Doc. 442

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

JOANNE JEFFERS, ADMX., et al.,

Plaintiffs,

-against-

Case No. 235970
JUDGE THOMAS J. POKORNY

SOUTHWEST GENERAL HOSPITAL, et al.,

Defendants.

EXAMINATION BEFORE TRIAL of Non-party Witness, VINCE VERDILE, M.D., held pursuant to Notice, at the court reporting office of Stephen N. Fiato, C.S.R., 112 State Street, Albany, New York 12207, commencing at 10:00 a.m., July 29, 1993, before Colleen B. Smith, a Shorthand Reporter and Notary Public for the State of New York.

ORIGINAL

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VINCE VERDILE, M.D.,

after first being duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY MR. MELLINO:

Q Doctor, would you state your full name and your business address for the record, please.

A Vincent P. Verdile, V-e-r-d-i-1-e. My address is A-139 New Scotland Avenue, Albany Medical College, Albany, New York 12208.

Q And what professional positions do you currently hold?

A I'm currently an associate professor and vice chairman of Emergency Medicine -- Department of Emergeny Medicine -- at Albany Medical College. And my clinical practice is in the Department of Emergency Medicine at the Albany Medical Center Hospital.

Q What does your clinical practice consist of?

A Patient care in the emergency department. Seeing and evaluating patients in the emergency department.

Q How much time do you spend seeing patients in the emergency department?

A Approximately 80 hours every month.

Q Could you tell me what training and education

you've undergone to become an emergency physician.

A Medical college was at Albany Medical College. I graduated 1984. I went to the University of Pittsburgh and trained in emergency medicine from 1984 through 1987. Then I was an attending faculty at the University of Pittsburgh from '84 -- I'm sorry -- from '87 until '93. From '90 to '93 I served as the director of the emergency department at the University of Pittsburgh Hospitals.

Q Is that it?

A As far as my training?

Q Yes.

A Yes. And my boards were completed in '91, I believe. Or perhaps '90. March of '90 I think they were finished.

Q Did you take two separate board certification exams?

A Yes. You do a written first and then a year later you do the oral. So it's a two-part examination.

Q Is that what the diplomate and the fellow --

A Fellowship status is within our academic college. Once you become board certified, then

you're inducted as a fellow of the college, meaning that you have completed your board certification process and they have some criteria that enable you to become a fellow in the college. It's different than board certification.

Board certification means you have completed a series of training and examinations that show your qualifications in the practice of emergency medicine. The fellowship status in the college is more of a recognition for completing that board certification process with -- they have a Chinese menu all the things you can accomplish; research, administration, different things, and they acknowledge you by giving you fellowship status.

Q It's not a separate examination?

A No. No, there's just one examination process, that's right.

Q Did you pass your written and orals the first time you took them?

A Yes, I did.

Q What hospitals do you currently have privileges at?

A I currently am working at Albany Medical Center

Hospital. We, as part of our group, provide physician coverage at several community hospitals as well. So I have privileges at Little Falls Hospital in Little Falls, New York, which sees about 15,000 patients in their emergency department; Nathan Litteur Hospital in Gloversville which sees about 25,000 patients in their department, and Hill Crest Hospital in Berkshire, Massachusetts, which sees about 12,000 patients in their department.

So part of our practice is -- our practice is primarily at the Medical Center, but we provide administrative and clinical support to these community hospitals on a contractual basis.

Q How much time do you personally spend at these other three hospitals seeing patients in the emergency department?

A Of my clinical times, upwards of 20 percent, usually, on a monthly basis.

Q That's included in the 80 hours a month you see patients?

A Yes. My clinical commitment -- my job is academic and clinical. So my clinical commitment to my job is 80 hours a month, the

majority that I stay at the Medical Center where I teach house staff, resident doctors and medical students. The other time we provide physician coverage for the community hospitals. There's a problem in New York State, as many other states, getting physicians that are trained in emergency medicine to staff their emergency departments. So we provide a service by providing them with coverage, and we also help them effect referrals into the medical center if they have patients that need to be transferred in for a variety of tertiary care facility, we help that process.

Q But of the 80 hours that you spend seeing patients a month, 20 percent of that is at these other three hospitals?

A That's correct. Roughly 20 percent of it will be at one of these other facilities.

Q Have you ever held a position as a house officer?

A Yes. During my training in emergency medicine, the first year of that program is a general rotating internship where you expend inpatient services, medicine or surgery, and you serve as house resident doctor as part of training.

Q Right.
A Not as a separate -- I was never a separate employee of a hospital as a house physician, that's correct.
Q You were retained in this case on behalf of Dr. Banaga, the house physician, correct?
A Yes.
Q You said it was one year in your training that you spend as, essentially, house officer?
A Yeah. We may be mixing semantics in terms in while you're training as a physician you spend time as a house officer. But as part of your training program, as opposed to I think what Dr. Banaga was, which was a paid physician to cover patients in the house.
Q Right. That's what I'm getting at. Did you ever hold a position similar to what Dr. Banaga does?
A No. I'm sorry. When you said "house officer," I immediately thought of a training position. But she was not in training in her capacity, she was retained by the hospital to manage patients in the hospital.
Q And you've never had --
A That's correct.

Q You've never done what she was doing in this case?
A That's correct.
Q This is your file that you have with you?
A Yes.
Q Is that your complete file?
A Yes.
Q Has anything been removed from there?
MR. MARKWORTH: Correspondence.
MR. MELLINO: Pardon?
MR. MARKWORTH: Correspondence with me.
MR. MELLINO: That has been removed?
MR. MARKWORTH: Yes.
BY MR. MELLINO:
Q Did you review any medical literature in order to form any opinions in this case?
A No.
Q Is everything that you reviewed in order to form your opinions in this case here in front of me?
A Yes. Well, the opinion that I -- my written report may be it was not based on all this, because I'm not sure I had all the depositions at the time of my written report.
Q I wasn't limiting it to your report. To any opinions that you're going to express here today

or at the time of trial.

A Right. What is contained in those reports --

Q It's all based on everything that's right in here?

A Yes.

Q I assume that everything that you had before you wrote your report, you've listed what you reviewed?

A That's correct.

Q That's the sum total of everything you reviewed in order --

A To formulate this written report, that's correct.

Q The items that are contained in your file today that aren't listed in your report, from what I can tell, are the experts' reports; is that correct?

A Yes.

Q Is that the only thing you reviewed since you wrote your report?

A Yes. I didn't realize that I had all the nurses' depositions when I did this, but I guess I did.

Q Okay. Well, you don't have all the nurses depositions, do you? I mean, you never reviewed

Jenny Knopf's deposition?

A No. That's why -- I don't think I have. That's why I said I didn't know that I had all the depositions up to this point. My report was based on this material, and this is my entire report that I have thus far. No, I guess I don't have Jenny Knopf's.

Q Okay. You didn't review her deposition prior to authoring the report, correct?

A I don't recall that name. Having reviewed it.

Q And it's not one of the depositions in your file?

A Right.

Q Did you ever ask to review it?

A No, I don't think I particularly did.

Q You did see her name in the chart, correct, when you reviewed the chart?

A Yes, I did. But she was the -- I'll try to sort out what she was. But I don't recall ever seeing her deposition.

Q As you sit here today, do you have a recollection of what her role was in the events?

A Yes. She did the intake assessment. I almost was positive I saw her report. I don't know why I don't have it here. That's the nurse that did

his initial intake assessment --

Q Correct.

A -- so I'm almost positive I saw her deposition. I don't know why it's not in my file.

Q Well, it's not only not in your file, it's not one of the things you listed as something you reviewed prior to authoring your report, is it?

A No.

Q And her testimony would be important in this case, wouldn't it?

A Yes.

Q How many cases have you been retained to offer an expert opinion in a medical malpractice case?

A How many cases by this firm?

Q No, total.

A How many cases total?

Q By anybody.

A I probably started doing this in 1990. Probably total cases -- maybe 50 or 60 cases total. I probably receive maybe 12 or 15 cases on an annual basis and turn down anywhere from a third to a half of them.

Q So the 50 to 60, that's all the cases you're contacted in?

A That I've been contacted with, right.

