In The Matter Of:

Mattie L. Cunningham, et al. v.
St. Alexis Hospital Medical Center; et al.

Martin J. Raff, M.D
***September** 2, 1999*

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Original File 990902MR.VI, 116 Pages
Min-U-Script® File ID: 2828575959

Word Index included with this Min-U-Script®

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[1] MR. RISPO: Doctor, if you would
[2] raise your right hand and be sworn in,
[3] please.
[4] MARTIN J. RAFF, M.D., of lawful age,
[5] called by the Defendants for the purpose of
[6] cross-examination, as provided by the Rules of
[7] Civil Procedure, being by me first duly sworn, as
[8] hereinafter certified, deposed and said as
[9] follows:
[10] CROSS-EXAMINATION OF MARTIN J. RAFF, M.D.
[11] **BY MR. RISPO:**
[12] MR. **RISPO:** Let the record
[13] reflect that this is the deposition being
[14] taken on cross-examination for discovery
[is] purposes by notice and agreement of counsel
[16] and I would like a stipulation that any
[17] defects of notice or service have been
[18] waived.
[19] MR. **SANDELL: Yes,** that's so.
[20] MR. RISPO: And specifically **the**
[21] fact that the reporter is present here in
[22] Cleveland rather than Louisville will not
[23] invalidate the deposition?
[24] MR. **SANDELL:** Nor the swearing of
[25] the witness, that's so, correct.

[1] MR. RISPO: Thank you.
[2] Q: Doctor, thank you for coming in this afternoon.
[3] As you have been advised, I'm sure, my name is
[4] Ron Rispo. I represent the hospital, St. Alexis
[5] Hospital, and I'm co-counsel for Dr. Mehta as
[6] well.
[7] I'll be asking you a lot of questions this
[8] afternoon. It will take at least an
[9] hour-and-a-half and I'm sure that other counsel
[0] will have questions as well.
[1] You have had your deposition taken before,
[2] I'm sure?
[3] **A:** On numerous occasions.
[4] Q: Okay. So I don't have to go through the rules of
[5] engagement, but I know that we're using a
[6] different technical setup here with the video
[7] conferencing and you may or may not be familiar
[8] with that. I believe that it will proceed along
[9] without any technical problems. If, however, we
[0] do have technical problems I'm sure we can
[1] reconnect within a short period of time and it
[2] will result in a minimum of inconvenience to you
[3] or to counsel.
[4] MR. **SANDELL:** Excuse me, Ron.
[5] Before we start, he has a page that he is

[1] required to answer. Can he do that?
[2] **A:** I just got paged.
[3] MR. RISPO: Sure.
[4] **A:** I was just paged. I'll be right back.
[5] MR. **RISPO:** That's fie.
[6]
[7] (Off the record.)
[8]
[9] Q: Dr. Raff, we have been provided with **a** copy of
[10] your CV, which is extensive. In fact, I believe
[11] it's some *67* pages. It's undated, so I presume
[12] that it's not too out of date. The last entry
[13] for your occupation, current occupation starts
[14] with 1995 to present. Is that still an accurate,
[15] up-to-date resume?
[16] **A: Yes,** nothing substantive has changed.
[17] *Q:* Would you give us your professional address
[18] presently, doctor?
[19] **A:** I have two. The first is University of
[20] Louisville School of Medicine Division of
[21] Infectious Diseases, Louisville, Kentucky *40292.*
[22] The second is University Medical Associates, PSC,
[23] *233* East Gray Street, Suite 810, Louisville,
[24] Kentucky, *40202.*
[25] Q: There **is** an address on your report, doctor, dated

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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

MATTIE L. CUNNINGHAM, et al.,)
)
Plaintiffs,)
)
-vs-) CASE NO. 323969
)
ST. ALEXIS HOSPITAL MEDICAL CENTER, et al.,)
)
Defendants.)

Videoconference deposition of MARTIN J. RAFF, M.D.. taken as if upon cross-examination before Dawn M. Fade, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the Forum Conference Center, One Cleveland Center, Cleveland, Ohio, at 2:00 p.m. on Thursday, September 2,1999, pursuant to notice and/or stipulations of counsel, on behal of the Defendants Rajendra K. Mehta, M.D. and St. Alexis Hospital Medical Center in this cause.

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'97 on Ridgewood Road; do you **still** maintain an office there?
A: That's my home. I have an office in my home.
Q: Okay. I understand that you are about 63, 62?
A: 62.
Q: And that you are licensed in at least three or four states, actually five; Texas?
A: Thank you. True. That's correct.
Q: Pennsylvania, New York, Kentucky, Indiana. Are those licenses, all of them still active?
A: The New York and Pennsylvania licenses are not maintained as an actual practice license, but I can renew them at any time.
Q: How about Texas, Kentucky, and Indiana?
A: That's true.
Q: They're all active?
A: They are.
Q: When was the last time that you practiced in Texas?
When was the last time you practiced in the state of Texas?
A: I'm thinking.
Q: Oh, okay.
A: 1967.
Q: Do you have any need to maintain that license in

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Texas or why is it that that **is** active and the New York and Pennsylvania are not?
A: Because my Texas license was obtained by examination and the other licenses were obtained by reciprocity and it is necessary to maintain the license that was obtained by examination.
Q: How long have you been practicing in Kentucky?
A: Since June of 1971.
Q: Continuously till the present?
A That's correct.
Q: Has your license ever been suspended or revoked in any **of** these five jurisdictions?
A: No, sir.
Q: Where are your hospital privileges?
A I am privileged to practice in all of the hospitals in the greater Louisville area.
Q: How many are those?
A: They are listed on the curriculum vitae. There **is** one that may not be listed and that is Southern Indiana Rehabilitation Center. If it would be easier I can tell you what they are.
Q: Well, I'm trying to find it. It's such an extensive resume or CV, doctor.
A: Let me see if I can't list them for you. There is the University of Louisville Hospital, Jewish

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Hospital of Louisville, Alliant Norton Medical Center, Alliant Pavilion and Alliant Childrens Hospital, there is Baptist Hospital East, Suburban Hospital, Alliant Audubon Hospital, Caritas Hospital, Southwest Hospital, the Veteran's Administration Hospital and then the three facilities in Southern Indiana are Floyd Memorial Hospital, Clark Memorial Hospital and Southern Indiana Rehabilitation Center. Oh, also Frasier Rehabilitation Center in Louisville.
Q: In all that's 15 hospitals?
A. I didn't count them.
Q: In the course of your usual practice, doctor, what percentage of time do you spend at each or where do you do your principal work?
A: At the current time the overwhelming majority of my time is spent at University of Louisville Hospital, Jewish Hospital, Alliant Norton's Hospital and Alliant Pavilion, Floyd Memorial, Clark Memorial and the two rehabilitation centers.
Q: Do you visit each of those every week?
A: Yes.
Q: Would you describe the nature of your practice, doctor? Is it, do you have a general practice of

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clients that you have, patients you have on your own or are they all referral?
A: No, I have a, roughly, a private office practice of about **300** patients and then I see patients in consultation at all of the facilities that I have listed for you.
Q: Sounds like you have mastered the art of being two places at once, doctor. I haven't figured that one out yet.
Have you ever had your privileges suspended or withdrawn at any one of these hospitals?
A: Yes.
Q: Tell us about that.
A: I was late in signing charts and occasionally they will, ostensibly, at least on paper, suspend your privileges until you finish signing charts.
Q: How often does that happen?
A: Three or four times perhaps.
Q: Have you ever had your privileges suspended for any other reason?
A: No, sir.
Q: Are your privileges still currently under suspension at any one hospital?
A: No, sir.
Q: So you're in good standing as of present

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everywhere?
A To the best of my knowledge.
Q: Okay. What percentage —
A: Although Jewish Hospital is pressing.
Q: What percent of your time do you spend in teaching as compared with active practice?
A: The two are not separable.
Q: Well, do you teach in the university setting or are your teaching responsibilities in a training setting?
A: I don't understand the question.
Q: Well, I was trying to interpret yours, actually. I shouldn't have done that.
Do you teach formally in the classroom at the University of Louisville or elsewhere?
A: Occasionally.
Q: A small percentage of your time?
A. Very small.
Q: And I gather from your earlier response that you may have responsibility for residents in training?
A: That is correct.
Q: And that's part of your active practice of medicine?
A: That is also correct.

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Q: Besides those two functions, do you also travel and write for medical publications?
A: I very seldom travel anymore. I used to do a great deal of traveling. I still, I am still doing some writing.
Q: I see that, from your resume, you have an extensive series of publications and presentations through '95, anyway. Have you then relaxed your efforts in that direction?
A: Yes.
Q: Do you spend 50 percent of your time in the active practice of medicine?
A: I would say it's closer to 95 percent.
Q: I apologize for these questions, doctor. I know they're routine for you, but we do have to ask. What percentage of your time do you spend in medical/legal consultations?
A: That's a very difficult question to answer because I don't know what you're using as a baseline. I do this in my time that would otherwise be free. I do not consider this a portion of my work obligations or responsibilities. I read these records in the evening at home and if I require time through deposition I have somebody cover for me while I'm

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gone then I pay them back.
Q: How many reports do you write a year?
A: Reports?
Q: Yes, reports of consultation.
A: Perhaps two or three.
Q: Is that scaled down from your prior activities?
A. No.
Q: Are you saying you have only consulted in two or three cases per year or are you saying something different?
A: Well, you asked how many consultative reports I write. I very seldom write the consultative report.
Q: If there is a difference, then, it may be because of our local procedure where we do require reports. Let me ask you then differently. How often have you consented to offer your opinions in any forum in a medical/legal matter?
A: It comes to about between 10 and 12 times a year.
Q: And how many years have you been doing this, doctor?
A: I am not certain of the exact year, but it's about 1976 at the time in which I did my first and it probably took about, this is just an off-the-wall guess, about six years to reach the

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level that I have maintained since that time.
Q: Okay. Doctor, I understand from your resume you are also a member of the bar of the State of Kentucky?
A: That is correct.
Q: And you have received your legal degree, law degree in 1988?
A: That is also correct.
Q: Did the number of consultations that you have taken from a medical standpoint increase after you received your JD degree?
A: No.
Q: So that you continued to offer your opinions about a dozen times a year before and after you received your admission to the bar?
A: That is correct.
Q: Have you ever practiced law, doctor?
A: I represented a friend once who had not been paid for his work as an expert witness and he asked that I would collect the fee for him from the attorney who had failed to pay him and I did so.
Q: Specifically I am familiar with other doctors who have JD degrees who from time to time participate actively in the presentation of a case at trial. Do you ever do that?

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A: I have never done that. I have never participated as an attorney in any activity other than the one I have just told you about.
Q: So you have never received a contingency fee in any of the cases that you have been involved in?
A: Absolutely not.
Q: Do you belong to a professional expert witness index or bank of experts?
A: I do not.
Q: Did you ever testified previously for Mr. Sandell?
A: I have not.
Q: Or his law firm?
A. I have not.
Q: What percentage of your time are you engaged on behalf of the plaintiff versus the defendant?
A: Up until approximately 18 to 24 months ago it would have been 70 percent plaintiff and about 30 percent defense, roughly. In the past 18 months the number of defense cases has increased, it's probably 60/40 plaintiff. That is just a rough estimate.
Q: How many states have you testified in, doctor?
A: About 30.
Q: 30 different states you have testified in?

