

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,

1 APPEARANCES:

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19 Billow, M.D., and Emergency Professional

20 Services, Inc.

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1 Detroit, Michigan

2 Monday, November 2, 2009

3 About 3:01 p.m.

4 RICHARD M. NOWAK, M.D.,
5 having first been duly sworn, was examined and
6 testified on his oath as follows:

7 EXAMINATION BY MR. LANSDOWNE:

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

10 A. Richard Michael Nowak.

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

15 A. Yes, I have.

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

21 A. I do.

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

1 A. I will.

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

5 A. Correct.

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

10 A. Okay.

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

14 A. Okay.

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

19 A. All right. Thank you for that.

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

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

24 Q. I have a C.V.

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

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

3 Q. Okay. Well --

4 A. Which is --

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

6 A. I can e-mail it to her.

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

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

12 Q. You say you're past chair.

13 A. Yeah.

14 Q. What are you currently?

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

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

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

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

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

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

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

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

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

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

25 A. Yes.

1 Q. Okay.

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

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

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

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

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

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

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

20 Q. Okay.

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

25 Q. That's just a change in name?

1 A. Yeah.

2 Q. Okay.

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

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

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

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

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

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

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

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

4 Q. And this is all at Henry Ford?

5 A. Yes.

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

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

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

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

13 Q. Yes.

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

19 Q. Okay.

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

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

25 A. Yeah.

1 Q. So that's still --

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

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

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

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

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

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

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

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

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

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

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

15 Q. Okay.

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

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

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

25 Q. Okay.

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

5 Q. Right.

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

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

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

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

19 A. Yes.

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

22 A. Yes.

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

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

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

3 Q. And so --

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

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

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

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

14 A. Yes, I do. I do.

15 Q. All that highlighting is making me nervous
16 now.

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

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

21 A. Want to know what I have?

22 Q. Yeah. Would you just tell me.

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

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

9 Q. I think that's Roland.

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

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

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

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

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

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

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

24 A. No.

25 Q. Okay.

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

2 Q. Okay.

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

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

8 A. Yes.

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

11 A. No.

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

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

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

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

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

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

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

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

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

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

13 Q. Okay. So you had different opinions --

14 A. Yeah.

15 Q. -- about the standard of care?

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

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

23 A. Yes, it was.

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

1 A. Correct.

2 Q. On behalf of the defense?

3 A. Correct.

4 Q. And -- okay. Were any of those cases with
5 Dr. Talan cases out of the state of Ohio?

6 A. You know, I don't remember. I just don't.

7 Q. Have you testified in Ohio before?

8 A. Yes.

9 Q. In -- have you testified in Cleveland
10 before?

11 A. Yes.

12 Q. I would think so.

13 MS. HESS: What was your question?

14 I didn't hear you.

15 BY MR. LANSDOWNE:

16 Q. I just said I would think so, your
17 connection to the case and everything. And --

18 MS. HESS: Oh.

19 BY MR. LANSDOWNE:

20 Q. When's the last time you testified in court
21 in Cleveland?

22 A. I'm really not good with these dates,
23 because when these cases are done, they're gone. I
24 don't remember them and I don't want to remember them.

25 I think it would have been within

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

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

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

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

11 A. That I don't know.

12 Q. Okay. How about Team Health?

13 A. That I don't know either.

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

15 A. Yes.

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

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

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

24 A. No. No. Not at all.

25 Q. Are the emergency department physicians at

1 Henry Ford employees of the hospital?

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

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

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

14 A. Yes, we would be similar.

15 Q. Okay.

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

17 Q. Sure.

18 A. -- but similar.

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

23 MS. HESS: Which one are you talking
24 about?

25 BY MR. LANSLOWNE:

1 Q. Meningococemia.

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

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

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

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

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

3 A. 34.

4 Q. 34. Sorry.

5 Ten cases?

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

9 Q. How about meningitis?

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

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

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

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

23 Q. Okay.

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

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

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

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

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

16 A. No.

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

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

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

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

1 clinical care.

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

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

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

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

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

17 A. To lead the organization in its mission.

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

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

1 we did.

