State of Ohio,)
) SS:
County of Cuyahoga.)

DOC. 352

Andrew Kurinsky, etc., et al,)
Plaintiffs,)
vs.) No. 237976
Marymount Hospital, et al,)
Defendants.)

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Deposition of CHARLES A. PECK, M.D., a witness herein, called for cross-examination by the Plaintiffs, taken before Michelle A. Bishilany, a Registered Professional Reporter/CM and Notary Public within and for the State of Ohio, at University Suburban Health Center, 1611 South Green Road, South Euclid, Ohio, on Tuesday, the 10th day of January, 1995, at 10:32 a.m.

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APPEARANCES:

Spangenberg, Shibley, Traci, Lancione & Liber, by
Mr. John G. Lancione,

On behalf of the Plaintiffs;

Arter & Hadden, by
Mr. George M. Moscarino,

On behalf of Defendant
Marymount Hospital;

Jacobson, Maynard, Tuschman & Kalur, by
Ms. Anna M. Carulas,

On behalf of Defendant
Dr. Prakash;

Jacobson, Maynard, Tuschman & Kalur, by
Mr. Steven J. Hupp,

On behalf of Defendant
Dr. Perez.

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EXAMINATION OF CHARLES A. PECK, M.D.

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CHARLES A. PECK, M.D.,
of lawful age, a witness herein, called for cross-examination by the Plaintiffs, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. LANCIONE:

Q. Would you state your full name, please, for the record?

A. Charles A. Peck.

Q. Dr. Peck, I've been given a CV of yours and I'd like to know if that's up-to-date.

A. Yes.

Q. On the last page it has activities. Are all those activities current activities that you're engaged in?

A. I haven't looked at the last page in a while. But I think the only thing that might not be current is I'm not presently on the Board of the Academy of Medicine.

That's true. All of these things -- actually all of these things are up-to-date. Yeah. The only thing -- yeah. The only thing that's different at all on the CV is that, as I just stated, I'm not on the Board of Directors at the Academy of Medicine.

I'm not participating in any of the activities of the Academy of Medicine of Cleveland.
Q. Are you still a member?
A. No.
Q. When did you cease to be a member of the Cleveland Academy of Medicine?
A. I think three months ago.
Q. What does your current practice involve you in?
A. About 70 percent of my practice is general internal medicine and 30 percent of my practice is rheumatology or arthritis.
Q. The internal medicine part of your practice, how does your time spent in that practice relate to the clinical treatment of patients?
A. 100 percent of the time.
Q. Is this your only office?
A. Yes.
Q. Do you see your private patients here on a daily basis?
A. Yes.
Q. Do you conduct what's known as executive physicals or annual physicals, general physical checkups?
A. Yes. Yes.

Q. How many of those kinds of patients do you see on a weekly basis?
A. Well I generally see between 30 and 35 patients a day and out of those patients probably anywhere from five to seven of those would be complete physical examinations.
Q. How many days a week is that?
A. Five days and sometimes five and a half days.
Q. How many patients do you have in the hospital as we sit here today?
A. None.
Q. Where do you admit your patients when you have patients in the hospital?
A. University Hospitals of Cleveland.
Q. Anywhere else?
A. No.
Q. Of the patients you see here in your office what percentage of those deal with your specialty, subspecialty of rheumatology?
A. I'd say about 30 percent.
Q. 30 percent.
What other special interests do you have within the field of your practice?
A. I take care of all -- anything that would be considered internal medical problems. In other

words, anything involving the care of people over the age of 13 that doesn't involve surgery.

So I see any non-surgical problems that involves the adult human being, diabetes, high blood pressure, heart disease, neurological problems, abdominal problems, psychological problems, anything that doesn't involve an operation.

Q. If something does involve surgery you refer the patients to a surgeon?

A. Yes.

Q. You have a special interest in tropical diseases?

A. No, not at the present time. When I did my training, I actually trained in rheumatology clinically, but there's an overlap between the rheumatology and infectious diseases in terms of immunological parts of both.

I did my fellowship with somebody who was involved in immunology whose model was schistosomiasis, which was a tropical disease. So my lab work, bench work was with that person and my clinical work was in arthritis.

Q. Do you see persons or at least screen persons who may have tropical disease problems?

A. No. I may see some people who do or if I do

I refer them to the Travelers Clinic at the hospital or tropical disease specialist here.

(Discussion had off record.)

MS. CARULAS: It may help if you could spell that schistosomiasis.

THE WITNESS: S-C-H-I-S-T-O-S-O-M-I-A-S-I-S.

MR. LANCIONE: S-C-H-I-S-T-O-S-O-M-I-A-S-I-S, correct.

MS. CARULAS: That's impressive.

Q. Have you ever had your deposition taken before?

A. Yes.

Q. On how many occasions?

A. As an expert witness?

Q. As an expert witness.

A. Maybe 15 times max.

Q. Have you ever been a party to a lawsuit and had your deposition taken?

A. Yes, one time.

Q. Where was that?

A. That was here.

Q. In those cases where you had your deposition taken as an expert witness were those medical

malpractice cases?
A. Yes.

Q. So in each case where you've been called upon to review records you've ended up being a witness and testifying by way of deposition?
A. Well I've been asked on multiple occasions to review records. What I normally do is I ask -- I get some background information about the case. Once I have the background information I'll decide whether or not I want to be involved in the case.
It so happens that the times I've decided to be involved I've ended up reviewing the records and I've given the expert testimony. But, as I say, I've only done it maybe 15 times in 11 years. I don't -- certainly don't make my living doing it.
Q. Well you do charge for your professional time, don't you?