Q How many of those have you written reports in?
A I don't know how many I've written reports in. I think I've probably refused anywhere from a third to a half of them based on I didn't believe there was merit in the cases. I've given about a dozen depositions and I've had one trial appearance.
Q You've given --
A About 12 depositions, and I've had one trial appearance.
Q Where was the trial?
A In Tulsa, Oklahoma.
Q Now, how many cases, other than this one, were you retained by Mr. Markworth or his firm?
A This is the only one.
Q Have you ever been contacted by an attorney in Cleveland or a case involving a Cleveland area hospital?
A I don't know that.
Q Have you ever been retained by the firm of Jacobson, Maynard, Tuschman & Kalur?
A I don't recall that name specifically.
Q How about Weston, Hurd?
A I don't recall that name either.
Q What states have you testified in?

A Other than Tulsa, Oklahoma, what states have I given depositions in?

Q That was a poorly worded question. I assume most of the depositions are in New York?

A Pennsylvania prior to coming to New York.

Q All right. What states have the cases been pending in that you've testified in?

A Maryland, Michigan, Virginia, West Virginia, Ohio. I think that's probably all. And New York as well.

Q You don't remember any other Ohio case, other than this one?

A I don't remember any other Ohio case that I gave a deposition on.

Q Were you retained in another Ohio case?

A Yes, I think that 1 have been retained in another Ohio case. I don't know that I've given a deposition on any cases in Ohio.

Q What law firm retained you in Ohio?

A P-f-a-u, Pfau, something like that. Pfau & Pfau or something like that. That's the only one I can recall.. And it was a case out of Ashtabula, but that's not been in the last several -- couple years. I don't recall the circumstances of the case. But Pfau & Pfau were the

attorneys.

Q Do you have any idea of what the breakdown is of the times you've testified? Has it been on behalf of a patient or on behalf of a hospital or physician?

A Regarding times I've testified, I couldn't tell you. But, generally, the cases I've reviewed, two thirds are plaintiff and a third are probably defendant.

Q The case that you testified in trial for, was that for a plaintiff or a defendant?

A That was a plaintiff.

Q Is this other Ohio case currently pending?

A It remains opened. I have not provided any testimony. Or deposition.

Q Have you written a report?

A No.

Q What were you asked to do in this case?

A I was asked to review the performance of Dr. Banaga.

Q Is that it?

A Yes.

Q Do you have any opinions about the performance of Dr. Binder?

A Otolaryngology is not my field of expertise, so

I don't have any specific opinions of his performance as an otolaryngologist.

Q You mentioned, I think when you were telling me about what your job was, that you train house officers?

A Yes.

Q And I assume that's one of the bases that you feel allows you to offer opinions on the performance of Dr. Banaga?

A No, I think -- instead when -- again, house officers, in my mind, are the physicians I train in emergency medicine. I don't train doctors to become house physicians like Dr. Banaga. But. I think the basis for my opinion would be that as an emergency physician, I routinely evaluate patients with headache, otitis, otitis media and fever, for example. So that's part of my daily practice, is to be the first line to evaluate those patients. Much like a house physician would after a patient's been admitted either directly from a physician's office or directly from the emergency department.

Q So when you told me you train house officers, you're referring to residents?

A Yes.

Q People in training?
A Yes. That's why we got confused. Semantics.
Q I should have used the term house physician.
A House physician is what Dr. Banaga was.
Q You don't train house physicians?
A That's correct.
Q Have you testified or been retained to be an expert in a case involving meningitis prior to this?
A I don't recall off the top of my head if I've had a case of meningitis. It's a very common problem. Meningitis is a very common problem in emergency medicine. But I don't recall that I've been retained to give expert opinion on a case.
Q What are you basing the statement that it's a very common --
A I think most of the emergency medicine risk management literature would support that meningitis is a very elusive diagnosis to make, and that it's an area of risk for emergency physicians.
Q When you're talking about it being missed as a diagnosis, you're talking about by an emergency physician?

A Yes, in the emergency department capacity, yes. In the capacity of an emergency physician in an emergency department.

Q When you do a physical examine in the emergency room of a patient, how long does that -- do you usually spend doing the physical exam?

A It's complaint-specific. If a patient has a sprained ankle, it may be five or eight minutes. If the person has a headache, it would be a detailed 30-, 40-minute exam, depending upon the patient's complaint.

Q What about a patient who presented with the same presentation as Mr. Jeffers?

A Mr. Jeffers, it would probably be a 20- to 30-minute examination, ballpark.

Q He had a headache when he presented, correct?

A Yes.

Q You just told me if the patient had a headache it could be a 30- or 40-minute exam. What's the difference?

A Mr. Jeffers had findings of acute otitis media as well as a headache and a fever.

Q Can otitis media turn into meningitis?

A Yes.

Q Is that common knowledge among emergency

physicians?

A Yes.

Q What about house physicians?

A I think it's probably pretty much common knowledge, for anybody that went to medical school, that meningitis -- being in close proximity to the central nervous system, could extend to meningitis.

Q So should the physician seeing Mr. Jeffers have been suspicious of meningitis given his presentation?

A Given his presentation, no. He had no clinical evidence for meningitis, either in the emergency department or by Dr. Banaga. At the time Dr. Banaga saw him.

Q Based on the fact that he was presenting with otitis media, before anybody examined him, let's say, should they have been suspicious for that possibility?

A I think the physician who cares for a patient with acute otitis media has to exclude meningitis as a secondary infection from the otitis media, that's correct.

Q And it has to be ruled out by the physician?

A It has to be -- yes.

Q Was that ruled out in the emergency department?
A The emergency department examination was probably not as detailed as **Dr**. Banaga's, but I think both physicians felt reasonably comfortable with their clinical assessment of this patient that meningitis was not clinically apparent at the time that either of those physicians saw this patient.
Q Well, what specifically did Dr. Jones do to rule out meningitis?
A He did a very cursory examination, but demonstrated that there was -- that. the patient's neck was supple, and that there was a causative factor for his headache and fever.
Q What was the causative factor?
A Bilateral otitis media.
Q And what are you assuming that supple means in this case?
A Supple means pliable, soft. It means that the patient with passive range of motion does not complain of pain or tenderness of his neck or spinal column.
Q Is that how you use the word supple?
A I think traditionally that's how it's used in physical assessment of patients.

Q My question though is is that how you use it?
A Yeah, absolutely. A supple neck is a patient who has a neck that you can move through the range of motion and he does not have pain or tenderness suggestive of meningeal irritation or infection in the CNS.
Q When you're talking about moving the neck through the range of motion, are you including attempting to move the patient's chin to his chest?
A Yes.
Q And are you assuming that because Dr. Jones put that the neck was supple, that he moved the neck through an entire range of motion?
A I don't know that he put it through an entire range of motion in every particular vector that's possible, but he was satisfied that the patient had a supple neck based on his examination of the patient. I don't know what Dr. Jones did to determine that, but he wrote that the neck was supple.
Q Well, is it important to know what Dr. Jones did to know whether he did an examination that met standards of care?
A Yes. In his deposition he said he did. He

flexed the patient's head and turned it. But what I'm saying is I'm not sure that he did a whole 360 degree rotation of the patient's head to assure himself that it was supple. By flexing the patient's head he probably thought that was sufficient based on the clinical findings of acute bilateral otitis media, fever and headache.

Q Well, fever and headache can also be signs of meningitis, correct?

A It can be signs of many, many things: Sinusitis, pharyngitis, sure. It can be signs of many things.

Q And if a patient has symptoms that are consistent with otitis media, I mean, you don't -- you can't necessarily rule out meningitis by attributing those symptoms to the otitis media, can you?

A No. You have to examine the patient's neck, that's correct.

Q All right. So if Dr. Jones didn't examine the patient's neck, then that would have been below the standard of care --

MR. HUPP: Objection.

Q -- of an emergency physician?

A If he did not examine this patient's neck, I would say yes.
Q What would an examination of the neck have to include to meet the standard of care of an emergency physician?
A Passive range of motion.
Q What does that mean?
A That the patient lies supine and you take the patient's head and move it forward and backwards and left and right.
Q What do you mean by forward and backward?
A Flexion is forward and extension is backwards.
Q What is a Kernig's sign?
A Kernig's sign is if you flex the patient's hip and knee they have meningeal irritation from the movement. Brudzinski's sign is when you passively flex the --
Q I didn't ask you about Brudzinski.
A It's the other sign of meningeal irritation.
Q I know. I'm going to get to it. I have to go slow though. All right. You said Kernig is when you flex the hip and thigh?
MR. MARKWORTH: Read back his answer.
(The record was read by the reporter.)
Q How do you flex the hip and knee? Can you

explain to me how that's done.