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

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

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

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

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

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

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

25 Q. Right.

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

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

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

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

13 A. It's to see emergency patients.

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

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

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

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

25 Q. Okay. And tell me about your teaching

1 responsibilities right now, if you would.

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

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

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

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

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

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

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

12 Q. Okay.

13 A. The worst possible disease process?

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

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

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

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

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

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

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

12 A. Oh, yeah.

13 Q. And --

14 A. We read them and sign off on them.

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

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

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

1 A. Yeah, you could. Sure.

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

6 A. Yes, you try to.

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

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

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

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

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

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

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

6 A. Yes.

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

9 A. Yeah.

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

13 A. Yes.

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

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

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

23 A. Yeah.

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

1 A. The evening, not the morning?

2 Q. Right. You did review that; correct?

3 A. Yeah. It was not the primary focus of my
4 review. I was asked to review the morning visit in
5 particular, the care provided by Dr. Billow.

6 Q. Okay. Well, that's a good point. When you
7 were contacted about this case -- and who contacted
8 you, by the way? Ms. Hess?

9 A. Ms. Hess' office, yes.

10 Q. Was it Ms. Hess or somebody --

11 A. I don't know. I don't know.

12 Q. Okay. Had you worked with that office
13 before?

14 A. Yeah.

15 Q. Okay. On how many occasions?

16 A. A few.

17 Q. Okay.

18 A. I just don't think I remember. It's not 20.
19 It's a few. It may be ten, somewhere -- six, somewhere
20 in there.

21 Q. Do you have any other cases besides this one
22 going on with that office?

23 A. I don't believe so.

24 Q. Okay.

25 A. Although, some -- the reason I say that is

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

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

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

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

11 A. Yeah.

12 Q. And you looked at it --

13 A. Yeah.

14 Q. -- reviewed it; right?

15 A. Mm-hmm.

16 Q. It's better if you say yes.

17 A. Yes. Yes.

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

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

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

24 A. On the evening visit?

25 Q. On the evening visit.

1 A. Yes. Yes. I have it.

2 Q. Now, with respect to vital signs --

3 A. Yes.

4 Q. -- you've got a lot of highlighting up
5 there, too.

6 A. I have highlighting everywhere.

7 MS. HESS: It's all highlighted.

8 BY MR. LANSLOWNE:

9 Q. And no blood pressure was obtained; is that
10 right?

11 A. It appears so, yes. I don't see one
12 written.

13 Q. I mean blood pressure is a -- it's a
14 vital -- one of the vital signs; correct?

15 A. Correct.

16 Q. It's important to obtain a blood pressure,
17 isn't it, on a patient?

18 A. If possible, yes.

19 Q. Well, what -- what are the reasons it would
20 not be possible to obtain a blood pressure?

21 A. You know, I mean, again, I -- I don't know
22 if there was one done later. I mean I didn't spend a
23 lot of detail on this particular visit. I mean I read
24 it, but if you're asking me a specific thing about
25 vitals or if there were more, I just don't know. I'd

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

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

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

8 A. Sure.

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

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

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

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

19 Q. But I mean as --

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

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

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

1 chart for that purpose.

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

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

8 Q. And you haven't done that?

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

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

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

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

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

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

1 the standard of care?

2 A. I was never asked to do that.

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

4 A. No.

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

7 A. The evening, okay.

8 Q. -- still in the evening --

9 A. Okay.

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

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

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

20 Q. What's the program?

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

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

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

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

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

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

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

14 Q. Oh, okay.

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

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

21 A. I do.

22 Q. And do you see the pulse is 116?

23 A. I do.

24 Q. Which would be tachycardic?

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

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

3 Q. Well, what grade would this be?

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

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

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

10 Q. You've got them highlighted.

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

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

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

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

21 Q. And pulse would be elevated, not normal?

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

25 Q. And of course tachycardia is not checked

1 under this box, is it?