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A: Roughly, yes, sir.
Q: As of March of this year, doctor, I checked with one of the expert witness index services and discovered that you had been engaged in at least 81 medical malpractice cases for the plaintiff and in only 2 medical malpractice cases for the defendant. Can you explain the difference between your description and that which I might have obtained from a professional witness index bureau?
A: No.
Q: You can't?
A: No.
Q: Have you ever been engaged to testify in a case involving the disease process we're discussing in this matter, the meningococcemia?
A: I don't believe so, but I could not state that with absolute certainty.
Q: Have you ever published articles in the, peer reviewed articles or made presentations which were not peer reviewed on the management of meningococcemia?
A: Yes.
Q: Can you identify those for us or describe them? Perhaps they're already listed in your CV.

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A: I don't believe there is an article to that effect, but I have discussed meningococcal meningitis and meningococcemia in various medical forums.
Q: Have any of them been reduced to a paper?
A: Not to my recollection.
Q: Or published beyond that forum?
A. No.
Q: Have you ever published any articles on the use or abuse of antibiotics?
A: Yes.
Q: I find on your CV three what appear to be presentations to various medical societies, in 1975 to the Berrien County Medical Society, to the Good Samaritan Hospital in Dayton and to the St. Elizabeth's medical staff in Covington, Kentucky back in 1975. Beyond those have you also published anything in writing on the use or abuse of antibiotics?
A. I don't recall, but I don't think so.
Q: So it was those that you were referring to in your previous answers?
A: I would imagine, yes. I may have discussed it in other medical forums. I am asked to speak with some frequency and not all of the talks that I

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have given are necessarily reflected in the CV. It's intendant upon the secretary that we had working for us.
Q: I was more interested in the peer review publications anyway, doctor, and from your answers I presume then that you don't have a current recall of any Deer reviewed publication that you have authored on the use or abuse of antibiotics?
A: I do not. Please excuse me for just a moment.
Q: Certainly.

(Off the record.)

Q: I'd like to direct your attention to this case then, doctor. When and under what circumstances were you engaged by Mr. Sandell?
A: I honestly do not recall.
Q: Can you tell from looking at your file?
A: That's what I'm looking for, to see if I have anything that would tell me. The best estimate that I can give you is some time in the spring of 1997.
Q: Fair enough. Do you know how it was that you were identified in this case, whether it was by

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referral from someone else?
A: I have no idea.
Q: What materials were supplied to you in connection with your review of this case? First of all, prior to writing your report and then later after reviewing your report, after publishing your report.
A: Well, the report is written in August of 1997 and I don't recall specifically what came before and after, but I can give you a list of the materials that I have reviewed.
Q: Well, you don't have to go through them if they're listed on the report of August 18th of '97.
A They are.
Q: Okay. I guess my question is besides the materials identified in paragraphs 1, 2, 3 and 4 of your report, were there any other materials that were supplied to you?
A: Consequently, yes.
Q: Limiting my question to the time before you wrote your report, did you have any other information or detail provided to you besides this? Specifically did you receive any memoranda, summaries, analyses from either Mr. Sandell or

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any other attorney or any other physician that were not in the format that you have described already in your report?
A: I may have, but I do not — I don't have anything like that in my file or in my possession. I don't recall specifically having received it. It's possible, but my tendency is to ignore those.
Q: Specifically in this case there are two other experts identified for the plaintiff that I know of, a Dr. John Luce from San Francisco, and a Dr. Keith Cartwright from Bristol, England. Did you see their reports prior to writing your report?
A. No. I have read Dr., the deposition that was taken of Dr. Cartwright. I do not know Dr. Luce.
Q: Would you have had occasion to communicate with either of those two before you wrote your report?
A: No, sir.
Q: Would there have been any other experts that were hired on behalf of Ms. Cunningham with whom you may have consulted before writing your report?
A: No, sir.
Q: May I assume that you have now seen Dr. Cartwright's report and deposition or just

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his deposition?
A: I don't think I have ever seen a report by Dr. Cartwright. I have read his deposition.
Q: Okay. Dr. Luce has not yet been deposed, so I presume you have not seen a deposition or a report from Dr. Luce?
A: That is correct.
Q: Have you seen the reports that were retained, reports that were written on behalf of the defendant hospital including reports of Dr. Lowell Young and Dr. Arthur Wheeler?
A: I remember reading Dr. Young's report. I may have read Dr. Wheeler's report, but I don't specifically recall.
Q: Doctor, on the standards of care, you're board certified in internal medicine and infectious diseases?
A: That is correct, sir.
Q: Do you know what the training or area of specialty is of Dr. Mehta?
A: I understood that Dr. Mehta was a board certified internist.
Q: Is there a standard of care for a house physician?
A: As opposed to what?

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Q: As opposed to a primary independent attending or consulting.
A: I don't think there's a different — my opinion is there is not a difference in the standard of care for anyone who is board certified in internal medicine unless you're dealing with subspecialty issues.
Q: If I may ask the question slightly differently. Are you familiar with the duties and responsibilities of a house physician as distinguished from an attending?
A: Yes.
Q: Would you outline those for us briefly?
A The house physicians with whom I have been in contact with in situations where I understand what house physicians do is that, depending upon the institution, depending upon the physicians for whom they are reporting their service, they may or may not be permitted to exercise independent opinions with regard to management of patients but rather to report to the primary care physician.
There are house physicians in other institutions, however, who, in essence, have full

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call for consultative advice from other physicians and it often varies in substance with the particular physician for whom they are performing their duties.
Q: And do you have an opinion or an understanding, let's say, with respect to this case which of those varying responsibilities or duties Dr. Mehta had at St. Alexis Hospital?
A: Do you mean do I know what he was permitted to do or not to do?
Q: Yes, that's my question.
A: No, I do not have a copy of his contract or the regulations under which he was retained.
Q: Since you wrote your report, doctor, have you received any additional documents other than depositions or medical reports? Have you been provided with anything other than depositions or medical reports?
A: Not to my knowledge, no.
Q: Have you reviewed any —
A: Oh, let me amend that. I do have a memorandum from Mr. Sandell listing the materials that he has sent me.
Q: And how many are there?
A: The list has 38.

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Q: 38 additional materials?
A: No, no. Total materials.
Q: Total. Can you run through there and tell me about anything other than hospital charts or deposition transcripts?
A: There are reports from a David Longworth, a Dr. Bruce Janiak, a Dr. Richard Blinkhorn, Jr., a Dr. Jonathan Glauser, a Dr. Michael Beeson, a Dr. Arthur Wheeler, a Shirley Heminger, MSN RN, a report by Dr. Ian Baird.
MR. SANDELL: Excuse me, can I interrupt a second. You asked him earlier was he supplied anything other than reports or depositions.
MR. RISPO: This time, however, I would be interested in the reports.
MR. SANDELL: Okay. Go ahead. I'm sorry for interrupting then. Go ahead.
A: The report of Dr. Rafiq Hussain, a report of Dr. El Sanadi, Nabil El Sanadi, a report of Dr. John M. Luce, a report of Denise M. Kresevic, RN, a report of Gary Gibson, M.D., and a report of Dr. Ian Baird.
MR. RISPO: Martin, I recognize all of those except Rafiq Hussain. Who is he?
MR. SANDELL: That is an expert, a later retained expert by Dr. Dar. He's an internal medicine expert.
MR. RISPO: Okay. And just to be sure, Dr. Gibson, do you know who he is?
MR. SANDELL: He's a plaintiffs' expert in internal medicine out of Warren, Ohio, Gary Gibson.
MR. RISPO: Oh, that's right. That's right.
So you really have four liability experts, don't you?
MR. SANDELL: Five. I have Luce, I have Gibson, I have El Sanadi, I have Cartwright, and I have Raff.
MR. SANDELL: And the nurse, **six.**
MR. RISPO: That's Kresevic, right?
MR. SANDELL: Denise Kresevic, however you pronounce it, yes.
MR. RISPO: Has Baird been supplied to us, Ian Baird?
MR. SANDELL: Ian Baird's report has been supplied to us.

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MR. RISPO: We will figure that out later.
Just for your understanding, doctor, we're having a change of counsel here. Mr. Leak has just entered the room, he has arrived from out of town, but we will continue if it's all right with you.
MR. SANDELL: Yes.
Q: Besides those reports, doctor, and the depositions and the hospital records, have you received any other memoranda, analyses, summaries or reports from any other physicians?
A. Not that I have in my possession, no.
Q: Have you ever received any that are not in your possession today?
A: I may have, but I'm not certain.
Q: Did you leave anything behind when you came today deliberately?
A: No.
Q: Have you received any reports in which the party providing the information indicated that he or she could not support the plaintiffs' case or offer an opinion that any of the parties failed to meet the standard of care?
A: No.

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Q: Or that they would not serve as an expert?
A: No.
Q: If you would, please, doctor, define for us or list the signs and symptoms which are specific or diagnostic for a bacterial infection?
A: Bacterial infection of what nature?
Q: A bacterial infection such as meningococcal septicemia.
A: Many of the signs and symptoms associated with meningococcemia are not unique to that disease but are rather common to all forms of sepsis. The definition of sepsis, which is basically systemic inflammatory response syndrome secondary to infection, are fever or hypothermia, tachypnea, tachycardia, leukocytosis or leukopenia or a significant left shift, significant number of immature polymorphonuclear leukocytes.
Q: Are you saying there are no specific or diagnostic signs or symptoms of the condition known as meningococcemia?
A. No.
Q: Well, then, can you list them, those that are specific or diagnostic?
A: Well, there are none that are diagnostic per se,

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that is one can have cutaneous lesions, a petechial or ecchymotic eruption associated with meningococcemia, but they are lesions that can also be associated with other infectious processes.
Let me, can I come back to something? I gave you a piece of misinformation earlier.
[illegible] all a case in which I testified about meningococcemia. It was in Memphis, Tennessee, I don't know how-long ago, and it was a young man with chronic meningococcemia. I testified on behalf of the plaintiff.
Q: What was the outcome of that case, doctor, if you recall?
A: Yes, I believe they found for the defendant.
Q: What were the circumstances in that case, doctor?
A: It was so long ago I don't remember the details. It was a case of chronic recurrent meningococcemia that lasted for weeks in the patient.
Q: Did he survive the event?
A: I don't recall.
Q: Did he have any mortality of any kind?
A: This was so many years ago I have only a vague recollection. I thought of it only, something

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that you mentioned about specific manifestations jogged my memory about that in terms of the fact that I had testified in that case, but I don't recall any of the details. I'm sorry.
Q: Okay. Well, I understand that. If during this deposition you should have another flashback and you could tell us some of the circumstances of that case I would appreciate if you would do so.
A: I will try my best.
Q: Getting back to the earlier line of inquiry, though, doctor, I gather from what you're saying is that although there are many signs and symptoms, none of them are specific and diagnostic for meningococcemia?
A: That's correct.
Q: So the flipside to that is that the only way you can diagnose it is from laboratory studies?
A: In essence that is correct. Now, there are circumstances — no, in essence that is correct, yes, it is a laboratory diagnosis.
Q: And by that we're talking about blood studies?
A: Not necessarily.
Q: What studies would provide us with the definitive diagnosis?
A: Well, for definitive diagnosis, yes, you must

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have cultural evidence of the presence of the pi organism.
Q: Are you distinguishing then between definitive diagnosis and diagnosis?
A: You can make presumptive diagnoses based on a variety of evidential factors.
Q: Let s take them step by step then. What laboratory studies would provide us with a presumptive diagnosis?
A: If you have petechial lesions that you unroot, smear out on a slide and are able to see Gram-negative epicocci by Gram staining, that will lead you to a presumptive diagnosis of either meningococcemia or gonococcemia. The differentiation between the two organisms would have to be made by specific culture.
In patients in whom there is a suspicion of meningitis a lumbar puncture with the presence of meningococcal antigen in the cerebral spinal fluid will also establish a presumptive diagnosis.
Q: I don't know if you hear that noise, doctor.
A: I hope it doesn't hit you.
Q: No, they're practicing for an air show about two blocks from here so from time to time there will

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be an interruption. I apologize for that.
A: I hope it doesn't involve missiles.
Q: Good help us, no, I hope not, too. You have mentioned two methods, lumbar puncture and smears of the petechial lesions. Are there any other diagnoses short of laboratory blood cultures which would —
A: Yes. Yes. You can make presumptive clinical diagnosis based upon a clinical presentation that's compatible with sepsis in an individual who has been exposed to other individuals with known meningococcal disease.
Q: Doctor, you're one step ahead of me. I'm still on laboratory studies.
A: I'm sorry.
Q: Which laboratory studies or are there any others besides the two you have listed?
A: Not to my current recollection.
Q: Okay. And the latter one you mentioned was the lumbar puncture which would be positive only for meningitis, right?
A: That is correct.
Q: So that as applied to the case we're discussing, meningococcemia, a lumbar puncture would not provide even a presumptive diagnosis?