A The patient is supine, on their back, you raise their leg and bend it at the hip so that their knee and hip come forward towards their cephalad. And you bend the hip and you bend the knee. The knee is flexed at the 90 degrees to the femur.

Q And what are the signs that you're looking for that tell you that there's meningeal irritation?

A Pain in the back and the neck.

Q Was that done by Dr. Jones in this case?

A No.

Q Should it have been done?

A No.

Q Why not?

A Because he had a supple neck in a patient that had a source for headache and fever.

Q Isn't a positive Kernig's sign a classic sign of meningitis?

A I don't know what you mean by "classic." What I think of with Kernig's and Brudzinski's sign is when they're present they're helpful, when they're absent they're not helpful. So they're not always present in a setting of meningitis, but they can be present.

Q But if you don't do the examination, you don't know one way or the other?
A If you don't examine the patient for Kernig's and Brudzinski's, that's correct. Although with the Brudzinski's, if you flex the patient's neck and he brings up his knees, you have de facto done a Brudzinski's test.
Q Let's talk about Brudzinski's now. What is that?
A That is flexing the neck and the patient draws up their knees, or a knee, but flexes their body. Again, because they have irritation of their CNS and their meninges. So by doing a full range of motion passively in a patient, you will elicit a Brudzinski's if it's present by bringing his neck forward the leg will come up or legs will come up.
Q And should the presence or absence of the patient bringing his legs up be charted by the physician if he's doing this examination?
A If it was evident to him, sure, he should chart it.
Q I mean, if it's negative shouldn't he also chart that in a patient that he is suspicious of meningitis in?

A I think the documentation of positive or negative clinical findings is important.
Q Let's talk about this specific clinical finding.
A I think that Dr. Jones excluded the diagnosis of meningitis based on his examination. Now, whether or not he followed through with the Kernig's and Brudzinski's and didn't document that, I have no idea of whether or not he did that.
Q I didn't ask you that question though, Doctor. In a patient where there's a suspicion of meningitis, shouldn't a -- first of all, can we agree that the Brudzinski's sign should have been done by a reasonable, prudent emergency room physician?
A No. We can't agree on that, because you said that we have a suspicion of meningitis. I don't know that we have a suspicion. We're obligated to exclude that as one of the causative factors for headache and fever in this patient, and in general.
Q I'll ask you to assume that we're suspicious of meningitis in the patient.
A That wasn't what you asked me though before. You asked me is meningitis a possibility for

extension from an otitis and I said yes, it is.
Q Okay. Assume that the emergency room physician should have been suspicious of meningitis --
A Fine.
Q -- does the standard of care require him to check for a positive Brudzinski?
A I think the standard of care would dictate that he or she needs to exclude meningitis if they think that's high on their list of suspicions. But Brudzinski and a Kernig sign are not always positive findings. A supple neck in a patient that's awake and alert with a source of infection, you can exclude the diagnosis. So no, I don't think the standard of care dictates that you have to do a specific reflex to elicit signs and symptoms to confirm or exclude a diagnosis.
Q Well, yeah, I thought you told me earlier, and I may be wrong about this, that if you suspect or that if you're ruling out meningitis, that you have to do an examination of the neck?
A Yes.
Q All right. An examination of the neck would include passively putting the chin to the chest?
A Correct.

Q And then you said that that was a de facto way to do a Brudzinksi?
A It can sometimes, that's correct. But it's not always a positive finding. Not every patient with meningitis has a Brudzinski.
Q Well, a way to check for Brudzinski is to passively put the chin to the chest, correct?
A That's correct.
Q All right. So that has to be done by the emergency room physician?
A That's correct.
Q And if he's suspicious of meningitis and he's trying to rule it out, doesn't the standard of care require him to chart either way whether that's positive or negative?
A I don't know that the standard of care dictates what is to be charted about a patient's examination. I don't know that Dr. Jones or Dr. Banaga didn't see or witness a Kernig's or Brudzinski because they didn't document it.
Q Right. So we don't know --
A It doesn't mean they didn't do it.
Q Well, we don't know one way or the other whether they did it or not.
A Right. We know simply that they put their head

through the range of motion. Passive range of motion.

Q Well, we don't know that from looking at the chart, do we?

A We know that from their depositions.

Q All right. But we don't know that from looking at the chart?

A No. I think because the documentation says the neck is supple. And that means that they put the patient through passive range of motion.

Q Did Mr. Jeffers have meningitis when he was in the emergency room?

A He did not have clinical evidence for meningitis in the emergency department or by Dr. Banaga's examination.

Q No. But in your opinion, based on the review of the records sitting here today, do you have an opinion one way or the other whether or not he had meningitis in the emergency department?

A I don't believe he had meningitis in the emergency department, that's correct. Or that's my answer. I don't believe that he had meningitis in the emergency department or at the time Dr. Banaga saw him.

Q When did he get it?

A Probably sometime in the early morning of the next -- or the same calendar day prior to going to CT scan. Because I believe his clinical condition deteriorated when he was in CT scan.

Q I mean, can you give me a time frame when you think he had gotten meningitis?

A I think that would be very difficult. I would probably defer that to some infectious disease specialist, but I will tell you that meningitis is not like a light switch, on/off. It's progression of an illness. So he could have had meningeal seeding starting at eight or nine or ten in the morning but was not clinically evident until one or two that afternoon when he had clinical deterioration.

Q If he had a stiff neck at the time that Dr. Banaga saw him, would that change your opinion as to whether or not he had meningitis at that time?

A Not necessarily. I think patients that have headaches and have otitis can have stiff necks from the muscles that are sore from holding their head still. So I don't think necessarily that a stiff neck, in and of itself, is specific for meningitis. It would make you worry about

it more and make you move on to other things to elicit that diagnosis.

Q So the fact that if I ask you to assume that he had a stiff neck at, say, 12:10 on the 4th -- May 4th -- then that wouldn't change your opinion at all as to -- it wouldn't change your opinion that he didn't have meningitis at that time? You still believe that he did?

A I could not tell you, based on the patient having a stiff neck, whether he did or he did not have meningitis without examination the patient. So I can't tell you -- if you tell me that the guy has a stiff neck, I can tell you that that means he conclusively has meningitis. Nurse Knopf in her nursing notes says the patient had a sore neck. So, yeah, people said that the patient had a sore neck. That is not the diagnosis of meningitis.

Q All I want to know is if it changes your opinion or not?

A I can't -- still cannot give you an opinion as to when meningitis started. I think that was the question.

Q All right. No, the specific question -- you gave the opinion that he didn't have it in the

emergency department or when Dr. Banaga saw him.
A It was not clinically evident at those times, that's right.
Q Okay. So if I ask you to assume that he had a stiff neck at the time Dr. Banaga saw him, does that change your opinion as to whether or not he had meningitis at the time she saw him?
A You want me to assume that --
Q That he had a stiff neck.
A -- in light of the fact that we know he had a supple neck by two separate physicians' examination?
Q Yes.
A So hypothetically, not in this case in general, but a patient with a stiff neck --
Q Right. Hypothetically. No, this patient. I just want you to assume that this patient had a stiff neck at the time Dr. Banaga saw him.
A And we're talking in a hypothetical sense? This patient hypothetically had a stiff neck?
Q Yes.
A That would be suggestive of meningitis and then other tests should have been done to elucidate that diagnosis, that's right.
Q If he had a stiff neck then, what other tests

should have been done?

A Well, in an adult patient with a stiff neck you look for local sources of infection, which he had. He had bilateral otitis. We have a CT scan that says he has internal otitis, so his inner ear was even infected.

Q We didn't have the CT scan until the following afternoon.

A Right. So you would have to -- we have one diagnosis of an infection, meaning an otitis media, bilaterally. That can cause patients to have a stiff neck. The lymph nodes get swollen, the patient holds his head rigid, the muscles get stiff. So there's a lot of reasons why a patient could have a stiff neck.

Q Well, a minute ago you told me if he did have a stiff neck --

A Yes.