A. Yes.

Q. What is your routine charge?

A. My routine charge for depositions is $250 an hour.

Q. Have you testified in court in medical malpractice cases as an expert witness?

A. One time.

Q. Where?

A. In Cleveland.

Q. When?

A. I think it was about seven or eight years ago.

Q. Who did you testify for?

A. For a plaintiff.

Q. What kind of a case?

A. It was a medical malpractice case involving a patient who was operated on by a general surgeon at a hospital in town.

Q. Of the total number of cases that you've given depositions in how many have been on behalf of the plaintiff and how many have been on behalf of the defendant?

A. I think it's been about half and half.

Q. Have you ever participated in reviewing cases for an insurance company?

A. No.
Q. Have you ever been represented before by the law firm of Jacobson, Maynard, Tuschman & Kalur?
A. No.
Q. Are you insured with PIE Mutual Insurance Company?
A. No.
Q. Have you ever been?
A. No.
Q. Do you have any teaching responsibilities?
A. Yes.
Q. At the hospital or at the medical school?
A. At the hospital, at the medical school and at the building here where I practice.
Q. On a weekly basis what are your teaching responsibilities at the present time?
A. They're not organized on a weekly basis. I attend on the medical service at University Hospitals once or twice a year which means that three hours each morning three days a week for a month I see all the patients that are admitted to that particular unit and instruct the residents and the interns as to how to care for those people.
I also one month out of the year -- sorry, six weeks out of the year have medical students whom

I teach how to do history and physical examinations on patients in University Hospitals.

I've been asked to give lectures in the rheumatology section of medical school training in the medical school.

We have residents and interns and medical students that come out to Green Road for outpatient training and I've given lectures to them on rheumatology, and I've had some of them in my office during the day seeing patients with me.

Q. Have you ever worked in an emergency room?

A. As an intern and as a resident, yes.

Q. When?

A. Between 1978 July when I first came here and I guess it would be June of 1983 when I finished my training and came out into practice.

Q. Where was that? At University?

A. At University Hospitals, yeah.

Q. Have you ever functioned as a house physician?

A. As an employed house physician by a hospital? No. I don't know if I consider a resident as a house physician.

Q. Well did you read the depositions of Dr. Perez and Dr. Prakash?

A. Yes.
Q. Dr. Prakash in particular talked about his responsibilities as a house physician?
A. Yes.
Q. I don't know technically whether he was employed by them, but he was certainly under their instructions and had to make himself available at least two days a week there and two days a week at St. Elizabeth's to be called and available 24 hours a day.
A. I never functioned -- I never functioned as that type of an employee.
Q. When you as an internist are seeing a patient for a complete physical and the patient has certain complaints or you find in your clinical examination certain signs or symptoms do you develop what is known as a differential diagnosis?
A. Yes.
Q. Is that something that most of the physicians ordinarily do, calling it one thing or another when they have a clinical presentation?
A. Yes.
Q. What is the criteria for entertaining a number of different disease entities or etiologies for a patient's presentation? In other words, what

do you use to set up the number of things you want to rule out?

A. Well the way I was taught which I practice at the present time is about 80 percent of what goes into making a differential diagnosis list is the history and physical exam; about 20 percent is laboratory examinations that are done to either confirm or deny your initial impressions.

Then based on the history, physical and certain laboratory tests you develop a list of possible diagnoses and then go down that list and do what you feel is appropriate to either rule in or rule out those particular diagnoses.

Q. How important is the historical data that you receive from a patient?

A. Very important.

Q. Are there occasions when it is more difficult to obtain an accurate history?

A. Yes.

Q. An obvious example would be if a patient's unconscious?

A. Yes.

Q. Or if a patient has a language barrier?

A. Yes.

Q. Or some kind of head injuries?

A. Yes.
Q. Some kind of mental disorder?
A. Yes.
Q. Is there any extra burden placed upon the examiner under those circumstances?
A. There's a tremendous extra burden placed on the examiner.
Q. In what respect?
A. Well if 80 percent of your impression is based on your history and physical and if at least 50 percent of that 80 percent is the history and you're not able to elicit a history, then half of the normal amount of information you would use towards making that impression isn't there. So now you have to make an impression based on only half of the normal amount of data, which makes it harder.
Q. Other than making it harder is there any burden to be more deliberate or more careful than you would ordinarily be without such a situation arising on the part of the physician?
A. I think that most all physicians that I work with do a physical exam in the same complete way whether the person is able to give them a history, talk or not talk.
So I don't think that you would be any less

or more complete in doing a physical exam on a person that you might not be able to talk to.

Q. When you do a complete physical exam, whether it's in the hospital or here in your office, *is* there a certain routine you go through?

A. Yes.

Q. Does it include any type of a neurological screening test?

A. Yes.

Q. What does that involve; would you tell me?

A. Assessing the person's mental status. Just in general conversation you can usually tell whether they're oriented, alert, know where they are, who they are.

If you find somebody is not and you're considering as one possibility for that, say that they're demented, then you might spend a little more time specifically asking questions to find out why they may not be as oriented or why they're confused.

