differentiate from a simple viral infection. The thing that is most extremely helpful is the rash, the characteristic rash that you get from meningococcemia. That really is what leads you to a different diagnosis.

Q. So did he have a rash?

A. Well, the medical personnel at the first visit, as far as I can see the medical personnel at the second visit, so this includes doctors and nurses, and the report, the autopsy report, all say no.

Q. So are you, as part of your evaluation of

Dr. Billow's conduct in this case, are you assuming that there was no rash?

A. I don't believe -- there's nothing in the medical record that says there was. There's nothing in the post mortem exam that says there was.

Q. So again, my question is, is part of your opinion in this case based upon your belief that there was no rash?

A. I have reviewed the medical records, and there's no indication in the medical records by anybody that there was a rash, so I believe there was not a rash.

Q. How do you explain the family's testimony?

A. I really --

MS. HESS: Objection.

A. -- don't know. I don't know. I looked at the pictures. I don't think he had a rash, myself.

BY MR. LANSDOWNE:

Q. Looking at the pictures?

A. Yeah. There's a little bit of darkening on each side of the nose. Does not look like a rash to me. But I don't know what that is. Certainly not characteristic of anything. And certainly nobody else that saw him thought it was characteristic of anything.

Q. Have you read any literature about the

evaluation of skin for rashes with African-American patients?

A. I haven't read any, but I treat -- the predominant patient type that we see is African-American, and I don't have a problem with the rashes. And if you treat African-Americans, I believe you don't.

Q. Right. Do you know what the experience of the -- these medical personnel was with treating African-Americans?

A. No. Actually, I don't.

Q. So you haven't seen any literature discussing that, particularly nursing literature?

A. I don't read the nursing literature.

Q. Okay. So you haven't seen it?

A. No. I don't read the nursing literature.

Q. All right. Do you do anything in your training of residents to make them aware of if a -- if one of your residents is not African-American, do you -- because of the population that you see, do you make them aware of the need to be particularly careful in looking for skin rashes in African-Americans?

A. Well, we try to be particular in all people, and African-Americans as well.

Q. In the patients that -- the few patients

that you've seen with the rash -- well, one of them was a petechial type rash.

A. But that's the characteristic. And it's characteristic in the trunks and on the extremities.

I've never heard of nor seen or seen a case report in my career of a localized rash, if you had it, that would be simply on the nose. I know of nothing in the literature; no case report, zero, that says that that can occur.

Q. Have you looked?

A. I've been doing this for 34 years. We have M & M's. Some of those have been infectious etiologies. I've never seen nor heard of a discussion of any particular rash only on the nose in someone that dies of fulminant meningococcemia.

Q. Have you looked?

A. No. I haven't specifically looked, no.

Q. So you don't know what the literature says about where the rash can appear?

A. Well, no. No, sir. I treat a lot of these patients when we evaluate them for this, so the discussion has always been, in people that come in who have rashes, what do they have, where are they, et cetera? We discuss this all the time. I've never heard or had any other staff or at rounds had anyone

report on this particular type of case. Never.

Q. I think my question, Doctor, was you don't know what the literature says about where the rash can occur, do you?

A. Sure I know where it can occur. Occurs in the -- the literature says it's truncal and in the extremities. That's where it characteristically occurs.

Q. What literature are you referring to?

A. Not specifically I don't know of any. Over my career I've read this many times.

Q. In what many times?

A. I read a lot of different journals, I read a lot of different texts, I read a lot of things. So if you're going to now expect me to be able to quote each individual paper, review article, text that I've read is very unreasonable.

Q. Just give me one, will you?

A. I don't know. You could probably just look in the Rosen's Textbook of Emergency Medicine if you like, and look up that chapter. I don't know what it says, but I assume it will say that.

Q. Okay.

A. Look it up.

Q. And if -- so Rosen's you'd accept as

authoritative?

A. No, I wouldn't. It's just a source. You asked me for a book. You didn't ask me for an authoritarian book.

Q. Well, I asked you for a book that said what you say. And you've said Rosen's, but you don't know what it says, so that's kind of nonsensical, frankly. But --

MS. HESS: I'm going to object, because he's told you that over his career he reads a lot of things and he can't quote for you line and verse which one it came from. So I don't know why we're going around in circles about it.

MR. LANSDOWNE: Well, I'm just trying to get a straight answer, frankly.

A. I'm giving you a straight answer.

MS. HESS: The straight answer was: I don't have the title of them off the top of my head.

