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STATE OF OHIO

COUNTY OF LUCAS

IN THE COURT OF COMMON PLEAS

THOMAS G. BALDWIN,

Plaintiff,

v.

Civil Action No.

96 2365

MARK E. REARDON, M.D., et al.,

Defendants.

_____/

DEPOSITION OF DAVID MURRAY WINSTON, M.D.

Taken at 2090 Commonwealth, Ann Arbor, Michigan, on October 7, 1997 commencing at or about 12:39 p.m.

APPEARANCES:

For the Plaintiff:

MS. DONNA TAYLOR-KOLIS (Via Telephone)
Donna Taylor-Kolis Co., L.P.A.
1015 Euclid Avenue
Cleveland, Ohio 44115

For Defendant Reardon:

MR. STEVEN A. SKIVER
Jacobson, Maynard, Tuschman & Kalur
333 North Summit Street
Toledo, Ohio 43604

REPORTED BY: Glenda J. Hall, CSR-2910, RPR
Certified Shorthand Reporter

ORIGINAL

I N D E X

Ann Arbor, Michigan

October 7, 1997

At or about 12:39 p.m.

* * *

DAVID MURRAY WINSTON, M.D.

Having first been duly sworn or affirmed, was examined and testified as follows:

EXAMINATION

BY MS. TAYLOR-KOLIS:

Q Doctor, just for identification purposes -- we've briefly been introduced, but for the record -- my name is Donna Kolis. I am one of the attorneys who has been retained to represent Mr. Baldwin in the upcoming trial of his lawsuit against Drs. Reardon, True and Sogocio, actually Dr. Sogocio's estate. Of course, I have intentionally chosen to handicap myself and not be here today so we have to do this by phone, of course.

It's like any other deposition. I'm going to ask you a series of questions, and hopefully you'll give me concise, straightforward answers, and this shouldn't take more than 30 minutes. The court reporter is there to mark any documents I may ask you

for, And I hope our phone line stays clear so we can understand one another.

Having said that, for the record, would you state your complete name and your business address?

A David Murray Winston, M-u-r-r-a-y. My business address is 2090 Commonwealth, Ann Arbor, Michigan 48105.

Q Doctor, do you have available, to give to the court reporter, a copy of your curriculum vitae?

A Yes, and it's done.

MS. TAYLOR-KOLIS: Great. Then we'll just mark that Exhibit A for the plaintiffs.

(Deposition Exhibit A marked for identification)

BY MS. TAYLOR-KOLIS, CONTINUING:

Q I have received, prior to today's deposition, a copy of what I believe is your CV, and it is a one-page document; is that accurate?

A Correct.

Q We won't waste a lot of time going through your background, but just let me ask you a couple of things to clarify my thinking.

There are no publications listed on your CV; is that correct?

A Correct.

Q All right. So during the course of medical school and thereafter, you elected not to participate in academic publications, I guess. Would that be accurate?

A Correct.

Q Okay. What do you do for a living?

A I am a practicing full-time general internist and gerontologist.

Q Tell me a little bit about your internal medicine practice. Are you in practice by yourself?

A I'm in a large group practice.

Q What kind of doctors are in your group practice?

A All general internists except for two rheumatologists, and that is just our internal medicine division. We actually have 86 doctors in our umbrella corporation.

Q What's the name of your umbrella corporation?

A Integrated Health Associates.

Q All right. And I would gather that you consider yourself devoted to the full-time

clinical practice of medicine then.
A Correct.
Q Do you teach?
A I do.
Q Okay. Explain to me what your teaching responsibilities are at present.
A I have several modes. One is the daily contact with interns, residents, and students in the hospital. I do make daily rounds. Two, I teach physical diagnosis to second-year medical students. Three, I have a third-year medical student that I meet with weekly in the office, and I also have regular weekly residents assigned to me from two different hospitals working with me in the office --
Q Okay.
A -- from the University of Michigan and St. Joseph Mercy in Ann Arbor.
Q Okay. When you say the hospitals where you have patients, would that be St. Joseph's Mercy and Beyer? Is that Beyer Hospital?
A Primarily St. Joseph Mercy, almost never at Beyer, and rarely at the university.
Q Okay. All right. I guess that pretty much tells me what you do with your time. And

somehow you manage to find time for you to become involved in these cases; is that right?

A Correct.

Q Okay. When were you initially contacted by Mr. Bodie to review the records in this matter?

A I'm not sure of the exact date, to tell you the truth.

Q Do you not keep a correspondence file relative to litigation matters?

A I see -- no, I don't.

Q All right. So how is it that Mr. Bodie came to contact you regarding this case?

A I don't recall.

Q Had you ever worked for him before?

A I don't recall.