Once you get past their general mental status then there's some baseline neurological tests that you can do and that you do do, for instance, checking their reflexes with a reflex hammer, as part of your examination, and you may not do this specifically as a neuro exam.

But part of my routine when I'm examining other parts of their body I normally have them do things that requires them to utilize their muscles, even if it's just getting up out of the chair and getting on the exam table or moving around a certain way, so I'm able to assess some **of** their muscular function that way.

If they appear to be neurologically intact by doing those assessments I don't necessarily do an extensive sensory examination, as an example.

But certainly in trying to rule out gross abnormalities, for instance, problems with cranial nerves that are inside somebody's brain or with muscular function or with urinary complaints that might be affected by something neurological, if any things like that crop up during the history or physical then I would probably spend more time on a more complete and extensive neurological examination. Now that could go **for** any organ system.

I mean, **I** think, you know, it's my job to make sure that there are no major abnormalities or functional problems with major organ systems, both on my physical exam and also by laboratory examination. If I think that there is I'll probably

focus and spend more time on that organ system. If I find that there isn't, then I probably would spend more time on other organ systems where there might be.

So there's a certain amount of art to this as well as routine, I guess is the best way to put it.

Q. For example, do you usually have your patients walk on their heels and walk on their tones, walk in tandem?

A. Routinely?

Q. Yes.

A. No.

Q. If there is an unsteadiness of gait which you observe if the patient gets up from the chair, examining table, do you then have the patient walk on their heels and walk on their toes?

A. That would be an example of what I just mentioned. I mean, if that organ system has an abnormality associated with it, namely the neurological organ system, and if you want to use an unsteady gait as an example, yes. I will observe them generally. I observe them walking into the room. I certainly observe them walking from the chair to the examining table.

If I observe an abnormality, then I will

further investigate that abnormality. And that would go for any organ system.

Q. Well let's just talk about an unsteadiness of standing or a weakness of the lower extremities, what do you do then?

A. Well I factor in what information I may already have.

Namely I might ask -- be sure that I know all the medications that they're taking to make sure that some of the signs or symptoms might not be related to medication.

I might ask them if they'd had any trauma recently.

I might just flat out if they're oriented and alert ask them why they're having difficulty with their gait, especially since most of the time I take care of people that I have long-term relationships with.

So if I've been taking care of somebody for two years, five years or 10 years and I know them like I know my family member and I see them the next time and there's obviously an abnormality from what I recall from before, I'll ask them about it. I think that that, the doctor/patient relationship, is very important for that one thing alone.

Q. Well if you're seeing someone for the first time?

A. I'll ask them flat out. If they're able to tell me I'll ask them have you noticed why -- have you noticed a problem with your gait, how long have you noticed it, can you think of any reason why you're having difficulty walking or feeling unsteady. And if -- sorry.

Q. If you don't get sufficient informat on that allows you to discount this and ignore it altogether what do you do as a clinician with respect to a neurological follow up?

A. If they're not able to give me historical information that helps me at all then I've got to objectively through examination try to assess why they're having the problem.

Q. What do you do? What kinds of tests do you do?

A. Well, some of the ones you mentioned: Tandem walking, heel walking, toe walking, walking a straight line, a Romberg sign which is a measure of how their cerebellum is working, which is to see if the balance center of your brain is working.

Q. Is there something called a Babinski test?

A. There's something called a Babinski test,

yes.

Q. Do you do that sometimes?

A. Sure.

Q. You're checking the person's reflexes?

A. Yes.

Q. Do you check the reflexes, motor and sensory?

A. I check -- as part of my routine in everybody I check reflexes. The reason that I do that routinely is because reflexes indirectly tell you a lot about motor and sensory function. If people's reflexes are normal, there's a very good chance that their motor and sensory function will be normal.

I don't check a Babinski on people who are otherwise normal.

Q. If someone would have weakness in the lower extremities, unsteadiness, would you then as part of your examination conduct a Babinski examination?

A. Yes.

Q. Any other signs that you would try to elicit, any other names of tests that should be used when you're looking into a neurological issue?

A. Well you're going to check, you know, vibration. You're going to check pinprick. You're going to check motor strength. You're going to check reflexes. You're going to check some of the

cerebellar signs that I mentioned. You're going to check cranial nerves.

Q. In your report you seem to state generally that there were no neurological signs or symptoms or no reasons to obtain an initial call consultation until sometime around 8:00 on the morning of the 17th of March; is that right?

A. Yes.

Q. Did you note that when Dr. Prakash was called, I think he was still in the emergency room, he was told that the patient had chest pains, immediately said get a cardiologist consultation?

A. Uh-huh.

MS. CARULAS: You must mean Dr. Perez.

Q. That was good --

MR. LANCIONE: Perez.

MS. CARULAS: You stated Prakash.

A. I know that a cardiology consultation --

Q. Right.

A. -- was requested, yes.

Q. Right.

That was good practice of medicine, was it, and appropriate?

A. I think so under the circumstances, yes.
Q. And also a psychiatric consultation was requested I think shortly after the patient arrived?
A. Yes.
Q. That was good practice, too, wasn't it?
A. Yes.
Q. By I think it was about 1:20 the patient had been seen in the emergency room and had been given an initial screening by the nurses. Did you note that that did take place?
A. I noted that the -- I was not privy to some of the times so I'm assuming what you're telling me about the times are correct.

I know that the patient was seen in the emergency room. My understanding is that he was -- he got to the floor somewhere between one and 3:00 that day.