Q -- that there are other tests that needed to be done.

A Yes. Okay. So in an adult patient you would necessarily need to have a CT scan of his head prior to doing any other diagnostic testing like lumbar puncture. So CT scan would have been in order had the patient had a stiff neck.

Q And in what time frame would you need to have done the CT scan?
A As soon as possible.
Q On a stat basis?
A Sure, I would probably order it as a stat CT scan.
Q Could you give antibiotics to cover the possibility of meningitis while you're waiting for the CT scan to be --
A You should give meningitis -- you should give antibiotics while you're waiting for a CT scan if you suspect the patient has -- clinically has meningitis.
Q Well, if you assume that the patient had a stiff neck at the time Dr. Banaga saw him, is that what should have been done in this case?
MR. MARKWORTH: Objection.
A In a stiff neck in the absence of other physical findings. That's why I kept asking you in a hypothetical case a patient with a stiff neck or this case with a patient with a stiff neck. In the hypothetical case a patient --
Q No, this case with a stiff neck.
A We know he didn't have a stiff neck. And he also has a source of infection.

Q Well, wait a minute. We don't know that he didn't have a stiff neck.
A Two independent physicians documented that he had a supple neck within two hours of each other.
Q Well, you know, I don't want to argue with you. I mean --
A I don't either.
Q Okay. But the nurse was the only one that there's any evidence in the chart did an examination of the neck, noted that he was unable to put his chin to his chest.
A That was active range of motion. That's very different. That's not passive range of motion. The nurse said, "Put your chin to your chest." And when the patient did that, his neck was sore. I'm not surprised. He had bilateral otitis media and a headache for days, so I'm not surprised that the guy had pain when he flexed his neck. Very, very different than the physical findings of a supple neck.
Q Well, you know, you didn't read her deposition, correct?
A I read her assessment.
Q Fine. All right. And you're giving me your

interpretation of her assessment.

A No. That's what it says.

Q No, it doesn't. It says "unable to put chin to chest," not that he had pain in his chest when he did it. He said he couldn't do it.

A Yeah, he couldn't do it, that's right. So that's active range of motion, not passive range of motion.

Q If he has a stiff neck, what difference does it make if --

A A world of difference. Because when you raise your head off the bed, you use your own muscles. That's voluntary as opposed to a passive range of motion when the physician takes the patient's head and moves it through range of motion.

Q But he couldn't --

A That takes away the muscles around the neck.

Q But he couldn't do it.

A I agree. I'm not disagreeing with you. I think that's a very good finding on her part. But it has nothing to do with meningitis.

Q All right. So that finding is totally irrelevant in terms of whether he had meningitis or not?

A It's totally relevant in the context of a

patient with bilateral suppurative otitis media and a headache for days. It's totally consistent with that. I'm not saying it's inconsistent with that.

Q I want you to assume that her finding meant that he had a stiff neck.

MR. MARKWORTH: Objection.

A I can't assume that because it's not the same as a physician's examination of a neck to exclude meningitis.

Q All right. If Mr. Jeffers had a stiff neck at the time Dr. Banaga saw him, should she have ordered a CT scan stat and given antibiotics to cover the possibility of meningitis pending the outcome of the CT scan?

A An isolated finding of a stiff neck would not necessarily trigger that cascade of events. I have to know more about this hypothetical stiff neck.

Q Well, when you say isolate a stiff neck, I mean, in Mr. Jeffers. I mean, he had other symptoms that were indicative of meningitis, didn't he?

A No, he had a multitude of nonspecific, insensitive symptoms of any patient with a headache and bilateral otitis media.

Q I see. So a headache is not a sign or symptom of meningitis?
A As well as sinusitis, cellulitis of the face, tooth abscess. You know, a laundry list of things. Otitis media, that can give you headache, fever and --
Q But he didn't have any of these things you mentioned, did he? He didn't have a toothache?
A Well, that's why -- we keep going from the hypothetical to this patient, that's why I'm getting confused.
Q Are you?
A Yeah. A hypothetical patient with a stiff neck, you have to exclude the multitude of things that would be from the top of their head to their clavicle that would cause them to have a stiff neck.
Q So you're confused right now?
A Only because we keep flipping from the hypothetical to this patient, that's all.
Q No, I'm not. I mean, I'm asking you in this patient if you assume he had a stiff neck.
A Right. Let's assume he had a stiff neck. He has evidence for bilateral otitis media. We have an explanation for why this patient had

pain with voluntarily flexing his neck.
Q Is an unrelenting headache that's not relieved with morphine, is that a sign of meningitis?
A No.
Q How about nausea and vomiting?
A No.
Q Photosensitivity?
A Nope. These in and of themselves are not making the diagnosis of meningitis. They can be with a patient with a simple headache. Have you ever had a hangover or a migraine, you don't like the lights. I mean the lights bother people with headaches.
Q Well, I usually don't take morphine for it though.
A No, I don't either, but everybody's pain is different.
Q And the inability to put your chin to your chest, to you that's not indicative of meningitis either?
A The patient's inability to voluntarily lift his head off the bed and touch his chest, to me does not make the diagnosis of meningitis, that's correct.
Q I didn't ask you if it made the diagnosis, I

asked you if it was indicative of meningitis.
A No, it is not indicative of meningitis.
Q It is not a symptom that somebody with meningitis would have?
A It is a symptom that people with meningitis can have, yes.
Q Would somebody who had an unrelenting headache that wasn't relieved with the use of narcotics, nausea, vomiting, photosensitivity and an inability to put their chin to their chest, would they require a lumbar puncture, or would that be a test that a physician acting reasonably prudent would do?
A A hypothetical patient now we're talking about?
Q Yes.
A Some hypothetical patient who presents to the emergency department -- go ahead -- or to the house physician with the following --
Q Unrelenting headache, unrelieved with narcotics, nausea, vomiting, photosensitivity and an inability to put their chin to their chest.
A Would that automatically warrant a lumbar puncture?
Q No. No. Would a physician acting reasonably and prudently do a lumbar puncture?

A Not as the first thing you would do, no.
Q But you would do it?
A After I've excluded all the other things that could cause that symptomatology, that's right.
Q What would you do to exclude all the other --
A Examine the patient.
Q Suppose you examine the patient and these were your findings?
A And you found that he had bilateral suppurative otitis media, then we have a diagnosis for why the patient has headache, nausea, the other things you told me. Photosensitivity.
Q So if you examined the patient and you found that he had bilateral otitis media, that would be the end of it?
A No.
Q You wouldn't do a lumbar puncture?
A I would not have done a lumbar puncture on this patient at the presentation to the emergency department or to the house physician based on what I saw.
Q No, I'm talking about -- we're still talking about the hypothetical patient that presented with these symptoms that I gave you.
A If I found that the patient had bilateral otitis

media, I would not have performed a lumbar puncture on that patient. I would have started antibiotic therapy. If the patient was unable to keep down his medicines by mouth because he was so nauseated, I would admit him to the hospital and have him ongoing evaluation and ongoing therapy as an inpatient. It's one of the indications for keeping patients in the hospital; they can't take their medicines out of the hospital. Which is what Mr. Jeffers had a problem doing.

Q Is that why he was admitted to the hospital?

A He was admitted to the hospital because he had persistent vomiting, he was not keeping his medicines down, and he had an elevated white count. And the emergency room physician thought that there may be something else going on and the patient needed inpatient observation. It's a very reasonable approach to this patient.

Q And I assume, if this hypothetical patient that I gave you before that had these symptoms also had a leucocytosis, you still wouldn't have done the lumbar puncture?

A Leucocytosis is nonspecific. The patient had -- we know the patient --

Q So you wouldn't have done it?
A Based on a leucocytosis, no.
Q And all the other symptoms?
A No. Not based on this patient. 'This patient. Not a hypothetical patient, this patient. High white count, all the things you told me, I would not have done a lumbar puncture as the emergency physician or as the house physician who saw the patient within a couple of hours, that's correct.
Q All right. You would have done the exact same thing that Dr. Banaga did in this case?
A Her responsibility was to examine the patient, do a history, physical examination, and verify that the orders that were written were appropriate for the patient. So that's what she did, and that was reasonable.
Q So you would have done the exact same thing?
A Absolutely.
Q And then you would have gone to bed and never seen the patient again?
MR. MARKWORTH: Object to the form. Go ahead.
A I would have saw the patient again if I was asked to see the patient again. If someone

asked me to see the patient again, I would have went and seen the patient again. I mean, in the emergency department I rely on the nurses coming to me and saying, "Doctor, I think this patient needs to be re-examined, there's a change in their clinical condition and you need to come back and see this patient." Now, we don't have the benefit of six-, eight-, ten hours in the emergency department, luckily, but --

Q What if the patient vomited a couple hours later; would you have gone to see him?