A. I did give you a straight answer, sir.

BY MR. LANSDOWNE:

Q. No, you didn't.

A. Yeah, I did.

Q. The record will speak for itself.

A. Absolutely.

Q. Now, have you read the infectious disease

expert's deposition in this case?

A. Yes, I have.

Q. Doctor, I'm not talking about Dr. Talan.

MS. HESS: He already said he reviewed Zenilman's earlier.

A. Yeah.

BY MR. LANSDOWNE:

Q. I'm talking about the defendant's infectious disease expert, Dr. Gianakopoulos. Is that how he says his name?

MS. HESS: Gianakopoulos.

MR. LANSDOWNE: Gianakopoulos.

A. No.

BY MR. LANSDOWNE:

Q. Have you seen his report?

A. I mentioned the reports I have. It wasn't in there.

Q. Well, did you know that there's an infectious disease expert retained by the defense in this case named Dr. Gianakopoulos?

A. No.

Q. Have you discussed that at all with Ms. Hess?

A. No.

Q. Do you know what he says, the infectious

disease expert, about where the rash commonly appears?

A. If I haven't seen it nor heard of it nor seen his dep, why would I know what he said?

Q. Well, maybe Ms. Hess told you.

MS. HESS: You just asked him that and he said no.

BY MR. LANSDOWNE:

Q. Well, I asked him about something -- so you just don't know?

A. I explained to you a number of times that I've not seen them, not read, not heard of, are not aware of this person being involved in this case.

Q. Would you defer to an infectious disease expert as to where the rash typically occurs, that is, the rash associated with meningococcemia?

A. If it was different from what I said, yes, I would. I would not -- I would not agree with him.

Q. You would not?

A. It's predominantly on the extremities and the trunk. Can spread elsewhere, but it starts there. If they said that were not true, I would disagree with them.

Q. Okay. Now, with respect to -- actually, if I've asked you this, Doctor, I apologize.

This report that you authored is

January 20th, 2009; correct?

A. Yes. If that's what the date on it is, yes.

Q. And that's just a preface for my question. This is your one and only report in this case?

A. Yes.

Q. And are there any additions to it?

A. No.

Q. Let me just ask that with respect to your conclusion that the emergency medical care did meet the standard of care, there's no particular book or protocol or guideline that would tell you for this particular patient this is the standard of care; correct?

A. No. It would be 34 years of practicing the specialty.

Q. Right. And that's what I'm getting to. You're -- this is your opinion based upon your experience and training; right?

A. Correct. You know, and my interactions with people all across the country at meetings.

Q. Sure.

A. And that's my sum total of experience in the specialty.

Q. Okay. Now, you've -- if I may. I apologize, Doctor. Obviously you disagree with

Dr. Erling's report. I guess there was only a few things that aren't highlighted here.

A. I highlight a lot.

Q. Yeah. And -- but obviously you have a disagreement with Dr. Erling?

A. Yeah. He believed this did not meet the standard of care, and I believe it did.

Q. Okay. And I don't know if you -- other than that, I don't know if you can -- if you're able to summarize, you know, where -- where you two depart in terms of getting to your -- your conclusion. You both reviewed the same records, you've reviewed the same testimony. What do you understand Dr. Erling's conclusions as to the breach of the standard of care to be?

A. Well, the standard of care was met --

MS. HESS: Objection.

A. -- by the records I reviewed. My job was not to assess why someone -- why they didn't meet the standard of care. My job was to look at the records and determine what the standard of care was.

This clearly, in my opinion, states that standard of care for this visit was met in terms of the assessment and therapeutic interventions, disposition, everything else.

BY MR. LANSDOWNE:

Q. I understand that, Doctor. And I'm not quarrelling with what you -- what you've said you've done. My question was, do you understand what Dr. Erling's criticisms are?

A. Not really well. I mean he seems to think that somehow this all should have been, you know, a diagnosis of meningococcemia or something that would have been made, you know, at the time. I don't think it could have been done.

MR. LANSDOWNE: Is Dr. Erling's testimony in here?

MS. HESS: Yeah.

MR. LANSDOWNE: Is it?

MS. HESS: Yeah.

A. I have his deposition. You know, it's -- it's of interest that Dr. Erling believes that there was a purpuric rash and that it was missed. And as we said earlier, we can't seem to find anyone else in the medical record that says that was there.

BY MR. LANSDOWNE:

Q. Mm-hmm. I assume you agree with Dr. Talan that if there had been a purpuric rash, that should have changed the approach to this patient?