I have an evaluation by the emergency room physicians that I've seen. I have a nursing admission database.
Q. Yes.
A. I'm not aware for certain that that was done in the emergency room, but I have that.
Q. Well it starts I think at 1:00 and then --
A. One p.m. on 3-16, that's the time on the

sheet.

Q. -- signed on the last page, I think it's signed at 1:20, 1:20 p.m.?

A. Yes, that's correct.

Q. So between one and 1:20.

Dr. Prakash testified on his deposition that he not only spoke to the emergency room doctors but he had access to and read the emergency room records and the records of the nursing assessment. Did you understand that?

A. I wasn't specifically aware of that, no. I assumed that he talked to the emergency room physicians because that's pretty much standard practice.

Q. Did you see whether there are any records that indicate the nature of the neurological examination that Dr. Prakash conducted when he saw the patient at about 2:30 in the morning?

A. Well, I have several, several notations by Dr. Prakash. One is his admission screening, history and physical that I believe was done at approximately three p.m., and then a progress note that was written by Dr. Prakash at about eight p.m. on that day, on the 16th, which included, I believe -- let me just check it.

No, it did not include any physical examination at that time. But then another note on the 17th at two a.m. which has some references to some neurological notation.

Q. What were they?

A. You're referring to the two a.m. note?

Q. Yes.

A. The two a.m.

Q. Two a.m.? I'm sorry.

A. Yes.

Q. I was talking about two p.m. on the afternoon of the 16th.

A. Okay. So you're talking about the initial.

Q. His initial history and physical.

A. Yes. His initial history and physical does note certain neurological facets of the exam that he did -- or that he noted. Those being that he notes no motor deficits, cranial nerves within normal limits, slowed speech and urinary retention which may or may not be neurological.

Q. Do you know what Dr. Prakash did in response to the indication that this patient was unsteady and wobbly in his gait?

A. What he did?

Q. What did he do when he learned of that

information?
A. Well I guess you're assuming he learned of that information from somebody else; I don't notice it.
Q. That's what he testified to on his deposition.
A. I see. All I can comment on is there's nothing specifically written in his note, his initial admission note, that either specifies the unsteadiness of gait or that he learned about that from somebody else or that he acted upon an unsteadiness of gait.
Q. Did Dr. Prakash elicit pain on movement?
A. I'm looking at Dr. Prakash's note, at least the physical exam part of his note. I don't see any notation of pain on movement.
Q. Does that make any difference to your opinion in the case?
A. I can only comment on what's objectively in the record. All I can say is that there's no notation of any pain on movement in his note.
Q. Well you're aware of the other -- the complaints that the patient had, aren't you?
A. I'm aware that the patient had generalized pain that was noted.

Q. In his neck?
A. Well Dr. Prakash noted in his note here in chief complaint: "Sore chest and stiff neck since yesterday according to the patient."
If he was aware of the nurses notes -- the nurses notes state that the patient was complaining of generalized pain and generalized weakness, which means pain everywhere, weakness everywhere.
If, in fact, that was the case then I'm not sure that anything could have been, that any -- you could have hung your hat on any of that other than the fact that the patient was complaining that he generally hurt all over which would make it very nonspecific as opposed to he said I hurt in my left leg. So --
Q. I'm asking you to assume that he said his neck hurt when Dr. Frakash moved it and also when Dr. Frakash palpated his neck he indicated that it was painful. I want to add those things in. Ask you if those two things added in to what he knew from the emergency room record and the nurses notes that ended at 1:20 p.m. before he saw the patient at approximately 2:30 or three?
A. Okay. If --
Q. Add that into it, to his examination at 2:30,

that those things were true; does that make any difference in your opinion?

MS. CARULAS: Well **I'm** going to object.

MR. LANCIONE: Okay.

MS. CARULAS: That question is long and rambling in light of his physical exam.

MR. LANCIONE: Okay.

Q. Yes, if you don't understand it --

A. **No, I** think **I** understand it.

If you're saying should it somehow be relevant or should Dr. Prakash thought certain other things assuming that the patient was complaining of a stiff neck and pain in the neck and assuming that Dr. Prakash was told by the nurses or the other physicians that the patient was complaining of pain in his neck or a stiff neck and assuming that on physical examination Dr. Prakash found that the patient had a stiff neck or a painful neck should he have thought of other things or certain things?

Q. Well in addition to that what he already knew from the nurses saying that the patient was wobbly and unsteady in standing and that they found he had weakness of his lower extremities and that he also

had urinary retention which the doctor knew about at around 2:45 or 3:00 also, I want to add all those things in.

A. Then I suppose that one of the things in his differential diagnosis would have had -- would have been to try to put all those things together, yes.

Q. What would the differential diagnosis be? Schizophrenia? Would that be one thing?

A. Possibly, but unlikely.

Q. A drug reaction?

A. Yes, absolutely.

Q. Cervical spine abnormality or injury question mark?

A. Possibly.

Q. Well that would be something you would include in a differential diagnosis in this patient assuming those things that I've asked you about, isn't it?

A. Yes. Yes.

Q. What other things should be in the differential diagnosis?

A. Musculoskeletal pain nonspecific, musculoskeletal pain secondary to trauma, which was also part of the history the patient gave, I mean that was probably the most prominent part of the

history the patient gave, if not the only part of the history, that he was lifting furniture and since that time had developed pain.