A He had been vomiting for days. That's one of the reasons he was staying in the hospital; he had been vomiting for three or four days.

Q So you wouldn't have gone to see him?

A Just with episode of vomiting -- I would have to know what else is going on with the patient. Has anything changed in the patient's clinical condition; does he still have a fever; is the mental status the same; anything else that worries you? "No, Doctor, everything's fine -- Then give him something for his vomiting, call me if there's no change."

Q Is that what Dr. Banaga did in this case?

A I don't know what exactly, conversation wise,

transpired. Hut she administered something for his vomiting. And that was the end of it. He slept the rest of the night.

Q Should she have gone to see him?

A For one 500cc episode of vomiting in a patient that's been vomiting for days and no other change in the patient; no, I don't think she needed to go see him.

Q Was he critically ill at one o'clock?

A No, I would not describe it as critically ill. As a matter of fact, his fever went away by three in the morning. He didn't even have a fever any longer.

Q So he was getting better?

A No, I didn't say he was getting better, he just didn't have a fever, so it is not someone that I would think is critically ill.

Q What antibiotic would you have given him?

A I think the antibiotic ordered by Dr. Binder is appropriate for what he thought the patient may have had, which was osteomyelitis or --

Q Let's go back to the hypothetical. patient that I gave you before that you said you would have prescribed an antibiotic for. This patient that had unrelenting headache unrelieved by

narcotics, nausea, vomiting, photosensitivity and an inability to put his chin to his chest and a leucocytosis, would you prescribe an antibiotic for that patient?

A If I found that he had bilateral otitis media, yes, I would definitely have prescribed an antibiotic.

Q And what antibiotic would you prescribe?

A Dr. Jones had the benefit of having an ear, nose and throat doctor on call and he deferred to his judgment on that. And I would not argue with that doctor.

Q So you wouldn't argue with the use of Cipro in this case?

A Cipro is a reasonable drug for external otitis and for osteomyelitis, which is what they thought this patient may have had since he had two to three weeks of otitis media.

Q You're saying Cipro is an appropriate drug for otitis media?

A No. No. No. It covers many of the same organisms; nostras influenza and strept pneumoniae, but it is used for otitis externa. The external part. And it's also used for osteomyelitis, which was the admitting

diagnosis, ruled out osteomyelitis.

Q What about for otitis media? I mean, your whole thing is you're assuming that he had an otitis media.

A Yeah, I don't know that it's an inappropriate drug for otitis media. The defense expert, otolaryngologist, said it's probably not a bad choice and watching the patient's clinical course.

Q What did Dr. Binder say?

A Dr. Binder say about the Cipro?

Q Yes.

A He ordered the Cipro.

Q Right. What did he say in his deposition about it? Did he feel it was an appropriate choice?

A I felt he thought it was an appropriate choice based on what he was told by the emergency physician. I could check.

Q For otitis media you're talking about?

A Yeah.

Q So it's your understanding that that was an appropriate medication to give for otitis media to Mr. Jeffers?

A I think that Dr. Jones and Dr. Binder had a discussion about the drug and they -- Dr. Binder

chose otitis because he thought that it was more of an external otitis than an internal otitis.

Q But Dr. Banaga, who is the physician that you were retained to evaluate, felt that he had an otitis media.

A She thought that he had otitis media, that's correct. She also saw blood in his ear canals, which can be externa as well.

Q So should she have discussed this drug with Dr. Binder?

A I think that the house physician is not trained in otolaryngology and if the otolaryngologist wants to use Cipro to treat his patients, I think she would defer to him. He is an expert in ear, nose and throat diseases. And if you look on the admitting record, it says, "Rule out osteomyelitis," and it's a great drug for treating osteomyelitis.

Q But she didn't find any evidence of osteomyelitis on exam?

A You could not on physical exam. It would be difficult, unless it was so far advanced that the skin had turned color, for example. Different things. But this patient had weeks of otitis infections and they were worried that he

had a contiguous bone infection.
Q Well, Dr. Binder hadn't examined the patient by the time Dr. Banaga had, correct?
A That's correct.
Q She was the only one who had done the physical exam of the patient?
A That's correct.
Q So wouldn't she have had a better idea what was going on with the patient than Dr. Binder?
A I would hope that Dr. Binder took responsibility for the patient that was admitted to his service and elicited the information he needed from the emergency doctor to administer the appropriate therapy. And I would assume, as the house physician, that you would hope that that took place as well.
Q Well, do you treat patients over the phone that you've never examined?
A Do I; no? Not in my practice I don't.
Q Do you think that's good medical practice?
A I treat patients over the phone -- over the radio with paramedics who take care of patients in the street. Over the phone. Over the radio. It's sort of an analogy I guess. Do I think it's a good practice? I think it's probably a

standard practice in most community settings.
Q Do you think it's good practice in this setting?
A I think it's standard practice. Whether or not it's good practice, I really don't have an opinion. I worked in that environment where the house physician covers a patient for a private doctor. It's pretty much standard practice in community hospitals.
Q Doctor, don't change the question, please. The question is do you think it's good medical practice to treat a patient, that you've never seen or examined, over the phone?
A Had he not been seen by an emergency physician, I would have thought it would be very bad to do. There's probably several malpractice cases by patients being treated over the phone by doctors without being seen. But the patient was seen by an emergency physician who then relayed the information to Dr. Binder, which was then the impetus for his orders. So I think that's standard practice. It's good practice. That's what goes on around the country. That's exactly how medicine is practiced in the community.
Q And you don't think -- all right. It's not a standard practice for a doctor to do an

examination of a patient prior to ordering any medication?

A That was Dr. Banaga's rule; to re-evaluate the patient when the patient got to the floor.

Q But she didn't do anything about the medication?

A No. She thought it was appropriate based on her findings and what Dr. Binder and Dr. Jones thought.

Q Wait, a minute. Dr. Binder ordered Cipro because he felt there was a possibility of osteomyelitis?

A That's correct.

Q And Dr. Banaga didn't find any signs of osteomyelitis on her physical exam, correct?

A There would not be any physical findings of osteomyelitis in someone that had an infection for two weeks. It would not be clinically apparent, particularly in the bones of the skull.

Q Well, she did a physical examination --

A Yes.

Q -- and your testimony was complete and thorough and met the standard of care, correct?

A Yes.

Q Based on that examination, her diagnosis was

otitis media, correct?

A Yes.

Q And she didn't say anything about there being a possibility *or* secondary diagnosis of external otitis, correct?

A She did not write that as a diagnosis, but she mentioned in it in her physical examination, that he had blood throughout his canal. In his ear canal.

Q But she didn't attribute that to being an external otitis. I mean she didn't make that diagnosis --

A She didn't make that diagnosis in her history and physical, that's correct.

Q So if she saw that there was at least a conflict between her diagnosis and Dr. Binder's diagnosis, shouldn't she have at least discussed that with Dr. Binder?

A I think that Dr. Banaga is obligated to examine the patient and be sure that there's nothing that she finds that's inconsistent with what the emergency doctor told Dr. Binder. And if there was some inconsistency or some variance, then she is obligated to call him and tell him that there's something that she *sees.* The admitting

diagnosis is acute bilateral otitis with rule out osteomyelitis. That' what she found.

Q But the drug Cipro was ordered because of the possibility of the osteomyelitis?

A I'm assuming that's what he thought. He thought the patient may have extended his otitis media to an otitis externa. And based on that, the possibility that there was a concurrent, yet undetected, bone infection.

Q If you have a patient that you treat in the emergency room with otitis media, what drug do you prescribe?

A Cipro is much too expensive for my patients. I use very basic generic, cheap drugs. Inexpensive medicines. So I wouldn't even know how to dispense or write for Cipro. It's too expensive for patients.