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

4 Q. Do you know why that is?

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

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

14 A. Elevated.

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

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

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

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

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

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

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

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

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

11 BY MR. LANSDOWNE:

12 Q. I understand that.

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

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

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

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

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

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

8 A. If you say so. Where is that?

9 Q. You were just looking at it.

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

12 A. 6 p.m.

13 BY MR. LANSLOWNE:

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

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

19 Q. Okay. I just thought --

20 A. This is not the point of my review.

21 Q. Okay. I understand.

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

1 A. No. Where are you looking?

2 Q. Right where you're looking. (Indicating.)

3 A. I.V. attempts times two without success at
4 18:20, I think. Is that what you have?

5 Q. That's what I'm reading it as.

6 A. Yep, I think that's what it is.

7 Q. And then?

8 A. Then it says: At 18:45 I.V. placed per --
9 and there's a name.

10 Q. Right.

11 A. And then labs sent, and it has increased.
12 I.V. fluids were increased.

13 Q. So at 18:45 is when the I.V. is placed?

14 A. That's what it looks like in review here,
15 yeah.

16 Q. And then the labs actually -- look at the
17 lab sheet. Labs actually are at 18:35?

18 A. Yes. Collected at 18:35.

19 Q. Do you know when they were reported?

20 A. Well, they were printed at 19:23. I don't
21 know how their ER works relative to reporting of labs,
22 whether it's electronic, whether it's paper. You know,
23 I don't know. Different places do it differently.

24 Q. So you don't know when those labs were
25 reported back to the -- to the emergency room?

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

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

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

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

12 A. Sick patient.

13 Q. Anything other than sick patient?

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

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

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

1 Q. How would you work the patient up?

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

6 Q. I understand.

7 A. The focus was --

8 Q. Yeah, I understand.

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

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

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

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

20 A. Yeah.

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

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

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

3 A. Mm-hmm.

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

5 A. Yes.

6 Q. And by resuscitate what do you mean?

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

10 Q. All right. What's HUS?

11 A. Where is that written?

12 Q. In the -- concerned about HUS.

13 A. HUS.

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

17 BY MR. LANSLOWNE:

18 Q. The attending's note.

19 A. What page; page 1?

20 Q. Page 2 of the attending's notes.

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

22 Q. Fourth line.

23 A. I don't know. Some sort of syndrome.

24 Hemolytic uremic syndrome? I don't know.

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

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

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

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

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

8 Q. Did I say a thousand?

9 A. Yes, you did.

10 Q. A hundred. I'm sorry.

11 A. Mm-hmm.

12 Q. You did see that?

13 A. Yes, I did. Right here.

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

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

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

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

1 Q. Okay.

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

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

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

11 Q. Okay. I just want to make sure.

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

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

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

18 Q. Okay. All right.

19 All right. That cuts down on time
20 there significantly.

21 A. Okay by me.

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

24 A. It's an obsession.

25 Q. Let me just do some housekeeping, then,

1 before I ask you about the morning.

2 A. Okay.

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

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

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

10 A. Correct.

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

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

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

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

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

21 A. No. Those are the charges.

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

1 A. I don't remember meningococemia. I do
2 remember meningitis.

3 Q. You have been involved in cases involving --

4 A. I believe so.

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

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

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

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

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

19 A. I don't remember.

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

23 A. No. No.

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

1 safety and length of physician shifts in the emergency
2 department?

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

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

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

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

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

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

1 statement says about physician shifts --

2 A. No.

3 Q. -- in the emergency room?

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

6 Q. What are the shifts at Henry Ford?

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

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

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

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

13 A. 95,000 people a year.

14 Q. Per shift?

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

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

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

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

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

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

6 Q. Today?

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

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

10 A. I don't know the exact numbers.

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

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

16 Q. Do what?

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

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

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

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

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

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

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

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

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

20 A. Yes.

21 Q. Okay.

22 A. Yes.

23 Q. And --

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

1 Q. Okay.

2 A. Someone can stay for two days.

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

5 A. No, I have not.

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

9 A. No, not specifically.

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

12 MS. HESS: Objection.

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

25 BY MR. LANSLOWNE:

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

7 A. No.

8 Q. Okay.

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

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

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

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

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

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

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

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

12 Q. Mm-hmm.

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

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

17 A. Sure.

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

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

24 Q. Why is that?

25 A. I review what people send me.

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

3 A. No. Never have been.

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

6 A. Correct.

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

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

11 Q. Anything that you noted about those
12 pictures?

13 A. Not -- no, not particularly.

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

16 A. No, I have not.

17 Q. So you have no way to know whether what you
18 saw on the photographs is how he looked prior to
19 10-23-06; correct?