Q. There was also a note in the emergency room records and the nursing notes that the patient had slurred speech?

A. Correct.

Q. Could that also be something that has neurological significance?

A. It could be.

Q. Could be related to drugs he was taking?

A. Absolutely.

Q. But you would certainly consider more than just the drugs he was taking for all of the symptoms that also would have neurological significance?

A. Absolutely.

Q. You're aware that the doctor, Dr. Prakash, was then called again at 3:50 and he catheterized the patient?

A. Yes.

Q. Do you know whether or not he conducted a further neurological examination at that time?

A. I've not seen any evidence of that on the chart.

Q. Do you see whether the patient's condition

had improved insofar as those complaints, signs and symptoms that existed prior to 3:50?

A. I don't see that the patient's condition had changed period.

Q. Did you see that the patient was called -- or that Dr. Prakash was called again at 10 after six?

A. I'm not aware specifically of 10 after six. Maybe you can show me where you're referring to or where that's noted.

I'm not aware of any note Dr. Prakash made specifically that he had been called at 10 after six, at least in the physician progress notes.

Q. It says -- at 6:10 there's a note that begins "Dr. Perez called" and then ends with "Dr. Prakash called."

A. Is that in the nurses notes?

Q. Yes.

A. Could you refer me to what page of the nurses note you're talking about?

Q. Right there. Just let you look at it (indicating).

A. You're talking about the 6:10 p.m.?

Q. Yes.

A. "Dr. Perez called. Foley to continuous drainage to be inserted."

Sorry. What's the question?

Q. Dr. Prakash was called, too?

A. Yes.

Q. Again?

A. Uh-huh.

Q. Do you know whether he went to see the patient?

A. It doesn't specifically state that here in this note by the nurse whether or not he did or did not.

It also doesn't state that he was asked specifically to see the patient. It just says that he was called.

Q. Did you note that at 8:30 p.m. Dr. Prakash was called again and he came in to see the patient?

A. Are we still working on the nurses notes?

Q. Yes, the same one.

A. There's a 8:30 p.m. note that says something that I can't make out by Dr. Prakash and I don't know what that first word is,

Q. Maybe I can help you. It says "IV Ativan."

A. I'm talking about the beginning of the note.

Q. 8:30, "Visit by Dr. Prakash"?

A. Oh, that's what that means, visit.

Q. Well I think that's what it means, it says

VS.

A. If that's what it says and it says visit, then Dr. Prakash saw the patient at 8:30 p.m.

Q. "IV Ativan"?

A. Right.

MS. CARULAS: It's "IM."

Q. "IM"?

A. "Ativan per order for complaints of back spasm and generalized discomfort. Restless and calling out. OOB," out of bed, "by self and respositioned self then complains of inability to move secondary to back pain."

Q. Would it be appropriate at that time for Dr. Prakash to conduct an examination of the patient?

A. Not necessarily.

Q. Just prescribe the Ativan and not examine the patient at that time and that's good and appropriate standard of care medicine as far as you're concerned?

A. No. I don't think it's appropriate for Dr. Prakash to undergo another complete physical.

I think that if Dr. Prakash is asked to address a specific problem and the nurse states that the problem is back spasm and generalized discomfort, then I would think that it would be

appropriate for him to address that problem; namely look at the patient and address the back spasm problem.

Q. Well how about the complaint of inability to move secondary to back pain, shouldn't the doctor examine a patient rather than just look at him when that is in the nursing note?

A. Yes. But I think that that would have also been -- if he examined his back then I would assume that that would also have been part of his examination as it refers to his back.

So I'm saying that, yes, I think that Dr. Prakash would have examined the patient in reference to the complaint. So anything having to do with his back pain complaint I would think Dr. Prakash would have examined him for.

Q. What's the likelihood in view of what we know now of what this patient's problem was that there would have been some neurological, some positive neurological findings?

MS. CARULAS: Objection.

A. Well I think if you look at the remainder of the nurses notes that there probably would have been very little likelihood because there are nurses notes that refer to physical findings that come and

go before and after his surgery that are not consistent with either pre or postsurgical neurological findings that one would expect.

So I don't think that there would have been anything that you would have been able to hang your hat on based on that.

Q. So you don't think that at any time up to the time we're talking about now that Dr. Prakash, 8:30 p.m. that we're talking about now, that Dr. Prakash should have called for a neurologist or a neurosurgeon to consult?

A. No, there's certainly nothing in these notes that refers at all to anything neurologically abnormal. We're talking about back spasm, back muscle spasms and back pain. Again I'm only going by what is in the record, and there's nothing in the record noted either by the nurses or Dr. Prakash that reflects on there being some neurological abnormality that's new from the time that the patient was admitted.

And frankly there's nothing in the record that I can find that objectively documents any neurological abnormality from the time the patient got to the emergency room.

So, you know, yes, I think that the patient

should always be assessed when the physician is called, and certainly the patient should be assessed prior to medication being prescribed. But if you look at the record and look at the neurological signs and symptoms that are referred to multiple times by the nurses, there is no consistent picture of anything.

Q. However, when the patient came in he had slurred speech which could be of neurological significance, true?

A. In the context of other neurological abnormalities, yes.

Q. He also had a wobbly stance and weakness of his lower extremities which could have neurological significance; isn't that true?