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A: That is correct.
Q: And by definition of your earlier description, you cannot do the smears on petechial lesions until you have petechial lesions?
A: That's correct. Now, there is another test that may show the organism in the circulation but it's one that's done very, very rarely and only by experienced infectious diseases persons.
Q: By definition and by your statement, then, you would not expect a, an internal-medicine or house physician to perform those tests?
A: Absolutely not.
Q: Okay. Would it be fair to say then, doctor, that prior to the appearance of petechial lesions there would be no way for, in my case here, Dr. Mehta, or the nurses, to arrive at even a presumptive diagnosis of meningococcemia present in Mattie Cunningham on June 13th, 1996?
A: If your question is specifically about meningococcemia the answer is yes, there is no way in which they could have made a diagnosis or suspected a diagnosis of meningococcemia in Mattie Cunningham prior to the occurrence of the petechial lesions.
Q: And to capsulize what you had said earlier, the signs and symptoms that would have been present prior to the arrival of the petechial lesions were the same signs and symptoms that could be found in numerous other bacterial or viral infections?
A: I would delete the word "orviral".
Q: You mentioned, I believe, fever. Would fever be present in viral infections?
A: Yes.
Q: As well as bacterial?
A: Yes.
Q: Hypothermia, same question, would it be present in a viral infection?
A: Very unusual.
Q: What do you mean by hypothermia?
A: Body temperature below 97 degrees.
Q: Do you know in this case when, if at all, Ms. Cunningham had hypothermia as defined below 97 degrees Fahrenheit?
A: I don't recall specifically whether she ever did.
Q: Tachypnea, would it be, would you find tachypnea in viral infection?
A: Yes, in the presence of pulmonary involvement.
Q: Tachycardia, would you find that also in viral cases?

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A: Yes.
Q: Leukocytosis?
A: Occasionally.
Q: Leukocytopenia?
A: Yes.
Q: And a left shift?
A: Unusual
Q: Of those seven signs and symptoms that you described to me I believe that you have indicated in the affirmative on five of those signs and symptoms that could be found in a viral condition as well and questionable or unusual in two of the others?
A: That is correct.
Q: And we don't know as we sit here, although we may be able to find it later, whether or not Mattie Cunningham ever was recorded as having a hypothermia, at least prior to the arrival of the or the appearance of petechial lesions?
A: No. She had fever.
Q: Back to my earlier question then. I thii if I can rephrase it, doctor, would it be fair to say that prior to the arrival of the petechial lesions the signs and symptoms exhibited by Mattie Cunningham would not have permitted either

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Dr. Mehta or the nurses on duty to arrive at a definitive diagnosis or specific diagnosis for meningococcemia?

A: That's correct.

Q: And indeed those signs and symptoms which she did exhibit before the arrival of the petechial lesions could have been interpreted as possibly viral in origin?

A: That is conceivable except for the fact that there were other associated symptoms which made viral infection highly unlikely.

Q: Tell us about that —

A: Mattie Cunningham initially presented with true rigors. True rigors are almost invariably a result of bacterial infection or of illnesses like malaria.

Q: What is the basis for your statement that she presented with true rigors?

A. It's well recorded in the medical records and in statements from Mattie Cunningham's daughter Tonya.

Q: How do you define rigors?

A: Shaking chills, limitation, not in full control of herself. As I recall, I believe — do you have Dr. Mehta's note here? I apologize. I have

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a requirement that I not rely upon my memory. I'd like to read the note. Is that okay with you?

Q: Yes. Could you explain that comment you made a moment ago, a requirement that you not rely on your memory?

A: Yeah. I tend not to rely on my memory and when I am not certain of what's going on I like to refer to medical records.

Q: Is that just a personal habit or is that a medical condition?

A: Oh, no. It's a, it's just a, I can't rely on my memory to document every medical piece of information. When you ask for a specific indication of where I got the information from I'd like to go back and look at the record.

Q: I understand. Yes, doctor.

A: There is a note somewhere where somebody writes — well, I know somewhere in this record someone has written rigors.

Q: Okay. Would you start that again?

A: I said, I apologize, there is, somewhere in this medical record I recall having seen a description of her shaking chills as rigors. I can't find it at the moment, but in the emergency room the

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initial report by the nurses states, shaking chills, shakes, aches all over and at the top under chief complaint it's chills and *dizzy*.

Q: Does that say that the patient was out of control?

A: Not specifically. Would you give me a moment, please?

Q: Certainly.

A: If you look at Dr. Mehta's note that was dictated on 6/13, 1996 at, under assessment, do you have that?

MR. SANDELL: Page 9 of the stamped pages in the lower right-hand corner. Do you have that?

MR. RISPO: That would be the history and physical?

MR. SANDELL: Yes.

Q: And you're talking about the assessment?

A: Yes. It says fever of sudden onset with chills and rigors.

Q: Now, what is the basis for your statement earlier that the appearance of rigors is suggestive or diagnostic of meningococcemia?

A: It's not.

Q: It's not?

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A: No.

MR. GOLDWASSER: Just says it rules out viral infection.

Q: Do I understand all you're saying is it rules out a viral infection?

A: It doesn't rule it out, it ***makes*** bacterial infection overwhelmingly probable

Q: Where would I go to find support and documentation for that opinion?

A: I have no idea.

Q: Do you recall seeing that written anywhere?

A: Specifically, no.

Q: Did you include that statement in your medical report of July — August 18th, 1997?

A: No. But there are a great many things that I didn't include and that report is an overview.

Q: Have you done any supplementary reports or advises to counsel?

A: No. I have had verbal expressions with counsel.

Q: Have you ever talked to Mr. Sandell about rigors?

A: Yes.

Q: Was that conversation before or after the deposition of Dr. Cartwright, which was in February of this year?

A: I have no idea.

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Q: Do you recall whether it was closer in time to this deposition or closer in time to the time when you wrote your report?
A: I have no idea.
Q: Isn't it a fact, doctor, that the discussion of rigors didn't come up until after you read the transcript of the deposition of Dr. Cartwright?
A: Wrong.
Q: Or that it came up after the deposition of Dr. Cartwright was taken?
A: No.
Q: But you don't remember when it occurred?
A. When I appreciated the fact that Mattie Cunningham had been described as having rigors, is that what you're referring to?
Q: Yes.
A: As soon as I read the medical record.
Q: When did you discuss it with counsel?
A: As I said, I don't recall.
Q: I guess there was confusion between us because I was asking initially whether the discussion you had with counsel about rigors was a discussion that took place after Dr. Cartwright's deposition or before.
A: Let me see if I can't make something very clear.

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Although I read Dr. Cartwright's deposition, I did not in any way rely upon it for my opinions and do not rely upon it for my opinions. My opinions were based upon my review of the medical records and the medical records alone. I read the reports of both defense experts as well as some of the participants in the care of Mattie Cunningham with interest but did not rely upon them for my opinions.
Q: I'm just curious, doctor. I'm not accusing you of relying on any other physicians, I'm curious as to why rigors could be such an important clinical sign and has not been referenced by any expert for plaintiff or defendant to date?
A. I have no idea. Perhaps they don't see very many patients with this.
Q: And if I understood your previous answer, doctor, you can't refer me to any published medical authority which would support your statement that rigors makes bacterial infection overwhelmingly probable?
A: I cannot refer you to a specific report, but I am certain if you read the literature you will find that being reported.
Q: Let me suggest this, doctor, since we have reached a stalemate on this issue, after this deposition, if you would have the occasion to research the issue and if you are going to do that, provide copies to Mr. Sandell and that you consider that in the form of a supplemental report to us, as well.

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MR. SANDELL: I'm going to object. I don't understand if you're directing him to do research, but if you are that would be improper. If he does any research and supplies the material to me with respect to that you will receive it.
MR. RISPQ: I guess we're on the same page, Martin. What I'm saying is I'm happy with his testimony today, but I don't want to be surprised between now and the time of trial if suddenly he discovers a documentary support for his opinion, he tells you about it and we don't know it before trial.
MR. SANDELL: We're on the same page. You will be entitled to know that and not be surprised at trial.
MR. RISPQ: Thank you.
Q: Getting back —

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A: Counsel, I'm sorry.
Q: Sure.
A: You asked me a question earlier which I responded in the negative and it's not correct. You asked me if Mr. Sandell had provided me with any other materials after my discussions of the case with him and he did provide of Mattie Cunningham as I requested.
Q: Okay. Thank you, doctor. I'm going to try and get back to the context of our previous discussion, doctor. I think I was asking you to affiim that prior to the arrival of petechial lesions the clinical signs and symptoms presented by Mattie Cunningham were equally probably interpreted as viral versus bacterial and to that you raised the exception that we just got through discussing about rigors.
To follow up, are there any other signs or symptoms that you would identify as distinguishing the viral, her signs and symptoms from a viral versus bacterial infection?
A: Not distinguishing, but more frequently associated with bacterial sepsis than with a viral illness would be alterations in mentation.
Q: I presume those are the two bases that you then

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rely upon as the distinguishing features between viral and bacterial?

A: For clinical manifestations in the absence of laboratory data, is that what you're asking?

Q: Yes. Yes.

A: Yes, that is correct.

Q: Then if you would please explain what it is that you have found or discovered regarding Mattie Cunningham's alterations in mental state or mentation?

A: It appears that there's little question that Mattie Cunningham had altered mentation after admission to the hospital. Are you referring to prior to admission?

Q: Actually I'm referring to any time prior to the appearance of petechial lesions on the afternoon of the 13th.

A: There appears to be substantive evidence in the chart or from the nursing personnel, and that's corroborated by statements from Mattie Cunningham's daughter, that she had alterations in mentation —

Q: Can you —

A: — prior to the onset of the petechial lesions.

Q: Can you list or identify those notes that you are

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relying upon and the substance of the testimony from her daughter?

A: It will take a while.

Q: Well, I'm not asking you to give me chapter and verse, but if you can give me at least a specific.