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

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

25 A. Sure.

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

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

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

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

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

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

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

1 reasonably trained emergency physician?

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

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

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

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

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

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

24 A. Physician.

25 Q. -- physician?

1 A. That's what --

2 Q. Or is it reasonably trained emergency
3 physician?

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

13 Q. All right.

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

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

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

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

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

24 A. Yeah.

25 Q. You knew eventually I was going to ask you

1 something about the morning visit.

2 A. I was hoping.

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

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

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

10 A. Your call. Your call, sir.

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

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

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

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

22 A. Mm-hmm.

23 Q. Better if you say yes.

24 A. Yes. Yes.

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

1 differential diagnoses that are going through your
2 mind?

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

12 Q. So nothing beyond viral syndrome initially?

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

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

19 A. Correct.

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

21 A. Yes.

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

23 A. Right. Yes, we do.

24 Q. All highlighted?

25 A. Correct.

1 Q. Again we've got tachycardia?

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

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

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

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

9 A. 19-year-old kid, no.

10 Q. Okay.

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

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

17 A. Not always, no.

18 Q. Not always?

19 A. No.

20 Q. Why not?

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

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

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

5 Q. I mean once you've --

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

9 Q. A couple minutes?

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

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

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

15 Q. Is that the only cost, time?

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

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

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

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

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

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

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

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

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

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

12 Q. That dehydration was causing the elevated
13 heart rate?

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

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

25 A. Correct.

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

3 A. In addition to the medications, yes.

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

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

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

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

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

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

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

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

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

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

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

11 Q. Okay.

12 A. And that would be a clinical decision.

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

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

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

22 A. I believe he said he examined him.

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

25 A. Or he went back and re-evaluated the

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

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

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

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

10 The answer was: No.

11 Q. Okay. Was that your understanding then?

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

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

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

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

23 A. I will. Thank you.

24 Q. Yeah. Why don't you.

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

1 the rest room. All right?

2 A. All right.

3 (A short recess was taken.)

4 BY MR. LANSDOWNE:

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

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

11 Q. So you --

12 A. So I was in error.

13 Q. Okay. That's all right.

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

17 MS. HESS: Objection. Go ahead.

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

22 BY MR. LANSDOWNE:

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

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

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

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

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

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

17 Q. I am specifically asking about Roland.

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

22 Q. I mean --

23 A. Would not have.

24 Q. -- wouldn't it be kind of a logical thing?

25 You've given this bolus of fluids

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

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

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

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

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

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

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

22 BY MR. LANSDOWNE:

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

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

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

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

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

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

8 A. Yes.

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

11 A. Yes, negative.

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

13 A. Strep throat.

14 Q. And basic metabolic panel; right?

15 A. Correct.

16 Q. What was that done for?

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

19 Q. And what were the results?

20 A. He had a minimally elevated creatinine of
21 1.5, the range being .8 to 1.3. A minimally elevated
22 glucose at 111, range being 70 to 100. And a minimally
23 decreased potassium at 3.4, with a range of 3.5 to 5.1
24 being normal.

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

1 the doctor about the volume status and hydration
2 status?

3 A. Probably dry.

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

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

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

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

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

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

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

1 A. Yes, the 94.4 would be.

2 Q. And what's the significance of that?

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

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

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

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

12 A. Some.

13 Q. What percent?

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

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

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

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

22 A. Demargination, don't know.

23 Q. Demargination, what are you talking about?

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

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

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

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

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

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

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

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

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

5 Q. What about meningococcemia?

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

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

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

20 Q. So did he have a rash?

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

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

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

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

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

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

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

14 A. I really --

15 MS. HESS: Objection.

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

18 BY MR. LANSDOWNE:

19 Q. Looking at the pictures?

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

25 Q. Have you read any literature about the

1 evaluation of skin for rashes with African-American
2 patients?