A. You keep referring to the weakness of his lower extremities as apart from generalized weakness and I've yet to see an objective note --

Q. Let me show it to you.

A. -- by any of the physicians in here. I'm talking about physicians now, I'm not talking about nurses notes, all right?

If you can show me where any physician documented specifically there was a neurological abnormality of his lower extremities or that there

was a symptom referable to that, then that's fine. But you keep making reference to this and there's no -- there's nothing referenced to that in any of the physicians notes.

Q. Well if you want to argue about it, Doctor, is there any reference whatsoever that Dr. Prakash made any neurological examination designed to reveal whether this patient had wobbly stance or inability to walk or had weakness in his legs?

A. No.

Q. Okay. But you won't accept a nurse saying a patient has weakness of the legs, would you?

A. No. No. I'm just asking you to show me where there's documentation in here where they specifically state that. I mean, I'm saying -- I'm looking at this record also and I see references to generalized weakness and 1 think we all see that. I'm just asking you to show me, maybe I haven't seen it.

Q. "Patient standing at bedside. Wobbly and unsteady. Problems with weakness.''

Now you're saying because it doesn't say weakness of his legs that that doesn't impress you?

A. No. No. I'm saying does it say weakness of gait or does it say generalized weakness and

unsteadiness?
Q. It doesn't say generalized weakness or unsteadiness, doesn't use that word.
A. Does it say weakness of legs? Does it say weakness or unsteadiness of gait?
Q. "Patient standing at bedside. Wobbly and unsteady."
A. Okay.
Q. That doesn't mean there's anything wrong with his lower extremities to you as a physician?
A. Not nec -- if the patient -- let's say the patient's on a drug, or let's just use a hypothetical. If a patient's on a drug, if I gave you some drugs, certain drugs, you might be unsteady. You wouldn't necessarily have objective weakness of your legs.
If you're saying could it mean that the patient had weakness of the legs, absolutely.
Q. In that same block it says: "Patient problems/need," it says "weakness."
So are you saying that you as a physician would ignore the fact that this may be a neurological problem of tremendous importance and significance and risk to this patient, but since it could also be from just a temporary, insignificant

reaction to drugs you would ignore the neurological findings?

MS. CARULAS: Objection.

A. I'm not saying that I would ignore anything. What I'm saying is that you're taking comments by nurses and making them neurological findings. They are not.

Neurological findings are findings on physical examination that's done by a physician. They're not subjective things noted by the nurse.

Patient appears weak, patient is wobbly, that is not an objective neurological finding.

If the patient is examined and found to have specifically weak quadricep muscles which would explain why they were wobbly or if the patient was noted to have other specific findings done by a physician as part of an exam, I would have no problem with it.

I'm just saying I think you're going from nurses notes to conclusions about findings or objective abnormalities and I just don't see that in this record. That's all I'm saying.

Q. Well, I've talked about what's in the record. But I'm saying that there should be an examination when any of these kind of complaints are noted in

the record, especially when a nurse notes them?
A. And if the physician is made aware of the nurses noting them, yes.
Q. Well if the physician isn't made aware of the patient's condition the nurses are negligent, aren't they, generally speaking?
A. If there's a new -- if there is a new finding that's noted by the nurses that impact on the patient's condition and if that physician is not made aware of that by the nurses then yes, you're correct.
Q. What is the responsibility of an admitting physician in a case like this where he admits a patient and then a house physician comes in and, as he expects him to do, and conducts a routine physical examination with respect to contacting that house physician or the house physician contacting the admitting doctor, either way?
A. The normal standard of care is that the attending physician should definitely see the patient himself within 24 hours of the time that the patient's admitted.
My personal experience with standard of care as far as the patient being admitted say in the middle of the night by a house officer, a house

physician, a resident, whomever, would be that if there were an acute problem that was noted or an urgent problem that was noted by that physician that well.

Q. So the attending physician then who leaves the patient under the jurisdiction of the house officer, resident, whoever is taking care of the patient, if he does not see the patient or initiate a call, what is his status with respect to being responsible for the patient's condition?

A. Oh, there's nothing to do with that. Once a patient of mine is admitted to the hospital that patient is my responsibility and I am responsible for every facet of the patient's care or uncare, so to speak.

All I'm relating to is that.

Q. I understand.

A. I would expect that the house officer if -- I would only admit to a hospital where I had faith and trust in the physicians that were working there. And if a physician admitted one of my patients in the middle of the night or in an hour when I normally would not be in the hospital, I would be to see the patient certainly well within 24 hours. I

would expect that house officer or house doctor or resident would call me with any emergent problems that needed to be dealt with no matter what time of the day or night that was.

Q. So one of the things that you've said here is once you accept a patient as the admitting physician you're responsible for either the care or the lack of good care, whatever happens to that patient?

A. That's correct.

MR. HUPP: Objection. Move to strike.

Q. When Dr. Perez was contacted apparently by the nurses, was it their responsibility to advise him of all of the findings that had been made and the patient's condition when he called -- and I think it was 6:10, the 6:10 note when he -- I think he made an order at that time. I think it was at 6:10. Let me check.

A. I don't think that I could specifically state it was the nurses' responsibility.

I think if the nurses had been in communication with Dr. Prakash, the house physician, it was certainly Dr. Perez's responsibility to find out what he felt was important in terms of this particular patient, findings that may have been

elicited by Dr. Prakash.

But I don't think it was specifically the nurses' responsibility unless he asked them to give him a report based on their particular findings.