A: I did not commit this medical record to memory.

Q: Then, fair enough, take whatever time you need, doctor.

A: To start off, the nursing assessment, I believe it is page 77, are you with me?

Q: I am. Yes. Thank you.

A Okay. Under cognition the nurse completing this form has circled disoriented to some spheres.

On page 79, are you with me?

Q: Yes.

A: Okay. On line **3,** slept or semi-delirious, okay.

Q: Thank you. Yes.

A: Okay. On page 90, Dr. Mehta's history and physical examination, I would refer you to system review is essentially negative in the second paragraph, sir.

Q: Yes.

A: Could not be completed because of the patient's unwillingness to answer the questions. Again,

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suggestive of some alteration in mentation.

In addition, **if** one looks at page *3* —

Q: Did you say 3?

A: *3.* If you look at the bottom of the page where it says patient's signature —

Q: Yes.

A: — that is not the signature generally of an individual who is competent of a neurologic function and that is why I asked to ***see*** Mrs. Cunningham's, Ms. Cunningham's signatures that had occurred prior to that. They're distinctly different.

Q: Were those signatures taken from the hospital chart or from some other handwriting exemplars?

A: I think that they were handwriting exemplars.

Q: Those would not be signatures, then, that the hospital staff would have routinely on file?

A: That's correct. I cannot say — I am not saying that the physician caring for Mattie Cunningham should have seen this and interpreted it, it is just evidence to support the contention made by her daughter that she was not in control of her mental facilities.

Q: Can you cite to the testimony of the daughter either by substance or by page number upon which

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you're relying?

A: I would have to go back and read her statement and deposition. Would you like me to do that?

Q: I don't even have my copy with me, but if you can refer us to at least page number and the substance I'd appreciate it.

A: Not without going back and reading it. I'll be happy to do that if that's what you want.

Q: You don't have it indexed, then?

A: No.

Q: All right. Well, then I'll be satisfied with your word on that, doctor. We will look it up later.

Then to understand your testimony, doctor, may I summarize by understanding that the four pages on the medical chart that you have referred to and the daughter's testimony are the basis and sole basis for your conclusion that Mattie Cunningham had alterations in her mentation?

A. To the best of **my** recollection at the present time, yes.

Q: Do you know whether **Mattie** had any psychiatric history?

A: I do not.

Q: So then when you rendered your opinion you did

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not know that she had a psychiatric diagnosis?
A: I don't recall. I really don't recall. I may have known that at one time, but I don't specifically recall.
Q: If she had a psychiatric diagnosis, doctor, would that explain her disorientation to some spheres?
A: I don't know what the psychiatric diagnosis was.
Q: If the diagnosis was schizophrenia, would that, could that explain the disorientation in some spheres?
A: If she was actively schizophrenic in specific spheres it could, but I would have to know the nature of the schizophrenia and I would have to know whether she had been functioning in a different fashion prior to the onset of this febrile state.
Q: Would your answers be the same with respect to the other references to sleep or semi-delirious, unwillingness to answer the question and her signature?
A: Not to her signature and not to semi-deliria. It is conceivable that her failure to answer questions, depending upon the nature of the schizophrenia, was a manifestation of that disorder. Conceivable but not probable.

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Q: Would you agree from your recollection of review of the chart, doctor, that Mrs. Cunningham was normotensive as of at least 12:30 p.m. on the 13th, that being the time when the nurse called Dr. Dar?
A: Yes.
Q: And would you agree that as of that time there were no focal neurological signs?
A: Yes.
Q: Would you agree that there was no evidence of hemorrhagic diesthesias prior to that time?
A: No clinical evidence of any hemorrhagic diesthesias, that is correct.
Q: Thank you. Would you agree that there was no evidence of petechia or purpura until sometime around 2:00 in the afternoon?
A: That is also correct.
Q: And that there was no record of nuchal rigidity?
A: There is no statement anywhere in the chart that I could find that Mattie Cunningham had nuchal rigidity and it wasn't commented on in any fashion.
Q: And would you agree that the white blood count was no higher than 10,000?
A: It was 10,400 in the emergency room.

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Q: Thank you. And that her platelet counts were normal as of 12:30 p.m.?
A: I don't know what her platelet counts were at 12:30 p.m.
Q: If they were 178,000 per cubic millimeter would that be normal?
A: That was in the emergency room. I have no idea what they were at 12:30 because they weren't done again.
Q: I stand corrected. The latest available **lab** reports indicated 178,000; and those would be considered normal, though?
A: Yes.
Q: And she had a normal pulse and blood pressure?
A: She was tachycardic.
Q: As of when?
A: In the emergency room her pulse was 92.
Q: But her blood pressure around noon on the 13th was *140* over 80.
A: That's correct.
Q: Would you consider that tachycardic?
A: Blood pressure has nothing whatever to do with tachycardia.
Q: Would you consider it a normal vital sign?
MR. SANDELL: I'm *sorry,* I didn't

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hear the question.
Q: Would you consider it a normal blood pressure?
A: Yes.
Q: Would you agree there were no abnormal respiratory symptoms?
MR. SANDELL: Still at 12:30, Ron?
MR. RISPO: Yes. P.m.
A: No.
Q: What would you consider an abnormal respiratory symptom?
A: She was breathing at roughly 24 times a minute at that time. She was breathing in 28 times a minute in the emergency room.
Q: Okay. So her respiratory rate was up is what you're saying?
A: Yes.
Q: But otherwise, were there any other respiratory symptoms?
A: Not that I'm aware of.
Q: Would you agree with me that there's no record of headaches in the chart before 12:30?
A: Yes.
Q: Would you agree, therefore, it was not a breach of the standard of care for the nurses to fail to

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make a diagnosis as of 12:30 p.m. of meningococcemia?
A I don't think it would ever be a breach of the standard of care for a nurse to fail to make a diagnosis of meningococcemia absent a telephone call from the laboratory with positive blood cultures.
Q: Right. But in this case that laboratory report wasn't available until the following day?
A: Right.
Q: And would you agree it would not be a breach of the standard of care for Dr. Mehta to fail to make the diagnosis before 12:30 p.m.?
A: The diagnosis of what?
Q: Of meningococcemia?
A: I don't think that anyone could have made the diagnosis of meningococcemia at that time.
Q: Would you agree with Dr. Cartwright's testimony that antibiotics, if they had been commenced at 12:30 p.m., would have made it possible to avoid loss of Mattie Cunningham's extremities?
A: Yes.
Q: Would you agree with Dr. Cartwright that even administration of antibiotics at a later time might have prevented loss of her limbs?

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A Yes.
Q: When according to your experience and knowledge would be the latest time that antibiotics could have been prescribed and avoided the loss of limbs?
A: Antibiotics by themselves were not the full cause or the failure to give antibiotics alone was not the cause of loss of her extremities. Loss of Mattie Cunningham's extremities was a combination of events that included the failure of earlier therapy with antibiotics but was not limited to that failure.
Q: I think I know what you're saying, doctor, but would you be more specific?
A: Sure. Tissue damage associated with overt sepsis from a meningococci is contributed to by a variety of events. Some of it is related to a true vasculitis that is produced by the host's reaction to the endotoxemia that may have accompanied this disease. Part of it is due to the coagulopathy that is also inducible by both the endotoxin and the host's reaction to that endotoxic material. Part of it is due to hypotension which may be due to loss of integrity of vascular walls with third spacing of liquids

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and inadequate replacement of circulating blood volume. There may be other associated causes for vasculopathy and tissue loss which might include embolization from other foci within the vascular tree as a result of inflammation from the meningococcus and all of those factors may contribute to the loss of tissue.
Q: Would it be fair to conclude that if antibiotics were administered promptly after the observation of purpuric lesions that Mattie Cunningham may have avoided loss of her extremities?
A: Assuming that the antibiotics were accompanied by adequate supportive medical care the answer is yes.
Q: Do you agree that antibiotics were in fact administered promptly after the discovery of purpuric lesions?
A: Yes.
Q: And they were administered, that is antibiotics were administered before the drops in her blood pressure?
A: Yes.
Q: And before the signs of disseminated intravascular coagulopathy?
A. We do not know that.

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Q: I'm sorry?
A: We do not know that.
Q: Are you saying that DIC may have commenced earlier?
A: Absolutely.
Q: But the signs and symptoms were not noted until after that time?
A: You cannot make a diagnosis of disseminating intravascular coagulopathy without laboratory measurements.
Q: Were there any?
A: There is an excellent review in a recent journal of medicine if you're looking for a source.
Q: I guess my question then is limited, doctor, to the signs, symptoms and lab records as they appeared in the chart. Is there any evidence that you know of that she began having DIC before antibiotics were administered?
A: All patients with bacterial sepsis have disseminating intravascular coagulation. It may not be to a degree which becomes clinically manifested in an overt fashion, but they all have it and should be measured for it.
Q: Are you aware of any measurements that were in the chart which would have been observable by the

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nurses or Dr. Mehta?
A: They were not ordered.
Q: Okay. Would you agree that if antibiotics had been started by 12:30 when Nurse Hopwood inquired of Dr. Dar about using antibiotics then the nurses would have discharged their standard of care?
A: Let me see if I can't answer this in a fashion that is — will you excuse me for just a second?
Q: Certainly.
A: I apologize.
MR. **SANDELL:** I'm going to take a restroom break.
MR. **RISPO:** Sure. We will do the same.

(Thereupon, a recess was had.)

A: I don't remember the last question.

(Thereupon, the requested portion of the record was read by the Notary.)

A: Number 1, it's a compound question. It makes the assumption that the time at which Nurse Hopwood

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called **was** 12:30; that's contradicted not only by the medical record but it's contradicted by Dr. Dar's testimony. Nurse Hopwood's note, as I recall — let me look to make certain. Yes. Nurse Hopwood's note is written at 8:00 a.m. or at least timed at 8:00 a.m. and Dr. Dar in his deposition several times indicated that it was 9:00 a.m. at the time that he received that telephone call, so the compound question is no longer valid assuming that you're using 12:30 the time the telephone call was received.
Q: What if I asked the same question and eliminate any reference to the time on the clock but limited it to the time when the nurse did make the call, whenever that was?
A: You're asking me now if antibiotics had been administered, and let's say as late as 12:30, would that have altered the clinical course so as to maintain the extremities, is that the question?
Q: Well, that was the previous question. But this question is based on the same assumption, the question is whether the nurse would have discharged his standard of care? It was a male nurse in this case.

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A: I think that for Nurse Hopwood he would have discharged his standard of care following his telephone conversation. On the other hand, there were other nurses involved earlier, in fact at about 6:15 when Mattie Cunningham **was** received on the floor, who should have been in contact with physicians.
Q: Which physicians?
A: Well, preferably any physician that was available, the house officer if necessary, but the physician, Dr. Dar, to whom the patient was referred.
Q: If I may, doctor, ask you to bear with me because this may not be the most eloquent question. Assuming that Nurse Hopwood made the call sometime before petechial lesions were noted and inquired explicitly of Dr. Dar whether he should order or would order antibiotics, regardless of what time that was, but assuming it was before petechial lesions were noted, would it be fair to say that nothing that those nurses did before that point in time would have made any difference to the outcome?
A: I just lost you entirely.
Q: Okay. I'm trying to focus on causation, I guess

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that's what I'm getting at here.
A: You're asking me at what time therapy should have been commenced.
Q: Well, no. Let me refine it further. Up to this point in time we have been talking about the nurse's standard of care and now I'd like to inquire about causation and I guess the question is isn't it true that if antibiotics had been ordered by Dr. Dar when he was called, whenever that was, so long as it was before the petechial lesions were noted, then nothing that the nurses or Dr. Mehta did prior to that point in time made any difference in the outcome?
A: I can't answer that question. It's actually several questions. If you would break it down into its individual components. And I will also say I'm not going to comment up until the time the petechial lesions developed because that's the time at which vasculitis was already manifest and she may have sustained tissue damage if antibiotics were begun at that point but the degree of tissue damage would have been limited had appropriate therapy been instituted. And by appropriate therapy it's not only antibiotics, you cannot focus entirely on antibiotics because

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this patient was not adequately hydrated and not adequately monitored during her time in the hospital, so all of those factors play a role here.