A. Well, clearly it would have raised more red

flags, yeah.

Q. I guess I don't need that.

Do you know a Dr. -- emergency room physician, Dr. Molinary (ph), at Hillcrest Hospital?

A. No. No.

Q. Have you been told anything about Dr. Molinary's statements in this case?

A. No.

Q. Or anything about her proposed testimony in the case?

A. No.

Q. Is there anything that you've asked for in this case that you haven't been able to review?

A. No.

Q. I think you said you looked at the 10-12 ER record?

A. 10-12-06, yes.

Q. Any significance to that record in your finding -- or your opinions in this case?

A. No. Well, no. Patient had what looked like a "URI."

Q. Okay. Do you have the ability at -- well, now you're on electronic, but prior to when you went electronic, did you have the ability to, if you saw a patient, to go back and see whether they'd been seen in

the ER in the past month, past six months, things like that?

A. Well, you'd have to pull the medical record, and that takes time.

Q. Okay. It wasn't something that you could get immediately?

A. No.

Q. Okay. The electronic medical record program that you have now that you discussed before --

A. Yes.

Q. -- were you involved at all in creating that software?

A. No.

Q. Do you have any proprietary interest in it?

A. No.

Q. Do you know who the -- the manufacturer, seller of that software is?

A. No.

Q. How long have you been on it?

A. It's been a couple of years, I think. Prior to that we had some electronic medical record with a different vendor and we could supplement it with dictations. And now it is all online. We don't dictate. So rather than dictate, you just type in and edit, you know, individual descriptions or plans or,

you know, what happened to the patient.

Q. I have to ask you these questions, Doctor. Has your testimony -- have you ever been precluded from testifying in a case?

A. No.

Q. And I assume you've never had any situation where your medical license has been suspended or revoked?

A. No. No.

Q. Or your privileges?

A. No.

Q. I apologize. You understand I have to ask these questions.

A. No, I understand. I understand.

Q. Let me just look at the -- at your file again quickly, Doctor. And then I'll probably be on -- I don't want to mix it up with my file.

A. No, I don't. Although they're easy to discriminate because of the yellow.

Q. Well, I sometimes highlight myself. This will just take a minute, Doctor.

A. I've got to write myself a note to get you a new C.V.

Q. Yeah.

A. Or else I may forget. I'm going to e-mail

it to Ms. Hess, and she can -- she needs it, and she can forward it to you.

Q. Okay. Thank you.

In laymen's terms, is what Roland presented with the morning of October 23rd, 2006 flu-like symptoms?

A. Yeah.

Q. About how much time have you spent on this case?

A. I don't know. Well, probably 10, 15 hours. Something like that.

Q. I mean have you sent a bill yet or --

A. Initial one that was paid, and then I still have some other stuff to send.

Q. Okay. Is there anything that you're planning on doing between now and the time of your testimony with respect to this case, other than re-review this?

A. Well, if -- for testimony I will, as I did for the deposition, just review everything, so that I'm prepared.

Q. Have we covered all your opinions in this case?

A. Everything I've been asked I've answered.

Q. Well, if there's an opinion that you plan on

expressing that we haven't discussed, would you tell me about that?

A. At the present time there isn't.

Q. Okay. And I think we've covered the bases for your opinions; right?

A. I believe you've asked and I've answered your questions.

MR. LANSDOWNE: Okay. Well, that will do it for me.

THE WITNESS: Okay. Thank you.

MS. HESS: I'll have him read it.

(Deposition concluded at 5:08 p.m. Signature of the witness was requested.)

ROLAND CUNNINGHAM, SR.,
et al.,
Plaintiff,
vs. Case No. CV07639012
MERIDIA HEALTH SYSTEM,
et al.,
Defendant.

VERIFICATION OF DEPONENT

I, having read the foregoing deposition consisting of my testimony at the aforementioned time and place, do hereby attest to the correctness and truthfulness of the transcript.

_____

RICHARD M. NOWAK, M.D.

Dated:

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF WAYNE)

I, Jacquelyn S. Fleck, a Notary Public in and for the above county and state, do hereby certify that the above deposition was taken before me at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth, and nothing but the truth; that the foregoing questions asked and answers made by the witness were duly recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to either party nor interested in the event of this cause.

_____

Jacquelyn S. Fleck, CSR-1352, RPR, RMR, CRR,
Notary Public,
Wayne County, Michigan
My Commission expires: August 16, 2006

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EXHIBITS

EXHIBIT PAGE

(Exhibits not offered.)