Q. At 8:30 p.m. when we looked at that note which talked about back spasms and inability to move secondary to pain, should Dr. Perez have been advised of that by either the nurses or Dr. Prakash?

MS. CARULAS: I'm going to object because that entire nurses note was not read. In fact, in that very same nurses note it states that: "The patient is out of bed by self and respositioned self."

MR. LANCIONE: Well I'm asking the question.

MS. CARULAS: Well I think it should be in context.

A. I think that if Dr. Prakash felt that it was a significant finding or if he found significant findings any time that he went subsequently to see the patient that in his opinion were things that Dr. Perez as the attending physician should know about or indicated a significant change in the patient's condition, then 1 think that it would have been appropriate for him to let Dr. Perez know. Short of

that, I don't think that it necessarily would have been required for him to let Dr. Perez know.

Q. But we are clear that, just so I'm clear on this, that the patient should have been examined at that point in time?

A. Referable to his back spasms?

Q. His back, his inability to move, whatever that might mean, the doctor should find out what that means --

A. Yes.

Q. -- from the nurse --

A. Yes.

Q. -- and examine the patient?

A. Yes.

Q. Those could or could not be neurological signs or symptoms or significant things?

A. May or may not be, correct.

Q. Was the differential diagnosis by Dr. Prakash of, one, chest pain, two, urinary retention, and three, schizophrenia, adequate and appropriate at the time?

A. I think from the information that he had at the time that those three things were certainly reasonable diagnoses to have in the differential diagnosis.

Q. Was it reasonable to leave out musculoskeletal injury, cervical spine dysfunction, something with reference to his neck?

A. I guess the only thing I'd say would be unreasonable would be that number four in there probably should have been stiff neck or pain in neck.

Q. When a patient presents like Mr. Kurinsky and is examined fully and adequately for all of the complaints and signs and symptoms, what does it take for an internist to seek a neurological or a neurosurgical consultation?

A. I think what it takes is that if the internist or non-neurologically related person feels that there's something neurologically or neurosurgically emergent, that that would certainly indicate a consultation, immediate consultation.

I think that if it was felt that some of the findings were consistent with a neurological abnormality that couldn't be explained by other things that the physician had found and there was a question in the physician's mind about what might be accounting for those things, that that would certainly be an indication to get neurosurgical -- or, I'm sorry, neurological consultation.

I think anything that was felt could not be handled or was beyond the purview of what a general internist normally would do and it involved something neurological, that that would be open to consultation by the neurological service.

Q. The assumption that you're making is a reasonably prudent and reasonably educated, trained and experienced internist practicing acceptable medical standards?

A. Correct.

Q. And conducting all of the examinations that should be conducted in connection with the patient's clinical presentation?

A. Correct.

Q. Do you ever refer or use Harrison's Text on Internal Medicine?

A. Yes.

Q. Doctor, what is an algorithm?

A. It's normally a thought process in steps, in the order of the steps that one would do, some sort of action.

For instance, you think step number one. Then step number one would take you to a fork in the road and you would decide from step one should I go to step two or step three. Once you decide which of

those forks then you have another step that you have to decide upon in which case there may be other forks in the road or possibilities that you would have to consider and decide which road to go down.

So it's sort of like a branch of a tree where you start out at the bottom with the trunk, as you go up there are more and more and more branches that branch off and things that you have to make decisions yes or no about and then move on to the next step.

Q. In a case where an internist is seeing a patient with neck pain complaints and he takes a history, conducts a physical examination and finds a neurologic deficit, would you agree that the next step would be immediate neurological consultation?

MR. HUPP: Objection.

MS. CARULAS: Object as well.

Q. Generally speaking.

A. I think I agree with you all the way up to the last step. I think that if one finds -- one does a history and physical and finds a neurological abnormality that needs to be investigated, that it might still be appropriate for the internist to then obtain -- go to the next step or obtain the study that he feels might reveal what the abnormality was.

And if the abnormality was there and appropriate, then to consult the appropriate party, whether it be a neurologist or neurosurgeon, et cetera.

Q. So you might include radiologic evaluation or MRI evaluation of the spine --

A. Right.

Q. -- if the neurological deficit could be related to a spinal cord injury?

A. Yes. If **I** thought that it was emergent **or** that it was something that in my differential I knew could potentially require neurosurgical intervention, then I might immediately go to the neurosurgical consultation or the neurological consultation.

If it was a neurological condition that **I** knew was not emergent and I had time to investigate then I might do some investigational studies myself and then decide who the most appropriate consultant would be. Sometimes it's not obvious who the most appropriate consultant would be unless you get more information.

Q. If one of the differential diagnoses is possible cervical spine dysfunction, I suppose as happened here there was no question about the emergency when Dr. Perez saw the patient and said it

was a catastrophe at 9:00 in the morning on the 17th and he contacted a neurosurgeon immediately --

A. Right.

Q. -- right? I mean, there was no question about that being good care at that point, was there?

A. Uh-huh, no.

Q. Is it your judgment that before that time there was no reason to consult with a neurologist or a neurosurgeon in this case?

A. It's my judgment that from the objective data in the record, meaning the physical findings that were done when the patient was examined, during the times that he was examined, both by the physicians and the nurses, based on the non-focality of the findings, meaning lots of remarks about generalized weakness, no specific notations by any physician that examined him of a focal neurological deficit, and in a patient who is a very difficult historian and on a patient who was on medications that can mimic a lot of, if not most of, the neurological abnormalities that were found, specifically if you assume the bladder, urinary retention was neurological and not something wrong with the bladder, then I don't see anything in here that would have indicated the need to call a neurosurgeon

emergently.