Now, let me just say that at the time that Nurse Hopwood —

Q: Correct.

A: — called, had the physician responded by seeing Mattie Cunningham and, depending upon his judgment, instituted appropriate therapy, I believe that she would not have lost her extremities. That is my opinion.

Q: Okay. That's exactly what I was asking. Thank you, doctor.

Do you agree that the overuse of antibiotics in cases where they are not needed will result in bacteria with a more resistant strain to antibiotics?

A: Can I rephrase that rather than answering yes or no?

Q: Be my guest.

A: The widespread use of antibiotics throughout the medical community in the absence of documentable clinical indications has led to the development of multi-resistant organisms throughout the

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United States and for that matter throughout the world.

Q: And that makes it even more difficult to treat a patient later when she really needs antibiotics?

A: Oh, that's nonsense.

Q: Well, if it results in a more resistant bacterial strain —

A: Yeah, but we're not talking now — you're mixing your metaphors here. We're talking on the one hand about societal changes that influence populations as a whole versus individual patients. Mattie Cunningham having been given antibiotics, whether or not they were indicated, is immaterial. Mattie Cunningham per se would not have been influenced by whether antibiotics were appropriate or inappropriate.

Q: I follow what you're saying, doctor, but what I'm trying to establish here with your permission is that it is not good medical practice for a practitioner to prescribe antibiotics unless he can document that there is a need for them?

A: That is absolutely correct. But it's even more devastating for a physician not to prescribe antibiotics when they're obviously necessary because otherwise you wind up with patients

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without arms and legs.

Q: But you would agree that in general the overuse of antibiotics where they're not needed creates or results in resistant strains of bacteria which could make it difficult to treat a patient in general who has contracted the more resistant strain?

A: Yes.

Q: Do you agree that the standard of care states that you don't prescribe antibiotics even if the chances are 50/50 of a bacterial infection unless the clinical signs are severe?

A: I don't know what clinical signs are severe means.

Q: What is your definition of severe clinical signs?

A: I knew that was going to follow. If I have assessed a patient and determined that to the best of my abilities it is my presumption that they have an acute bacterial infection, that is that there's a high probability that there is acute bacterial infection, I will treat that patient empirically until I have either shown that it is not a bacterial infection or that I believe that the patient has received sufficient coverage so that they will not sustain

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significant morbidity as a result of my failure to treat.

Q: What about the condition of Mattie Cunningham would lead you to that conclusion that you would be required or would be, in the discharge of the standard of care you would administer antibiotic coverage empirically prior to the appearance of petechial lesions?

A: You had an otherwise healthy 33-year-old woman presenting with shaking chills, fever, tachypnea tachycardia and possibly, and possibly a left shift who was not adequately further evaluated. That patient should have been adequately evaluated and it is my expert medical opinion that had those evaluations been performed there would have been substantial evidence to indicate that antibiotics were required.

Q: Doctor, would you agree that there are certain seasons of the year when meningococcemia is less likely to occur?

A: Yes.

Q: And that the month of June is one of the months when we see the lowest incidence of this disease?

A: Yes.

Q: Would you agree that meningococcemia in the U.S.

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is a very rare condition?
A: No. Well, I don't know what rare means.
Q: In your experience how often does it occur?
A: I had one last week.
Q: And how often have you seen it in the course of your practice?
A: Several times a year.
Q: And your specialty is infectious disease?
A: Yes.
Q: And what is several times a year for you?
A: I don't understand your question.
Q: When you say several, do you mean two, three, four or ten or a dozen?
A: Oh, three to five.
Q: Per year?
A: Yeah.
Q: And in your area of specialty you would likely see a patient with that condition more often than would a general practitioner or a specialist in internal medicine, is that right?
A: Absolutely.
Q: If I recall correctly your earlier testimony, doctor, for a patient who is normotensive who has no focal neurological signs, no evidence of, no exterior clinical evidence of hemorrhagic

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diesthesias, no evidence of rash or lesions or petechial lesions, no nuchal rigidity, a white blood count of 10,400, a patient with a normal platelet count of 178,000, normal vital signs, no respiratory symptoms except I think you said —
A: The patient did not have normal vital signs.
Q: You said higher respiration rates. Well, as of noon her pulse was 92, wasn't it, and her blood pressure was 140 over 80, which you previously conceded were normal?
A: The pulse at noon was not recorded.
Q: I'll accept your amendments then, doctor. Given this patient with those conditions, no headache, no nuchal rigidity, the patient presents during June of the year, and, incidentally, she is middle-aged rather than a child or an older patient, do you still feel it would be appropriate or necessary to treat her with antibiotics prior to 9:00 a.m. in the morning?
A: Yes.
Q: Would you consider her condition as severe, her clinical signs as severe prior to 9:00 a.m.?
A: She was septic.
Q: How do you know that?
A: She meets the definition of sepsis as in fact

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described by one of your experts.
Q: I wonder if you could enlighten us as to what you mean by a patient having clinical signs of sepsis?
A: She had fever, tachypnea, tachycardia, altered mental status, and rigors, that is a septic patient.
Q: Without, however, the reference to rigors or mental status, altered mental state, the symptoms you have described are equally consistent with virus?
A: In and by themselves potentially absent all other considerations.
Q: Just a few follow-ups, doctor. How long does it take for hypotension to result in a loss of a limb?
A: I don't know.
Q: Is it true that routinely patients have in fact had a tourniquet for upwards of an hour and do not lose a limb?
A: That can be correct, yes. Most patients are usually hypothermic, they are kept, their extremity is kept in cold, in controlled conditions and not in association with ongoing sepsis.

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Q: Did I understand you to say earlier, doctor, that the mechanism or cause for tissue necrosis is more related to the release of endotoxins than it is to the timing of the administration of antibiotics?
A: No.
Q: Could you explain that?
A: What I said was that tissue loss is a result of multiple factors acting in concert. I cannot assess the degree to which each factor contributed to the loss of the extremities in Mattie Cunningham.
Q: You cannot say which, is that what you said?
A: That's correct. No, not which, I said to what degree each individual factor may have contributed to the degree of the tissue loss experienced by Mattie Cunningham.
Q: What is a minimum adequate level of intake and output of fluids to maintenance adequate perfusion of a patient?
A: That depends upon the individual patient and that is why it is so essential to monitor input and output in any individual with a serious condition of this nature.
Q: Would you say that generally speaking 25 to 30

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cc's an hour is adequate?
A. For whom?
Q: For Mattie Cunningham.
A: No.
Q: What is the basis for your statement?
A: My medical knowledge and long experience of an infective patient in concert with volumes and volumes of literature on the subject.
Q: What would you consider, if you have an opinion, to be an adequate level of perfusion for Mattie Cunningham on the 13th?
A: Perfusion is the degree to which blood and therefore oxygen is reaching tissues and has nothing whatever to do with your volume of liquid that is being administered.
Q: Okay. Then what would be the minimum adequate level of blood, of liquid volume for this patient?
A: There is no way of determining that short of intense, careful, repetitive monitoring of intake and output and a variety of vital signs and close nursing and physician surveillance combined with appropriate laboratory assessments.
Q: Do you have an opinion as to whether adequate levels of perfusion were maintained and blood

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levels?
A: I have no way of determining that because of the paucity of information contained within these medical records.
Q: So you do not have an opinion one way or the other?
A: My opinion is that in all probability she was not being adequately maintained, but it's impossible to document that because of the failure of the personnel at this particular hospital to document appropriately the intake and output and the failure of the physicians caring for her to obtain the appropriate laboratory testing.
Q: Then what is the basis for your opinion that she probably did not receive adequate input of liquids and fluids?
A: The fact that there were periods of hypotension and the fact that she ultimately lost significant portions of her four extremities.
Q: The periods of hypotension were limited to about 50 minutes, is that right?
A: That's correct.
Q: And the fact that she lost her limbs is not a defitive test as to whether she had adequate fluids, is it, doctor?

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A: I beg your pardon?
Q: The mere fact that she lost all four limbs —
A: Let me go back for just a second. I agreed with you when you said 50 minutes, but there were two episodes each of about 50 minutes.
Q: Okay. And what do you define as hypotension?
A Blood pressure that is roughly 20 percent below routine blood pressures for that individual.
Q: You're using a relative measurement rather than an absolute measurement?
A: That's correct.
Q: If diastolic is routinely for that patient in the range of 80 to 90, 20 percent of that would be a reduction of perhaps 15 points, so then is it your opinion that hypotension would be something below 75?
A: Diastolic pressure?
Q: Yes.
A: It may be. It's relevant to the situation. It's like the supreme court defines pornography.
Q: But normally a diastolic of 80 or above is considered normal, isn't it?
A. As a general rule, yes.
Q: Just a few follow-up questions about the disease in general, doctor. There are at least four

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different types of meningococcal diseases, aren't there?
A: When you say diseases, what does that mean?
Q: Well, meningitis, chronic meningitis.
A: You can have asymptomatic carriage of meningococci, you can have meningococcemia that is acute and abrupt and fulminant in onset, you can have chronic recurrent meningococcemia, you can have meningococcal meningitis.
Q: Of those four, doctor, or five, the fulminant meningococcemia is the most virulent infection, isn't it?
A. Meningococcal meningitis is one of the most virulent infections known to man. I can't really give you a differential in degree of severity or the mortality rates of fulminant meningococcemia versus meningococcal meningitis.
Q: It's associated with a high level of mortality?
A: Probably 20 to 30 percent if treated.
Q: If it's not diagnosed, however, it would probably be associated with mortality upwards of 50 percent?
A: Not in Mattie Cunningham. Let me make a comment here. I never expected anyone to have made the diagnosis of meningococcemia in Mattie Cunningham

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prior to the receipt of her blood culture or the clinical appearance of the lesions highly suggestive of meningococcemia. What should have been responded to here was a picture of a septic patient. It didn't matter what the organism was.

Q: Would you agree with Dr. Cartwright's statement in his report on page 5 that meningococcal septicemia is associated with a mortality rate between 20 and 50 percent?

A: Dr. Cartwright is one of the world's knowledgable experts on meningococcal disease. If he is quoting statistics, I don't have statistical information that would contradict his stated opinions. It is a fulminant disease. I cannot give you percentages. I also, when you quote statistics of that nature it does not defiie the types of patients in whom the disease is occurring, what their ages are, how well-nourished they are, whether they have other underlying disease, whether the disease has been in existence for varying durations of time, it is too ill defined for me to agree or disagree with, but I would bow to his opinion for overall statistical analysis.

Q: If you accept his opinion and statement, doctor,

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then would it be fair to say that Mattie Cunningham had ran the risk when she arrived at the hospital of losing some limb or death?