Q That's the only reason you wouldn't prescribe it in an otitis --

A That would be my reason for not prescribing it in otitis; is that it costs too much for patients.

Q But other than the cost, you think it's equally effective for otitis?

A No, I -- it covers many of the same organisms

that cause otitis. But it's traditionally used for lower respiratory tract infections as well as osteomyelitis, urinary tract infections, skin infections. A lot of different things. But it's not a first line agent for an acute bilateral otitis media. In my practice.

Q That has nothing to do with the cost of it, that has to do with the efficacy of it, correct?

A That's right.

Q So if Dr. Banaga does an examination and finds that he has otitis media and makes no findings of osteomyelitis or external otitis, and she sees that the drug that he's being given is not the first line for Cipro -- I mean, not the first line for otitis media, then why wouldn't she call Dr. Binder and discuss that with him?

A Well, because I think the admitting diagnosis was to rule out osteomyelitis, and this is an appropriate drug to cover someone that may have osteomyelitis. So I don't think there's inconsistency there. The patient had otitis media, he had evidence for otitis externa as well, and he's being admitted to rule out osteomyelitis. And the otolaryngology expert thought that Cipro was not an unreasonable drug

to start. The patient was being admitted to the hospital for observation.

Q Well, if he had externa otitis, she would have seen that, right?

A She did see that. She didn't write it as her diagnosis. But she said the patient has waxy blood stuck in his ear. I think she said on the right side. So she clearly did see that, she just didn't put that down on her differential --

Q Would that be consistent with otitis media?

A Otits externa is the outer ear. The canal of the ear.

Q So you're saying that she misdiagnosed otitis externa? She should have made --

A She found the physical findings, but she did not put that as her admitting diagnosis. But the patient clearly had otitis media, inner ear, as well. Middle ear as well.

Q So it's your testimony today, under oath, that this patient had an otitis externa?

A No. My testimony is that his exam is not inconsistent with early otitis externa. On the right side.

Q Well, did he have it?

A No, he did not have it.

Q And Dr. Banaga didn't think he had it either, did she?
A She found findings of the external canal.
Q If she thought that he had it, she would put it down as her diagnosis, wouldn't she?
A She should have put it down as part of her diagnosis for admission. That was what the admitting orders were written for. So you're right. It was written on the admitting order, she did not complete that on her handwritten note or dictated note.
Q Now I'm confused, Doctor. You're saying he didn't have an external otitis, correct?
A He did not find -- he did not have an external otitis when Dr. Binder saw the patient the next day, that's correct.
Q We're talking about Dr. Banaga. When Dr. Banaga saw him.
A Dr. Banaga saw him --
Q Did he have an external otitis or otitis externa?
A No, obviously he did not have if he didn't have it at eight o'clock the next morning when Dr. Binder saw him. **All** I'm saying is that on her physical examination she says there's bloody,

waxy dried blood in the ear canal. So that is evidence for or suggestive of otitis externa, the outer ear. But he did not have it when Binder saw him, the ear, nose and throat specialist, that's correct. But what I'm saying is her findings are not inconsistent with what was written for orders for this patient.

Q But she didn't think he had otitis externa. I mean, she ruled that out.

A I don't know that she ruled it out, but she did not put that down as an admitting diagnosis.

Q All right. She's the one that did the examination of him --

A That's correct.

Q -- at one o'clock. But she didn't put that down as a diagnosis?

A That's correct.

Q But you think that she didn't need to call Dr. Binder because of this finding of the wax in the ear?

A No, I would not have called Dr. Binder to tell him the patient had bloody wax in his ear because he was admitted with that diagnosis.

Q The question that we originally started out on was what would -- why shouldn't Dr. Banaga call

Dr. Binder and tell him that she did an examination of the patient, that he has otitis media, and that he doesn't have otitis externa, according to her examination and findings, given the fact that the drug prescribed was not the first line for otitis media?

A I would think that the patient was admitted with a diagnosis of rule out malignant external otitis. He had evidence of pathology in his ear canal. And Binder is an ear, nose and throat specialist which she deferred the choice of antibiotics to. So that would be my deductive reasoning as to why she didn't call him and say, "Gee, by the way, he has otitis media as well as possibly otitis externa and possibly osteomyelitis."

Q Where do you see any evidence she thought he possibly had otitis externa?

A That was the admitting diagnosis.

Q No. Dr. Banaga, in her note or in her deposition, do you see anywhere that she said that?

A In her handwritten note and in her dictated note she finds bloody, waxy material stuck in the canal of that patient on the right side.

Q I understand, but she never said anything about possible or secondary diagnosis of external otitis?

A No, she did not. I agreed with you.

Q *So* you're basically reading into her examination where she found bloody ear wax that she saw, that was something that's not reflected in the chart?

A No. You asked me if I would have called Dr. Binder based on the findings, and I'm saying I can only deduce that she felt that her findings were consistent with what she felt this patient was being admitted for, which was external otitis, rule out osteomyelitis. And the choice of antibiotic for that is appropriate; Cipro.

MR. MELLINO: Okay. We can take a break now, Doctor.

(A recess was taken.)

BY MR. MELLINO:

Q Doctor, should a house physician be aware of what's in the nursing notes or nurses' assessment before she does a history and physical on a patient?

A I don't know that necessarily before, because the house physician should make an independent

assessment of the patient and not be jaded by someone else's assessment and opinion. But at some point in time the house physician, or any physician, should familiarize themselves with the nurses' reports.

Q Sometime either before or after she does the physical examination?

A Yeah, sometime during the patient's evaluation.

Q That's what the standard of care requires?

A I don't know that the standard of care dictates that you have to review nurses' notes. I think it's common practice and standard practice.

Q Well, what does the standard **of** care mean to you?

A That you would treat -- that the same -- given the same clinical presentation, signs and symptoms, the same -- a reasonably prudent physician would be the same in Cleveland as they would in Albany as they would in Pittsburgh. So data gathering is data gathering and you should gather as much data as you can about the patient.

Q Sure. That's what a reasonable, prudent physician does?

A Right.

Q And is an inability to put your chin to your chest a symptom that somebody with meningitis might have?
A Is it a symptom that someone with meningitis might have; sure. That's a possibility.
Q Should that raise the suspicion of meningitis in a physician's mind if they have a patient who's presenting with an unrelenting headache unrelieved with narcotics, nausea, vomiting and photosensitivity?
A I think Dr. Banaga excluded neck stiffness by demonstrating that his neck was supple.
Q We're going to get to that, but I haven't asked you that yet. If you want to answer the question that I asked, I'd appreciate it.
A Would the presence of neck stiffness on voluntary movement make one suspicious of meningitis; was that your question?
Q The inability of a patient to put his chin to his chest.
A In the absence of any other findings?
Q No, in a patient such as Mr. Jeffers.
MR. MARKWORTH: You changed it.
A We keep flipping back and forth from hypothetical to this patient. And I'd be happy

to answer the question either way.

Q In Mr. Jeffers.

A In this patient?

Q Yes. I mean, why is that a hypothetical to you? He did have an inability to put his chin to his chest according to Jenny Knopf.

A Yes, he did.

Q Okay. So what's so hypothetical about that?

A You use hypothetical or suspicion of. ***So*** you said in this patient his inability to flex his neck voluntarily.

Q That doesn't say anything about voluntarily in the chart, does it?

A **It** says the patient is unable to flex his neck.

Q Yeah. Where did you get that information that it was voluntary? Because you didn't review Jenny Knopf's deposition, did you?

A I did review it. I don't know where it is. But I think he --

Q Wait a minute. Wait a minute. Wait a minute, Doctor.

A I mean, I know all the history from her assessment of the patient.

Q Doctor, why did you just say that?

A I think that I reviewed it, but I don't have it.

That's my whole point. I don't have it with me and I don't know where it is.

Q Why do you think you reviewed it? It's not listed as one of the things you reviewed in your report.

A It isn't, you're absolutely right.

Q It's not here in your file.

A I agree with you.

Q So show me some evidence that you reviewed it.

A I have no evidence that I reviewed it. I just said that.

Q Okay. So it doesn't say anything in the chart about whether it was voluntary or not, does it?

MR. MARKWORTH: Objection. Asked and answered. He explained that before.

A The nurse's note says "The patient is unable to flex his neck."