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

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

11 A. No. Actually, I don't.

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

14 A. I don't read the nursing literature.

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

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

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

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

25 Q. In the patients that -- the few patients

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

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

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

10 Q. Have you looked?

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

16 Q. Have you looked?

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

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

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

1 report on this particular type of case. Never.

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

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

9 Q. What literature are you referring to?

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

12 Q. In what many times?

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

18 Q. Just give me one, will you?

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

23 Q. Okay.

24 A. Look it up.

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

1 authoritative?

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

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

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

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

16 A. I'm giving you a straight answer.

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

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

20 BY MR. LANSLOWNE:

21 Q. No, you didn't.

22 A. Yeah, I did.

23 Q. The record will speak for itself.

24 A. Absolutely.

25 Q. Now, have you read the infectious disease

1 expert's deposition in this case?

2 A. Yes, I have.

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

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

6 A. Yeah.

7 BY MR. LANSLOWNE:

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

11 MS. HESS: Gianakopoulos.

12 MR. LANSLOWNE: Gianakopoulos.

13 A. No.

14 BY MR. LANSLOWNE:

15 Q. Have you seen his report?

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

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

21 A. No.

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

24 A. No.

25 Q. Do you know what he says, the infectious

1 disease expert, about where the rash commonly appears?

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

4 Q. Well, maybe Ms. Hess told you.

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

7 BY MR. LANSLOWNE:

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

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

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

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

18 Q. You would not?

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

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

25 This report that you authored is

1 January 20th, 2009; correct?

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

3 Q. And that's just a preface for my question.

4 This is your one and only report in this case?

5 A. Yes.

6 Q. And are there any additions to it?

7 A. No.

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

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

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

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

21 Q. Sure.

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

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

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

3 A. I highlight a lot.

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

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

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

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

17 MS. HESS: Objection.

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

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

1 BY MR. LANSDOWNE:

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

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

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

13 MS. HESS: Yeah.

14 MR. LANSDOWNE: Is it?

15 MS. HESS: Yeah.

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

21 BY MR. LANSDOWNE:

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

25 A. Well, clearly it would have raised more red

1 flags, yeah.

2 Q. I guess I don't need that.

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

5 A. No. No.

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

8 A. No.

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

11 A. No.

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

14 A. No.

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

17 A. 10-12-06, yes.

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

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

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

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

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

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

7 A. No.

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

10 A. Yes.

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

13 A. No.

14 Q. Do you have any proprietary interest in it?

15 A. No.

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

18 A. No.

19 Q. How long have you been on it?

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

1 you know, what happened to the patient.

2 Q. I have to ask you these questions, Doctor.

3 Has your testimony -- have you ever been precluded from
4 testifying in a case?

5 A. No.

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

9 A. No. No.

10 Q. Or your privileges?

11 A. No.

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

14 A. No, I understand. I understand.

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

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

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

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

24 Q. Yeah.

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

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

3 Q. Okay. Thank you.

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

7 A. Yeah.

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

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

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

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

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

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

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

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

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

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

3 A. At the present time there isn't.

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

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

8 MR. LANSLOWNE: Okay. Well, that
9 will do it for me.

10 THE WITNESS: Okay. Thank you.

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

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

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1 ROLAND CUNNINGHAM, SR.,

2 et al.,

3 Plaintiff,

4 vs.

Case No. CV07639012

5 MERIDIA HEALTH SYSTEM,

6 et al.,

7 Defendant.

8

9

10 VERIFICATION OF DEPONENT

11

12 I, having read the foregoing

13 deposition consisting of my testimony at the

14 aforementioned time and place, do hereby attest to the

15 correctness and truthfulness of the transcript.

16

17

18

RICHARD M. NOWAK, M.D.

19

20 Dated:

21

22

23

24

25

1 CERTIFICATE OF NOTARY

2 STATE OF MICHIGAN)

3) SS

4 COUNTY OF WAYNE)

5

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

18

19

20

21

22 _____
Jacquelyn S. Fleck, CSR-1352, RPR, RMR, CRR,

23 Notary Public,

24 Wayne County, Michigan

25 My Commission expires: August 16, 2006

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4

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10 EXHIBIT PAGE

11 (Exhibits not offered.)

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