A: Absolutely not.

Q: Regardless of the type of care she was given?

A: Absolutely not.

Q: You wouldn't consider that she could be within the 20 to 50 percent of patients who would have experienced some mortality regardless of the care provided?

A: I think it is my expert opinion that if Mattie Cunningham had been started on antibiotics in the emergency room or upon arrival in the morning at 6:15, on the ward at 6:15, that she would not have lost her limbs.

Q: Okay. Doctor, I'm near the end. I think I have one or two more questions.

In the course of your report you made a specific statement that the procedures and policies in place at St. Alexis Hospital and the conduct of their employees as a group was outrageous. I'm referring to the last page.

A. That is my opinion.

Q: You didn't mean to state that their conduct was malicious or intentional, did you?

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MR. SANDELL: Objection. He is not a lawyer. He's not a lawyer and you're not going to characterize —

MR. VOUDOURIS: He is a lawyer.

MR. RISPO: He is a lawyer, Marty.

MR. SANDELL: He's not a practicing lawyer. I mean, if you want to give him the definition in Ohio of malice so that he understands that fairly that's a proper question.

MR. RISPO: Well, we all know —

MR. SANDELL: If you want to tell him that malice in Ohio means a reckless disregard for the rights of Mattie Cunningham, perhaps then he will be able to answer that question.

MR. RISPO: Let me take it one step at a time. I'll satisfy you. Don't worry.

MR. SANDELL: All right.

Q: Doctor, the first question, you didn't mean to say it was intentional or malicious, did you?

A: No. I don't think anybody intended for Mattie Cunningham to be harmed.

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Q: Okay. And you didn't intend that or you didn't intend to say that the personnel at the hospital were acting out of hatred, ill will or in the spirit of revenge, were you?

A: No, I was not.

Q: And you were not stating that they had a conscious disregard for her rights or safety?

A: That's a very difficult question to answer. And it goes to the root of what conscious disregard means. This was a critically ill patient to whom very little appropriate attention was paid. They failed to monitor her appropriately, they failed to maintain appropriate consultative advice, they failed to contact the hospital administrative authorities after multiple efforts to obtain physician input were unsuccessful. I think there were multiple breaches, deviations from any acceptable standard of medical care. Absent intent, I think their behavior was outrageous, that's the only word that can easily come to mind.

Q: So you're most comfortable with the word outrageous?

A: Personally, yes.

Q: And when you continued in your report by saying

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that this behavior deviated so far from normal standards of medical and nursing practice that it is possible to speculate that the training and supervision of the employees of this facility were grossly inadequate, that was based on speculation in your own words, was it not?

A: Actually I should not have used the word speculation. What I mean is that it is my opinion that the training and procedures were inadequate.

Q: Thank you, doctor.

MR. RISPO: I have no further questions. Thank you, sir.

MR. GOLDWASSER: Marty, this is Gary.

MR. SANDELL: Want to break for a minute?

MR. GOLDWASSER: Marty, before we break I want you to note that your picture has been frozen at your end for about 20 minutes. If we break for a few moments would you ask the technician on your end to try to fix that?

MR. SANDELL: You mean frozen in the sense that you can't move it or what?

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MR. RISPO: No. You're not moving on our camera.

MR. GOLDWASSER: You are in the same position without moving your eyelashes for the last 20 minutes. The picture is frozen.

MR. SANDELL: Okay. I will ask the technician. We will bring him in now.

MR. GOLDWASSER: Thank you.

(Thereupon, a recess was had.)

CROSS-EXAMINATION OF MARTIN J. RAFF, M.D.

BY MR. GOLDWASSER:

Q: Dr. Raff, do you agree a known complication of meningococcemia is tissue damage which can lead to limb amputation?

A: Yes.

Q: Absent altered mental status and rigors, would you agree that it would be reasonable to conclude that a patient is not septic?

A: I don't understand your question.

Q: In the setting in which Mattie Cunningham presents, assume that her presentation is as you observe it from the emergency record, but I want you also to assume that there is no evidence of altered mental status, no evidence of rigors, if that were true would you agree that the patient is not septic?

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A: No.

Q: Would you agree that it is reasonable for a physician to conclude that a patient is not septic?

A: Are we talking about Mattie Cunningham?

Q: Yes. Absent altered mental status and absent rigors.

A: It is not acceptable for a physician to make that determination.

Q: Why not?

A: Because as I defined it, sepsis is fever, tachypnea, tachycardia with leukocytosis or leukopenia or a significant left shift. You need not have all of those elements.

Q: So if other physicians in this case have testified that absent altered mental status it is reasonable for an emergency medical physician not to have considered the patient septic, you would disagree?

A: I would disagree, yes.

Q: For the reasons you have just stated?

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A: And others.

Q: What others?

A: The fact that this patient was not adequately evaluated from a laboratory standpoint.

Q: What other evaluations should have been conducted from a laboratory standpoint?

A: She should have had a manual differential count. What was done was done by computer. The computer will not differentiate between mature granulocytes and bands or metamyelocytes or even, or more immature forms of cells. She should have had a set of arterial blood gases performed.

Q: Anything else?

A: In my expert medical opinion had such studies been done it would have shown a large number of immature polymorphonuclear leukocytes and furthermore it would have shown a respiratory alkalosis common for metabolic acidosis, signs which would have been totally and completely incompatible with viral illness.

Q: Do you agree that there was no apparent cause for Mattie Cunningham's infection when she presented to the emergency room?

A: Yes. And that is even more reason for them to have done appropriate studies and to institute

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therapy empirically.
Q: Do you believe that infection should have been considered by the emergency medicine physician when he was —
MR. SANDELL: Excuse me. Can I interject? Are you talking about the bacterial infection?
MR. GOLDWASSER: Yes.
Q: Do you believe bacterial infection should have been considered by the emergency medicine physician when he discharged her from the emergency room to the hospital floor?
A: It was considered.
Q: Pardon me?
A: It was considered.
Q: What did Dr. Mounajjed fail to do as relates to important aspects of the physical diagnosis?
A: He failed to examine the patient's conjunctival surfaces, he failed to perform a full detailed mental status exam, he failed to do a detailed neurologic exam, but most importantly he failed to follow up with repetitive exams during her time that she was in the emergency room.
Q: Anything else?
A: Not that I can think of at the moment.

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Q: You state that he failed to perform essential diagnostic procedures, you have mentioned a few. Is there anything else that you haven't mentioned?
A: I can't think of any at the moment.
Q: You state that he did not obtain laboratory data necessary to establish an appropriate diagnosis. Anything in addition to what you have already stated?
A: Again, not that I can think of now.
Q: You state that he failed to accurately assess the degree of illness. What do you mean by that?
A He failed to follow the patient to see the progress of her illness as time elapsed.
Q: And you state that he did not treat her appropriately and expeditiously. What do you mean by that?
A: What I mean by that is that she should have received empirical antibiotics and an assessment of intake and output and should have been admitted to the hospital far more rapidly than she was with appropriate orders to the nursing staff in the absence of immediate physician input from Dr. Dar to whom **he** had referred the patient.
Q: Do you agree that Dr. Mounajjed conducted a

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complete and thorough examination?
A: I have already stated otherwise.
Q: Well, in what respect was his physical examination defective? You mentioned, doctor, the absence of neurological evaluation, I believe?
A: Yes. I see in his note that he says neurological within normal limits. Often that's abbreviated WNL, but WNL also means, as I tell my students all the time, is **we** never looked.
Q: You mean to say you do that at your hospital, you never look?
A: You bet.
Q: Well, so that's bad medicine, huh?
A Yeap.
Q: How do you know they didn't look in this case?
A: If he looked he didn't bother to record his findings.
Q: Well, maybe the findings were negative. Do you have any reason to believe otherwise?
A: I'd like to hear what he has to say.
Q: Well, do you have any reason to believe that it was not medically reasonable for the patient to have had a normal neurological examination when she presented to the emergency room?

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A: In fact she may well have had a normal neurological examination except for her mental status exam.
Q: Well, why do you believe that the patient was not alert and oriented times 3?
A: Not only did her daughter testify otherwise, but there is further evidence from her signature that something was substantially wrong with her.
Q: Doctor, we do know that she had chills, she had shakes and she had high fever. I mean, clearly -- there is something substantially wrong with her, correct?
A: Yes.
Q: We do know that Dr. Mounajjed did not send her home, but said to the admitting doctor, this patient is sick enough that she should be admitted to the hospital. That's certainly an indication he felt something was wrong with her, didn't he?
A: Yes.
Q: You have a nurse who admits this patient who says she was alert, who admits her from the emergency room, doesn't she?
A: What are you looking at, sir?
Q: Page 10, level of consciousness, alert.

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A: She checks off level of consciousness, alert, yes.
Q: Then you have a doctor who, thereafter, examines this patient and he observed that she is in no distress, she is alert and oriented times 3 and comfortable with the examination. Do you have any reason to believe that is not a true and accurate observation by Dr. Mounajjed?
A: I think that is an issue for the fact finder in this case.
Q: Well, what about you as a medical examiner, what do you think?
A I don't think that she was awake, alert and oriented.
Q: Why not?
A: I have already given you multiple reasons.
Q: Well, you told me because of her signature and because of what you believe the daughter observed. Anything else?
A: I thought I answered this question in some detail earlier. I'll go back through the chart.
Q: Well, I'm not talking about now, doctor, her admission to the hospital. I'm talking about while she was present in the emergency room.
A: No. there is no further definitive evidence in

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the emergency room.
Q: Now, doctor, let's turn to the admitting history and admission assessment by the nurse that begins on page 75 of the record.
A: Okay.
Q: Do you know whose —
A: I got you.
Q: Do you know who is giving the nurse the medical history.
Let me ask you this: Do you have any reason

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able tu relate a history of questionable arthritis of the knee, of past psychiatric problems, and that she was going to Mt. Sinai for regular checkups, is that true?
A: I guess so.
Q: You are also concluding that the daughter is relating a history that she has four to six hours of sleep pattern and has a knowledge of what her smoking, cigarette habits are, right?
A: As I said, I am relying upon the information that I have available to me and whether it's true or not true is up to the fact finder.
Q: Well, but, doctor, you are assuming facts to be true in order to arrive at your opinions and conclusions, are you not, sir?
A: I do not need the information concerning the issues that you're referring to here in order to reach my conclusion.
Q: So are you telling me that if hypothetically Mattie Cunningham was in fact alert and oriented when she was in the emergency room that nonetheless does not change your opinion?
A: That's correct.
Q: Dr. Raff, how many times in the last five years have you evaluated a patient in the emergency.

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room?
A: Hundreds.
Q: How many times have you been the admitting emergency medicine physician in the emergency room in the last five years?
A: Never. You mean on call in the emergency room?
Q: Yes.
A: Never.
Q: When is the last time that you have — well, strike that.
How many times have you made the diagnosis of meningococcal septicemia in the emergency room as it relates to adults?
A: I have no idea.
Q: Well, could you give me a guess as to how many times a year you make that diagnosis in the emergency room?
A: I don't guess.
Q: Would you at least agree that it would be an extremely rare occurrence?
A: It is extremely uncommon.
Q: What is the extent of your training and clinical experience in the medical specialty of emergency medicine?
A: You mean general emergency medicine?