And I don't really see anything in here that would have necessarily had somebody as part of their differential put a neurosurgical emergency even on the list let alone at the top of the list.

I mean, I think that -- and again I'm basing this on the whole picture and what's specifically noted and said on here by the nurses and the physicians.

And I was not privy to being at the depositions, there may be other information that came out there that I'm not aware of. I'm basing what I'm saying strictly on the medical record that I was given, based on the hospitalization of this patient.

Q. So again there wasn't any neurological or neurosurgical emergency until 9:00 when the patient was paralyzed, is that what you're saying, according to the records?

A. Yes, based on the records I don't find anything that indicated that there was a neurosurgical emergency prior to that time.

Q. You're assuming that Dr. Prakash who's the one who was really seeing the patient during those hours from around 2:30 or 3:00 through and till the

patient fell out of bed at two in the morning, you're assuming that he conducted an adequate and appropriate neurological examination?

A. I'm not assuming anything. I'm basing what I say on what he recorded. I'm not assuming anything that's not in this record. If he didn't put something in this record I'm not assuming that he did it. I'm only basing what I'm saying on what is in this record.

I'm basing what I'm saying on the fact that he notes the cranial nerves and that he notes the no motor deficits and that he notes the patient had urinary retention, the things that are written in here I'm basing my assumptions on, not on things that might not be written in here.

Q. Then you're assuming that he didn't examine the patient at 8:30 and conduct a neurological examination, 8:30 p.m.; is that right?

A. That's correct, there's nothing.

Q. And you say that's good and appropriate medical care at 8:30 p.m. when the patient was complaining of back spasms and an inability to move secondary to back pain, you're saying it was good and appropriate care for Dr. Prakash not to conduct a neurological examination at that time?

MS. CARULAS: I'm going to object. We have been round and round and I think now you're putting words in as far as what he said earlier.

MR. LANCIONE: This is my examination of your expert. I think your expert can take care of himself. I would appreciate you not interrupting.

MS. CARULAS: Well I think you're saying things that he didn't say and that's my point.

MR. LANCIONE: He can tell me that.

MS. CARULAS: That's my point.

MR. LANCIONE: You don't need to advise him what to do, that he needs to do that.

A. I think I've already stated for the record that if any physician is called for a specific problem with the patient, that I would expect the physician to examine the organ systems referable to the patient's complaint.

So if you're saying at 8:30 p.m. in the nurses notes it's noted that Dr. Prakash was called and that Dr. Prakash was physically there and the

nurse told Dr. Prakash that the patient was complaining of back spasms and back pain, then yes, I think that it should have been appropriate and it is appropriate and should have been done that Dr. Prakash should have examined the patient.

Your original question did not have anything to do with standards of care, and did I feel it was appropriate. I think if you're asking me that question I've already stated that I think it should have been done, that Dr. Prakash was -- part of his job he should have examined the patient when he was called, assuming that he was there, okay, which appears he was if the VS means visit by Dr. Prakash, that, yes, he should have examined the patient for the patient's complaint.

Q. And if he didn't do it, he was negligent, right?

A. If -- yes.

Q. Are you familiar with a text that is called Presenting Signs and Symptoms in the Emergency Department, Evaluation and Treatment, by Glen Hamilton?

A. No, I'm not aware of that specific text.

MR. LANCIONE: Okay. That's all I have, Doctor.

THE WITNESS: Okay.

EXAMINATION

BY MR. MOSCARINO:

Q. Dr. Peck, my name is George Moscarino.

A. Hello.

Q. I didn't meet you today because I was running late. I apologize.

I represent Marymount Hospital. I just have a few questions for you.

Drawing your attention to your report of March 29th, 1994, specifically the last paragraph. You state that you find no fault with the treatment rendered by the nursing personnel, correct?

A. That's correct.

Q. That's still your opinion today?

A. Yes.

Q. So it's your opinion that the nursing personnel who cared for Ronald Kurinsky on March 16th and March 17th, 1991 complied with the pertinent standard of care?

A. Absolutely.

Q. That's your opinion *to* a reasonable degree of medical probability?

A. Yes.

Q. That opinion is based upon your education,

your training, your experience and the review of the specific records in this case, true?

A. Yes.

Q. So in defense of the doctors in this case as one of the expert witnesses you are in no way going to blame the nursing staff for some kind of miscommunication, right?

A. No.

MR. MOSCARINO: That's all I have.

MS. CARULAS: Okay.

MR. MOSCARINO: Thank you.

THE WITNESS: Welcome.

MS. CARULAS: You have the right to read the transcript over to be sure everything has been taken down accurately.

THE WITNESS: That's fine.

MS. CARULAS: You'll read it?

THE WITNESS: No, I'll waive it.

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State of Ohio,)
) SS: CERTIFICATE
County of Cuyahoga.)

I, Michelle A. Bishilany, a Registered Professional Reporter/CM and Notary Public within and for the State of Ohio, do hereby certify that the within named witness, CHARLES A. PECK, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 11th day of January 1996.

Michelle A. Bishilany, Holland & Associates, Inc.
608 TransOhio-Tower, Cleveland, Ohio'
My commission expires 1-11-96.