Q All right.

A It does not say voluntarily or passively, that's correct.

Q Should that finding, given all the other symptoms that Mr. Jeffers had, cause -- should it have caused Dr. Banaga to be suspicious of meningitis?

A Yes. I've answered that question. Yes, I agree

with you.
Q And therefore, she was obligated to rule out meningitis?
A And she did that clinically, that's correct.
Q How did she rule it out?
A By demonstrating the patient's neck was supple on passive range of motion and by --
Q What specifically did she do?
A She flexed his head forward and backward, at least by her deposition.
Q Okay. That's nowhere in the chart?
A No. In the chart she says the neck is supple.
Q Right. She doesn't say anything about how she made that determination?
A In her deposition she tells us how she did that though. As any physician would do the same to demonstrate the patient's neck is supple.
Q But how do you know what any physician would do?
A Given the same patient with the clinical presentation --
Q Sure.
A -- the same clinical circumstances, the standard of care would dictate that the patient -- that the physician would exclude meningitis by doing examination. In this particular patient the

clinical examination revealed that he had a supple neck and the evidence for otitis media.

Q Okay. Now, a patient could have both otitis media arid meningitis, correct?

A That's possible, that's correct.

Q And some symptoms that a patient has could be the same for otitis or meningitis, correct?

A In a hypothetical patient, symptoms of meningitis and otitis can be similar, that's correct.

Q Okay. Can a patient with meningitis have an unrelenting headache, nausea, vomiting, photosensitivity and an inability to put their chin to their chest?

A Can a patient with otitis media have those things; yes, I forgot if you started with otitis or if you started with meningitis that time. But a patient with otits can have those symptoms, yes.

Q How about meningitis?

A Absolutely, sure.

Q And isn't meningitis much more dangerous than otitis?

A More dangerous, yes. I think it has a higher morbidity/mortality than just otitis.

Q So just because the patient has otitis, can a physician acting reasonably and prudently attribute those symptoms to otitis and exclude the possibility of meningitis simply because there's another source?

A In a hypothetical patient, and in this patient, yes. I covered both. Hypothetically and in this patient you have a focus of infection with that clinical presentation and a supple neck, normal mental status, normal neurologic examination, and the patient is admitted and observed for changes.

Q Dr. Banaga also noted that the neck was tender, correct?

A Yes.

Q But you don't think that that indicates, in any way, that his neck was stiff?

A That's correct. I think he had a tender neck for a variety of reasons. One, he's had unrelenting headaches, so he holds his head stiff and rigid. Two, with otitis media for two weeks --

Q Where did you see in the chart that he held his head stiff and rigid?

A A patient, I guess, hypothetically, with a

headache, unrelenting, would tend to hold their head stiff and not move it about freely. So their muscles in their neck tend to get stiff.

Q So you're talking about a hypothetical patient?

A Hypothetical patient. Secondly, hypothetical patients with otitis media for two weeks have lymph nodes in their neck which are tender to palpate. So there's several reasons why this patient could have muscle stiffness.

Q Is there any note by Dr. Banaga that the lymph nodes were enlarged or tender?

A No, she did not detect large nodes in his neck.

Q Or that they were tender?

A She did document that his sides of his neck were tender where the lymph nodes are, that's correct.

Q But she doesn't attribute that to lymph node tenderness, does she, anywhere in the chart?

A I don't think she draws a conclusion as to why he has tenderness in the sides of his neck.

Q Did Dr. Banaga -- let me ask you a different question. Did you see any evidence, start out, in the chart that Dr. Banaga tested for Kernig's or Brudzinski's sign?

A There was no evidence for that in the history of

physical.

Q And did you see any evidence of that in her deposition?

A I don't recall her saying that in her deposition. I can check, but I don't recall that.

Q Did you see any evidence that she checked for photosensitivity?

A Yes. She said that she examined his eyes during her examination.

Q Is that in the chart or in her deposition?

A I think both. Yes, in her note.

Q What does it say about the eyes?

A Pupils are two millimeter and reactive.

Q If there's positive findings by another observer of clinical symptoms, should the physician then document, when she does the examination, whether or not she has positive or negative findings of those same symptoms?

A In general? In hypothetical cases, I think if you know in advance that another physician has found something positive and you want to verify that or exclude that, then you might want to document that you verified that or excluded that. Nursing documentation and nursing

assessment is very different from physician documentation and physician assessment.

Q Why is that?

A Level of training, level of understanding, expertise. These nurses, this is the first patient with meningitis that they've ever seen. Many of them had said in their depositions -- "How many times have you seen a patient with meningitis -- Never."

Q Maybe it was an advantage for them then. So the fact that -- all right. So if the nurse makes a positive finding, you don't feel that that requires any action on the part of the doctor then?

A It requires the doctor to make an independent assessment of the patient to verify their physical findings. *To* document their physical findings. And in her deposition she said the patient didn't respond with photosensitivity and in her chart she did not write that the patient had photosensitivity.

Q She didn't say one way or another whether he had it or didn't have it?

A Right. Did not state.

Q I don't believe you ever told me specific drugs

that you prescribe for otitis media. What are those?

A Most patients with otitis media I see go home, and I would use one of the penicillin type medicines.

Q Like what?

A Ampicillin, Amoxicillin.

Q And if those drugs were prescribed to Mr. Jeffers, would those have also treated his meningitis?

A Intravenous Ampicillin is one that wouldn't be sufficient to cover all the causes of meningitis. But clearly not oral Ampicillin would not be effective to cover meningitis.

Q What was the last drug you talked -- Ampici11in?

A Ampicillin or Amoxicillin would be for outpatient treatment of otitis media.

Q But he was treated in the hospital.

A Right. And the otolaryngologist thought that Cipro was a good choice of drug for him.

Q But if he had been given Ampicillin, say, would that have treated his meningitis?

A Ampicillin alone would not be sufficient coverage for meningitis.

Q What about Ceftriaxone?

A Ceftriaxone is a bit more broad spectrum and it would be a very good agent for first line meningitis treatment.
Q And could that be prescribed for otitis media?
A It is not usually prescribed for otitis media.
Q Is it effective against otitis media?
A Yes.
Q What about Ampicillin with Chloramphenicol?
A That would be reasonable to cover both of those agents.
Q Does it cover otitis media and meningitis?
A Those agents would be used to treat meningitis I'm not sure that they would necessarily be used to treat otitis.
Q Well, Ampicillin you said already would be given to treat otitis.
A Right. Ampicillin alone. That's right.
Q Who's responsibility was it to diagnosis the meningitis in this case?
A Whatever clinician detected it at the time it was clinically present.
Q And you don't feel it was clinically present until he lapsed into a coma: is that your testimony?
A No, that's not my testimony.

Q When was it clinically present?
A His clinical condition changed when he went to have his CT scan done. That's when he had, according to his wife's deposition, changes in his mental status, was agitated, asking for pain, holding his head, holding his neck. So his change -- his clinical presentation changed on or about the time he went for CT scan. And I don't remember the time -- when he came back from CT scan, I think it was midday.
Q Do you think holding his head and holding his neck were changes in his condition?
A No. The agitation, irritability, change in his mental status. He had been holding his head since he had been sick.
Q So it wasn't until that time that it was clinically present?
A It would have been clinically apparent at that time that his otitis had extended to meningitis.
Q So you don't feel it should have been diagnosed at any time before then?
A Based on the nursing assessment that was going on during the night, no. The patient was afebrile, he was sleeping, he was easily arousable, his headache was resolving, he had

one small emesis at 0300 hours. His vital signs were normal.

Q So you feel he was getting better through the night?

A I didn't say he was getting better, there was just not clinical evidence for meningitis during the night.

Q Well, nobody examined him during the night, did they?

A The nurses made repeated examination of the patient.

Q Did they make neurological exams?

A According to their depositions they did Glascow coma scales, they did examinations of him.

Q And even if he had meningitis at the time that Dr. Banaga saw him, you don't think there's any responsibility on her part to diagnosis it?

A I think she excluded the diagnosis of meningitis when she saw him. It was not clinically apparent at the time she evaluated the patient.

Q And that's based on what again?

A Based on her examination of the patient and her pertinent clinical findings, which would be accountable for his signs and symptoms.