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Q: Yes.
A: I teach. I teach infectious diseases in the emergency room, emergency care of patients with infectious diseases to the emergency room staff and to the residents in training. I have no background otherwise in other aspects of emergency care besides internal medicine.
Q: How often does a specialist in emergency medicine in a community hospital diagnose meningococcal septicemia in adults?
A: I have no idea.
Q: Would you have any reason to disagree with the statement that it is exceedingly rare?
A: No.
Q: Is it your opinion that while Mattie Cunningham was in the emergency room she presented with signs and symptoms of an illness which was life threatening?
A: Not necessarily.
Q: Would you agree that untreated meningococcemia is life threatening?
A: Yes.
Q: Would you agree that treated meningococcemia is potentially life threatening?
A: It depends upon how long it has been in

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existence, in whom, and under what circumstances.
Q: How long had it been in existence with Mattie Cunningham?
A: It's very difficult to know.
Q: How would you try to *make* that assessment?
A: I would want a detailed hourly assessment of how Mattie Cunningham felt from the time she was last feeling totally well until the time at which she arrived in the emergency room.
Q: We d, don't we?
A: No.
Q: So when the record states, quote, "This is a 33-year-old black female who states that approximately two hours prior to coming into the emergency room she started to have some chills and fever at home with absolutely no other symptoms prior to that," end quote, that doesn't tell you anything?
A: No, it doesn't, because if you ask a patient what symptoms have you had they may say none. But if you take a detailed history from the patient and say when is the last time that you were feeling totally well, when is the last time, when is the first time that you noticed that you might be running a fever, when is the fist time that you

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felt that you were becoming abnormal, you will hear different responses than if you ask the patient if they had any other symptoms. Often patients don't know what symptoms, the word symptoms means.
Q: Well, how does a physician know if a patient has had a, any upper respiratory infections?
A: They say have you had a runny nose, have you had a sore throat, have you had an earache, do you think your sinuses may be congested, do you have a headache, are you coughing, is your cough productive of sputum, does your throat feel thick or swollen. There are many questions which can be asked.
Q: Well, you don't know specifically what questions Dr. Mounajjed asked, but you do know that he inquired as to whether or not the patient had upper respiratory infection, did he not?
A: He asked that question apparently.
Q: He asked her about any gastrointestinal or urinary tract problems, did he not?
A: Again, that's what is stated in the record.
Q: He asked her if she has had sweats, nausea, vomiting, did he not?
A: That's what's in the record.

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Q: Well, doctor, isn't that an indication that you have got an emergency medicine physician who is doing his best to determine if this patient's statement that prior to two hours previous she was just f i e is valid?
A: Yes.
Q: Are you critical of the fact that he did that?
A: No.
Q: Do you believe he didn't go far enough?
A: Yes.
Q: Why?
A: I have already answered that question several times.
Q: Mr. Rispo at the beginning of your deposition was asking you about peer reviewed articles. Doctor, how many peer reviewed articles in journals of national circulation have you authored as the lead author?
A: I have no idea.
Q: Were there any?
A: Yes.
Q: Which journals?
A: Journal of Infectious Diseases and in the Journal of Medicine, multiple other journals. And lead author does not mean anything. Very often the

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articles are written by me with the assistance of a fellow or a resident and I will always place their name first.

Q: But you have already acknowledged, I believe, if I recall, that you have not published in any peer review journal an article dealing with the subject of the diagnosis of meningococcemia?

A: That's correct.

Q: Have you authored any articles appearing in peer review journals as relates to the standard of care in the emergency room?

A: No.

Q: Doctor, in view of your telling us of your extensive experience as a practicing lawyer, and I don't mean to be facetious, I know you just said there was one case you handled, how is it that you qualify to be listed in the Who's Who in American Law?

A: I have no idea.

Q: Don't you feel you had an obligation to call the Who's Who publishers and say, hey, gentlemen, I don't think it's fair that I should be included in this? Did you do that?

A: No. That never even entered my mind.

Q: Am I correct in concluding that it's your opinion

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that if the medical care providers who followed this patient once she left the emergency room, if they had done what they should have done in your opinion that Mattie Cunningham would not have lost her limbs?

A: Yes, I think that's correct. On the other hand, it is essential for each individual caring for a patient to do his utmost to provide adequate care and Mattie Cunningham did not receive adequate care in that emergency room.

Q: Other than not giving empirical antibiotics, what omission or commission was there as relates to the treatment that she received in the emergency room?

A: I see nothing in the record in the emergency room from the time she arrived there until the time she departed for the ward to indicate what her state of hydration was or what her urine output was.

Q: Well, you do know that they started her on IV solutions, right?

A: Yes.

Q: And that was specifically for the purpose of keeping her hydrated, wasn't it?

A: Yes, but there is no measurement of how well she

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was being hydrated, how much she actually acquired. Patients who are febrile to greater than 103 degrees, patients who have a temperature in excess of 103 degrees and with a respiratory rate of 28 lose liquids at a very rapid pace. In addition, patients who have ongoing bacteremia and sepsis may be third spacing fluids and require far more in the way of intravenous infusions than an individual with no such conditions. In order to carefully assess the volumes of fluid necessary to be administered it is essential to monitor the patient's input and output.

Q: Over what period of time?

A: From the time she's admitted to the hospital, that is to the emergency room and subsequently to the hospital until she is stable and out of danger.

Q: So it is your testimony that it is the required standard of care in an emergency department setting for a patient's input and output to be carefully measured before admission to the floor, is that true?

A: If there's going to be any substantive delay in admission, yes.

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Q: Do you think there was a delay in admission in this case?

A: Absolutely.

Q: Why?

A: Why? Because it took them over four hours to get her from the emergency room into the hospital and there is absolutely no indication in the chart what was going on during those four hours or no indication in the chart that she was being monitored for changes in her overall condition during that time period.

Q: When Dr. Mounajjed states that the case was discussed with Dr. Dar on call for internal medicine, did you ever learn from any source as to what was discussed with Dr. Dar?

A: I don't recall.

Q: As you have answered already, Dr. Mounajjed certainly thought of an infectious process as being a possible cause for her symptoms, did he not?

A: Yes.

Q: Do you have any reason to believe that he did not discuss that with Dr. Dar?

A: I have no way of knowing.

Q: Do you have any reason to believe that he did not

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discuss with Dr. Dar the fact that he ordered a blood culture and that the patient was going to be admitted for additional work-up and follow-through?

A: I don't recall what Dr. Dar said. I haven't seen anything by Dr. Mounajjed.

Q: Well, if in fact the emergency medicine physician spoke directly with the admitting physician, discussed his concerns about the patient with the admitting physician, told the admitting physician he was concerned she may have an infectious process and the admitting physician accepted the responsibility of admitting that patient and following her, did not Dr. Mounajjed under those circumstances meet his obligations?

A: No.

Q: For the reasons you have told me, is that true?

A: Yes.

Q: Anything else?

A: Yes.

Q: What?

A: In his admission to the floor he gave an admitting diagnosis of fever of undetermined origin. Fever of undetermined origin is a very, very well-defined clinical entity that requires

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that the patient either be febrile for two weeks as an outpatient or in the alternative be monitored in the hospital documenting fevers for a week with a totally negative detailed evaluation. Using that term as an admitting diagnosis can be grossly misleading to the physicians to whom the patient is being referred.

Q: Well, have you concluded then that Dr. Dar was misled by Dr. Mounajjed's stated clinical impression?

A: I have no way of knowing. What I do know is that Dr. Dar took his sweet time in getting to see the patient.

Q: Would you —

A: That may have been at least in part a result of Dr. Mounajjed's — how do you pronounce that?

MR. SANDELL: Mounajjed.

A: — Mounajjed's description of fever of undetermined origin.

Q: Well, how was it that Dr. Mehta saw the patient so promptly?

A: Dr. Mehta was in-house.

Q: Yeah. But somebody had to tell —

A: He didn't see the patient for over two hours after the patient had been admitted.

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Q: Well, who told Dr. Mehta about the patient?

A: I have no way of knowing.

Q: What do you mean by the statement or use of the words, quote, "casually negligent," end quote? What does that mean to you? You are the one who used it.

MR. SANDELL: Gary, could you refer us to it in its context?

MR. GOLDWASSER: Second page of his report. It is difficult to imagine that this many different individuals would have been so casually negligent, et cetera.

A: It means that they did not do this intentionally, but they did not pay close attention to the management of —

Q: Doctor, your last five words just missed us here. Could you repeat that?

A: I said it meant that I did not believe that the individual medical providers for Mattie Cunningham were intentionally negligent, but rather that they were rather casual or exhibited a lack of appreciation or concern for her severe medical condition.

Q: When you talk about the effect of treatment to avoid the loss of limbs was antibiotics and

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adequate supportive care, what adequate supportive care are you making reference to?

A: Maintaining adequate input, hydrating the patient appropriately, monitoring her arterial blood gases and her state of acid base balance and electrolytes, maintaining her blood pressure at levels that are necessary to support tissue perfusion, maintaining oxygenation at a higher than normal level to compensate for the failure of release of oxygen from red blood cells in an acidotic individual. There are multiple levels of care in a critical care situation that were not done in this particular circumstance.

Q: And do you believe that all that you have just alluded to should have been done in the emergency medicine setting, emergency room setting?

A: Of course not. I did not know you were referring to the emergency room.

Q: No. Doctor, I wasn't. I just asked the question and you have answered it and I thank you. I have no further questions, Dr. Raff. Thank you.

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CROSS-EXAMINATION OF MARTIN J. RAFF, M.D.
BY MR. LEAK:
Q: Dr. Raff, my name is Doug Leak and I'm here for Dr. Dar.
A: I beg your pardon?
Q: Doug Leak.
A: Leak. How do you do, sir?
MR. SANDELL: Doug, it's hard for us to hear you, that's why he — I can't hear you very well either. Can you move over to a microphone?
Q: How is that, doctor? Is that good?
A: Much better.
Q: You just answered a couple questions I was going to follow up on. What I do want to know is you had mentioned that the tissue loss was due to multiple factors and you could not say which one to what degree, but can you give me that list of the multiple factors?
A: I think if you go through the deposition it will be in there.
Q: Well —
A Do you want me to?
Q: Well, I just need to know the multiple factors you're talking about. I know you said you

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couldn't say to what degree each one was, but —
A: I enumerated them earlier in the deposition.
Q: Will you do that for me very quickly right now?
A: Sure. Disseminating intravascular coagulation, acute vasculitis, hypotension, and the possible presence of microembolitation.
Q: Doctor, how often are you the admitting physician for someone to the hospital in your practice?
A: I don't understand what you're getting at.
Q: Well. Dr. Dar was the admitting physician. How often do you admit patients like on an on-call basis?
A Every day. We have an — one of our clinical services at the University Hospital is as an infectious disease admitting team. Any patient whose primary problem is an infectious problem is admitted to our team directly or we will respond to requests from the emergency room to evaluate patients who go to the emergency room, we will go to the emergency room, evaluate them and admit them from the emergency room.
In addition, I and the other individuals in our division admit patients from o w private practice with regularity.
Q: Those are for patients that there is a suspicion

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of an infectious process, correct, that you are the admitting physician?
A: Overwhelmingly, yes.
Q: Under what circumstances in this case was Dr. Dar the admitting physician?
A. I believe from my reading of the materials, and I don't know whether Dr. Dar was, happened to be the internist on call or what the circumstances were, but that Dr. Mounajjed called Dr. Dar.
Q: Dr. Dar was not called as the admitting physician strictly for an infectious process, was he?
A: I have — I'm not sure I understand the question.
Q: Well, when you get a call to admit a patient you're going to have a suspicion of an infectious process in your practice, correct?
A: If I get a call to admit a patient I ask the physician who has called me what's wrong with the patient. I then go and see the patient as a physician.
Q: Would you agree, then, that a physician in, an infectious disease physician who is asked to admit a patient probably has a higher suspicion of an infectious process as opposed to just a regular admitting internist?
A: That's a very difficult question. I don't know

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what the expectations are of physicians. It is not infrequent that I will be called to admit patients that turn out not to have infections when the ostensible reason for admission has been suspicious of infection on the part of another doctor.
In addition, our general internal medicine, I will have patients with multiple disorders admitted to my service. I see patients with acute diabetic acidosis, I see patients with a variety of metabolic disorders, I see patients with overdoses. I don't know how to respond to your question.
Q: Would you agree then that the admitting physician, like Dr. Dar, has to rely upon the individuals that call him to let him know what the condition is of the patient?
A: No. Dr. Dar has an independent responsibility to see and evaluate the patient on his own. To rely upon the opinion of another physician is often a disaster and it's not infrequent that I will have a patient described to me on the telephone only to arrive at the bedside and wonder whether I'm actually seeing the same patient that the physician who called me had seen.

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Q: Is it reasonable for —
A: So any individual physician has an independent responsibility to see and evaluate the patient on their own.
Q: Do you have an opinion as to how soon that physician is required to see that patient on their own?
A: That depends upon how well they understand the illness that's in progress.
Q: Doctor, are you still —
A: As a general rule, if the emergency room physician has appropriately evaluated and managed the patient prior to admission the subsequent visit by the in-house physician or the physician to whom the patient is being admitted can be delayed by an hour or two, but that requires an intimate knowledge of what has transpired with the patient and a full assessment of the laboratory data, much of which was nonexistent in this individual.
Q: What time do you believe Dr. Dar should have arrived at the hospital in this case?
A: Around 8:00.
Q: What time was he called at?
A: I don't know. Dr. — wait a minute. Sometime

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prior to the admission at 6:15 because Dr. Mounajjed, whatever his name is, wrote a note that said, discussed with Dr. Dar, will admit.
Q: Was it reasonable for Dr. Dar to rely upon the emergency room physician that the appropriate care and course of action had already been taken?
A: As I said, if Dr. Dar had discussed with Dr. Mounajjed the details of the patient and was aware that appropriate laboratory evaluation had been performed, he was familiar with the results, he could then arrive at a decision as to whether his visit might be delayed, but he had an obligation to see the patient within a very brief time period after they had been admitted.
Q: With regard to the house officer, Dr. Mehta, was it reasonable, was it reasonable for Dr. Dar to —
A: I'm sorry, that's an emergency. Off the record.

(Off the record.)

Q: Doctor, I think we're going to be able to wrap this up soon. It's been a long deposition. I think my last question had to do with is it reasonable for the admitting physician to rely

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upon the house officer to do the proper work-up, then the proper care?
A: No.
Q: And why is that?
A: He has an independent responsibility for his own evaluation. I don't rely upon my residents, I don't rely upon my fellows who are board certified to tell me what is wrong with the patient without getting involved. You have an independent responsibility to care for your own patients.
Q: And I'm assuming then if Dr. Dar, your opinion is if Dr. Dar had gone in earlier he should have done the appropriate care and treatment that you have spoken about throughout the deposition then?
A: That is correct.
Q: Why don't you give me all of your opinions at this point regarding Dr. Dar.
A: Well, number one, failure to come in and see his patient in an appropriate time period, number two, inappropriate reliance on another physician's assessment in the absence of full knowledge of the laboratory data, the history and physical exam, the failure to provide appropriate history and physical in a timely manner, the

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failure to order appropriate testing, the failure to institute antimicrobial therapy and to order laboratory data that would have allowed him to assess the fluid and electrolyte balance of this patient and to order appropriate fluid and electrolytes replacement and to monitor the patient appropriately.
Q: Is it fair to say — I'm sorry?
A: And the failure to administer antibiotics.
Q: Is it fair to say your opinions with regard to Dr. Dar mirrors those of the other physicians?
A: Yes.
Q: Is there some point — we know Dr. Dar got there at approximately 2:30 — is that accurate?
MR. SANDELL: Around 3:30.
A: I believe it was around 3 something.
Q: Okay. Do you have any criticisms of Dr. Dar in his care and treatment subsequent to his arrival at the hospital?
A: Absolutely.
Q: And what is that?
A: The same things that I have indicated previously. Failure to appropriately monitor and administer fluid replacement and provide supportive measures that would have enhanced the tissue perfusion of

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Mattie Cunningham and led to the maintenance of the overwhelming majority of her tissues.

Q: Would you agree that when he did come in he did call in an infectious disease consult, correct?

A: Yes. Dr. Bass.

Q: And was he — who then was primarily responsible for these things you're talking about at that point when the infectious disease consult was brought in?

A: Well, that depends upon the relationship between the infectious disease consultant and Dr. Dar. I don't know the particular circumstances here. As a general **rule** it's the responsibility of the primary treating physician to maintain the primary medical care for the individual with advice on appropriate antimicrobials to be given by the infectious diseases consultant.

Q: Well, I believe you listed about eight things that should have been done. Would you agree that those eight things are within the specialty of the infectious disease specialist by that time?

A. Again, the infectious diseases specialist is there to **make** suggestions and to work with the primary care physician who has the primary responsibility for writing orders and determining

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the basic medical management of that individual. The antibiotics selection may be due predominantly to the infectious disease consultant..

Q: And you would agree that Dr. Dar can rely upon the expertise of that infectious disease expert to pursue the entire course of treatment, correct, to take that into consideration after 3:30 p.m. on that day?

A: I lost you. I have no idea what you asked me.

Q: Well, basically this is an infectious disease process, correct?

A: Yes.

Q: That was recognized at least by 3:30, correct?

A: ***Yes.***

Q: And the treatment of that falls in the realm of the specialty of infectious diseases, correct?

A **Yes.**

Q: So it would be reasonable for Dr. Dar to rely upon any suggestions or recommendations from Dr. Bass, the infectious disease specialist, correct?

A: It would be helpful for Dr. Dar to elicit appropriate recommendations from Dr. Bass where he does not feel that he is competent to make those decisions by himself.

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Q: Doctor, if all of those measures were taken which you have discussed by 3:30 p.m., are you of the opinion that Mrs. Cunningham's limbs would have been saved?

A: I believe Mrs. Cunningham may have lost some tissue, but I cannot tell you to what extent that loss would have occurred by 3:30.

Q: Are you able to tell us at what point on this day, June 13th, that her limbs were salvageable if these measures were undertaken?

A: Probably sometime between 12:30 and 2 something, at which point the lesions appeared on her hand, she probably would have had completely salvageable extremities. After that point she probably would have lost tissue from those extremities, but, again, I cannot say to what degree that loss would have occurred.

This is a continuing process. The longer the delay and the longer the inappropriate management with regards to blood pressure and so forth, fluid maintenance, correction of electrolyte abnormalities and other factors of that nature, oxygenation, so forth, the greater the degree of loss. And in this situation it was basically a continuum, the longer they waited the greater the

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lack of appropriate management the greater the tissue loss.

Q: Doctor, I'm looking at your report on page 2, and we basically have gone through the paragraph pertaining to Dr. Dar, correct? In terms of your claim that there was a failure to include — well, failures included incomplete and inadequate histories and physical examinations, deficient laboratory analysis, that's what we have discuss=, correct?

A: Yes.

Q: I want to go to the last sentence of that paragraph pertaining to Dr. Dar. "In the case of Dr. Dar, it is my opinion that his actions or lack thereof were egregious deviations." What do you mean by egregious deviations?

A: I suggest you pick up a dictionary.

Q: Well, I want you to give me your defiition, doctor. You're the one using it.

A: I think that any physician who is called for a patient who is septic, who receives multiple calls from nurses during the course of the day, fails to respond and fails to deal with that patient appropriately is so grossly and completely beyond any acceptable standard of care

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that I would term it egregiously —
Q: Doctor, what was that?
A: As I said, when you have a patient admitted from an emergency room where they have already been for four hours, 6:15 in the morning, and you fail to show up until late in the afternoon at a time in which the patient is already potentially morbid, that is totally, completely unacceptable.
Q: Doctor, what in those telephone calls to Dr. Dar suggested that he was informed that this patient was septic?
A: Dr. Dar had an obligation to ask any and all questions that he felt were appropriate for him to obtain sufficient information for him to be familiar with the state of the patient.
Q: Doctor, my question is what do you know or what are you aware of in terms of what was communicated to Dr. Dar that would tell him that this patient is septic?
A: When you locate Dr. Mounajjed in Pakistan he can tell all of us.
Q: Okay. So you need his testimony to finish that opinion, don't you? Doctor, I just want to know what —
A: I have no way of knowing the nature of what that

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conversation was.
Q: How about any other medical care providers, nurses or house officers, any other phone calls that were made to Dr. Dar that you, that Dr. Dar was made aware that this patient was septic?
A: I don't recall specifically. There are numerous comments. There's a voluminous amount of material. If you refer me to specific statements I'll be glad to respond to them.
Q: Well, I'm asking you to point me to any evidence.
A: Are we staying here for four years?
Q: Doctor, you are the one rendering opinions that Dr. Dar should have known from the phone calls that this patient was septic and I want to know what the basis of that opinion is?
A: No, what I said was Dr. Dar had an independent obligation to see the patient expeditiously or in the alternative to delay his examination by obtaining from the medical personnel who were seeing the patient as much information as was humanly available and to direct them to do the appropriate testing where it was not available to him. He failed to do those things.
Q: Do you see anything in the records that indicate that Dr. Dar was told that this was either an

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urgent, emergent, or a stat situation?
A: No.
Q: Thank you.
MR. LEAK: I have nothing further.

FURTHER CROSS-EXAMINATION OF MARTIN J. RAFF, M.D.
BY MR. RISPO:
Q: Doctor, I just have one question. This is Ron Rispo. Did you receive or have you reviewed the transcript of the deposition of Dr. Mehta? I don't see his name listed in your report.
A: Hang on just a second. I'll go through the materials that I have. Yes. It was sent to me.
Q: It was received then after you wrote your report of August '97?
A: Yes.
Q: And when you arrived at your conclusions and opinions as stated in your letter of August '97, you did not have the benefit of the testimony of Dr. Mehta?
A: That's correct.
Q: Thank you, doctor.
MR. RISPO: I have nothing further. Anybody else?
Well, thank you for your time,

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doctor. Just one formality on the record. Would you like to read or waive your signature?
THE WITNESS: I would like to ask what the attorneys would like me to do.
MR. RISPO: That's up to Mr. Sandell. Marty?
MR. SANDELL: Normally I wouldn't have any problem with waiver, but the doctor has indicated to me during the recess that he is not entirely comfortable with the video deposition. I don't think he has ever given one before. In addition, there were some problems in —
MR. GOLDWASSER: Let's cut it to the quick. You don't waive, okay?
MR. SANDELL: Fine.

MARTIN J. RAFF, M.D.

CERTIFICATE

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

I, Dawn M. Fade, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named MARTIN J. RAFF, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was iater transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ___ day of _____, A.D. 19___.

Dawn M. Fade, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 27, 2002

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