Q Well, what are the pertinent clinical findings;

that his neck was supple?
A That he had evidence for otitis media; that his neck was supple; his mental status was normal.
Q Any others?
A No, I think those were the main things. And his antecedent history obviously is very contributory, that he had weeks -- a week to two weeks of otitis, drainage from his ears, ongoing headaches, nausea and vomiting for several days. Those are all contributory factors in her evaluation of the patient.
Q Wouldn't the fact that the longer he had it make it more likely that it would have spread into the meninges?
A Not necessarily. He had very adequate treatment as an outpatient for the first time. But perhaps it didn't eradicate the entire infection which is why it recurred.
Q Well, it not only recurred, it was worse, wasn't it?
A I don't know that because I don't know how it was the first time.
Q Did you do anything to find out how it was the first time?
A I talked -- I read his wife's deposition who

said he never talked much about pain until the day of Sunday the 3rd.

Q Does that indicate to you that it was getting worse?

A No, it indicates to me that the patient was sick. He was vomiting. Could have been from the Augmentin, could have been from the Vicodin. He had headache from his otitis, he had fever from his otitis.

Q I think we talked about this with Dr. Jones, but not with Dr. Banaga. If Dr. Banaga did not examine his neck and passively put his chin to his chest, that she would have been acting below the standard of care in this case; is that true?

A If she did not examine this patient's neck given his presentation, I think it would not have been appropriate care, that's correct. Would not have been the standard of care. She should have evaluated his neck, and she did.

Q And that includes passively putting his chin to his chest?

A That includes determining that his neck is supple, that's right. And that's what she testified in her deposition for and that's what she documented in her note.

Q And does that include the testing for Kernig and Brudzinski?
A I think that she was reasonably satisfied, as was the emergency room physician, that this patient did not have clinical manifestations of meningitis. So she did not do a Kernig's and Brudzinski's.
Q Did the standard of care require her to check for Kernig's and Brudzinski?
A The standard of care dictated that she should exclude meningitis as an ongoing infection in the presence of a chronic otitis, which she did.
Q So is your answer to my question no?
A The answer to your question is she excluded meningitis at the time of her evaluation. I don't remember what your question was. Do you want to repeat it, I'd be happy to answer it.
Q Sure. Does the standard of care require her to test for Kernig's and Brudzinski's signs?
A I think the same thing with Dr. Jones. I don't think the standard of care dictates a specific reflex test. That's not the standard of care. The standard of care would dictate that she has to exclude meningitis at the time she's evaluating the patient.

Q Well, the only thing she checked for, according to her deposition testimony, is a stiff neck.
A No, that's not true. She checked his neck, she checked his eyes, she did an examination, she --
Q Well, we're talking about the neck findings on the examination of the neck.
A Right. She did check and determine that his neck was supple.
Q And you say she checked his eyes. I mean, there's nothing in there about whether or not he was photosensitive or not, correct?
A There was no documentation on her part that he had photosensitivity, that's correct..
Q And there's nothing in there about her checking for Kernig's or Brudzinski?
A That's correct.
Q There's nothing in there about whether he has -- well, it does say his neck is tender, correct?
A The sides of his neck are tender, that's correct. Not over his vertebral bodies which is where your spinal cord is. The muscles of his neck are tender.
Q It doesn't say anything in there about his ability or inability to put his chin to his chest?

A Yes. It says his neck was supple.
Q All right. Other than her finding that the neck is supple, what other evidence is there that she ruled out meningitis?
A Normal mental status and an obvious acute infection.
Q How do you rule out meningitis in a patient that has both otitis and meningitis?
A You know, again, it's not the light switch phenomena, you turn it on, you turn it off. The patient was admitted to the hospital, he was observed, continued to be monitored by the nurses. If his clinical condition changed, then that would warrant a further evaluation, ongoing monitoring the patient. This is wonderful, they had the benefit of having the patient in the hospital to monitor him. In emergency practice I send these people home with otitis. If they get meningitis they have to come back. So this is a patient that's in the hospital being cared for by the nurses and the doctors in the hospital.
Q And if Mr. Jeffers had an inability to put his chin to his chest at the time Dr. Banaga examined him, do you still feel that she met the

standard of care?
A If on her examination she determined that his neck was not supple, then she should have called Binder and discussed her findings with him. If there was a change in the examination from the emergency department to her clinical evaluation on the floor, which is several hours, then she is obligated to report a variance or a discrepancy to Dr. Binder, the attending physician.
Q So if -- I'm not sure if you answered my question or not.
A I'm not sure either.
Q Well, let me ask it again. If Mr. Jeffers was unable to put his chin to his chest --
A On her examination you're saying?
Q On her examination, right. Do you still feel that she met the standards of care?
A No. I answered that. If her examination revealed that his neck was not supple, then she would have been obligated to call Dr. Binder and say, "I found something different than the emergency doctor found two hours ago. Let's rethink this case." But from the emergency department evaluation to her evaluation,

identical physical exam, more extensive history, same conclusion.

Q And in between the emergency room physician and her exam there was an examination done by Nurse Knopf who made that finding, correct?

MR. MARKWORTH: Made what finding?

A What finding?

MR. MARKWORTH: What finding are you talking about?

MR. MELLINO: The finding that I've been talking about for the last ten minutes; the inability to put the chin to the chest.

MR. MARKWORTH: His response was about the passive movement.

MR. MELLINO: Yeah, I heard his response. Don't try to testify, please.

MR. MARKWORTH: Well, you're changing the question.

MR. MELLINO: No, I'm not changing the question.

MR. MARKWORTH: You're continually changing it.

MR. MELLINO: Oh, yeah. Maybe your confused because the doctor's changing the questions, not me.

MR. MARKWORTH: Not at all.

THE WITNESS: The nurse's note says that the patient was unable to put his chin to his chest.

BY MR. MELLINO:

Q That's right.

A That's right.

Q And that's different from your belief as to what the emergency room physician found and what Dr. Banaga found, correct?

A But I've already testified that they're not inconsistent. I've already agreed with you that it's possible the patient was unable to voluntarily lift his head off the bed. I've already told you that. But that's different than a patient who has a neck that's supple. I've already agreed with you on that before, I think. I could be wrong.

Q So he wouldn't have pain in his neck if you passively lifted it as opposed to actively?

A I think because when you move someone's head for them -- they are supine and you move their head for them, you remove their muscle work. You remove their moving and flexing their muscles, so you isolate only the spinal cord and the

spinal column by doing that. When the patient moves their head and neck voluntarily, they have to flex their muscles to do that. And he had pain in his neck that -- he complained about that before, he complained about that to Nurse Knopf. In her note she says, "Patient complains of pain in his neck." So it doesn't surprise me that with voluntarily moving his neck, he had pain and was reluctant to do that. And I agreed with you. But that's very different than the physical findings of a supple neck on a passive range of motion when the patient doesn't participate in moving his neck.

MR. MELLINO: I don't have any other questions for you, Doctor.

MR. MARKWORTH: Steve?

EXAMINATION BY MR. HUPP:

Q Doctor, it's your opinion that Dr. Jones met the standard of care in this case?

A Yes.

Q Was there any indication for Dr. Jones to have done a lumbar puncture in the emergency room on Mr. Jeffers?

A No.

Q Is it my understanding that you feel that you're

not qualified to comment on Dr. Binder's care because he's an otolaryngologist and you're not an otolaryngologist?

A That's correct.

Q So you don't have any opinions about Dr. Binder's care?

A I would not offer any opinions about the care he delivered.

MR. HUPP: Thank you. I have no further questions.

MR. SWITZER: I don't have any questions.

I N D E X P A G E

STATE OF NEW YORK)

SS.:

COUNTY OF)

I VINCE VERDILE M.D., HAVE READ the foregoing record of my testimony taken at the time and place noted hereof, and I do hereby acknowledge it to be a true and correct transcript of the same.

_____

Sworn to before me this ____ day of _____

County.

My commission expires

Notary Public, State of New York

resident in _____ County.

C E R T I F I C A T I O N

I, COLLEEN B, SMITH, a Shorthand Reporter and Notary Public for the State of New York, do hereby certify that the above and foregoing is a true, correct and complete transcript of the proceedings as mentioned in the heading hereof, to the best of my knowledge and belief.

Colleen B. Smith

COLLEEN B. SMITH