Q Had you ever done any medicolegal work for his law firm, Jacobson, Maynard, Tuschman, prior to this particular case?

A I suspect I have, but I don't recall the particulars.

Q Okay. How frequently have you testified in the last ten years, either by deposition or at trial?

A I probably have a deposition every three

months.

Q How many cases do you review a year?

A Probably ten or 15.

Q And can you tell me, is that exclusively for physicians?

A Medical malpractice or are you saying plaintiff versus defense?

Q Plaintiff versus defendants. In other words, it was my understanding, but perhaps it's in error, that generally speaking you testify only for physicians.

A I probably am 85 to 90 percent defense.

Q Okay. When is the last time that you had the opportunity to render an opinion on behalf of the patient, the plaintiff?

A In the last two weeks.

Q Okay. And is that for someone in Michigan?

A Yes.

Q Okay. All right. Suffice it to say, you were probably contacted a few years ago, although you just don't remember the particulars, correct?

A Correct.

Q All right. Can you tell me, do you have a file regarding this particular case?

A I do.
Q Can you tell me what's in your file?
First, is your file with you, wherever it is that you're sitting giving this deposition?
A Yes, I have it. And it includes office records of Dr. -- Drs. Reardon, True, and Reams, Westec Medical Center records, and Flower Hospital records, office records of Dr. Sternfeld, and a report of Dr. Bowman, and a report of Dr. Fry.
Q Okay. Have you had the opportunity to read the depositions that were by Dr. True and Dr. Reardon?
A I have not.
Q Have you asked to see their testimony?
A I have expressed some interest today.
Q Okay. You have not, prior to today, received then even a summary of what their testimony was?
A No.
Q Okay. Have you been provided with an oral or written summary as to the content of Dr. Fry's testimony that he gave earlier, in September?
A No. I just have his written report.

Q Okay. Fair enough. Do you intend, prior to trial, to review the testimonies of Drs. Reardon, True, and Dr. Fry?
A Sure.
Q Have you been asked to come live to the trial?
A Sure.
Q Are you planning on coming for trial?
A Yes.
Q Okay. Let me ask you this question first. Do you have an opinion, to a reasonable degree of medical probability, as to a time frame or a point in time when you believe that Mr. Baldwin's appendix actually perforated?
A I think that would be very difficult to determine with medical certainty and would involve a high degree of speculation.
Q All right. I think I understood what your answer was. However, I guess your answer may not be responsive to my question.
A I do not have --
Q Are you going to testify at trial as to what point in time the perforation of this appendix occurred?
A No.

Q You will offer no testimony whatsoever on that issue?

A No.

Q Okay. If Dr. Fry testifies that the appendix itself perforated at or about the time of the initial hospitalization in 1990, will you be disagreeing with that?

A Only in that I might disagree in that I do not think there's any way to prove it and that it would be highly speculative.

Q Okay. Why do you think that it would be highly speculative to ascertain the point at which the appendix in this case perforated?

A Because there were no symptoms in retrospect that would make me highly suspicious that he, in fact, had perforated. And also, it is possible that you can have some recurrent attacks of appendicitis, and he, therefore, could have perforated later with one of his subsequent bouts in a subsequent year.

Q Okay. What symptoms in retrospect would you have expected to see that would have made you suspicious that there was a perforated appendix?

A I'm not sure he ever did have highly

suspicious symptoms for a perforated appendix.
Q Okay. That's what I'm asking you. I probably didn't ask it very articulately. What will you be testifying to at trial would be the hallmarks of a perforated appendix?
A Sometimes someone will endure symptoms of appendicitis and then they sometimes can even get better at the time of a perforation. And then after perforation, there may be less pain, but the patient may continue -- or develop recurrent significant fever and sweats and signs and symptoms of ongoing infection, which he didn't have very much of, by the way.
Q Okay. I still don't know that I'm very clear about your answer so we'll probably just try to do it in a textbook fashion.

I gather that you, as part of your internal medicine practice, have had the opportunity to evaluate people who you have diagnosed as having appendicitis. Would I be right about that?
A Correct.
Q Okay. Please tell me, from your technical point of view, what it is that you need, A, to initially diagnose appendicitis.

MR. SKIVER: Objection. Go ahead, Doctor.

THE WITNESS: I think in general appendicitis is diagnosed by a constellation of symptoms and clinical signs and is usually, in fact, operated on presumptively, without absolute evidence of appendicitis.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q Okay. And I think that I might agree that it is operated on presumptively, and we'll deal with that issue in a minute. What is included in this constellation of symptoms?

A Of appendicitis?

Q Yes.

A Well, there is almost invariably some sort of abdominal pain. There is usually a low temperature. There may well be a mildly elevated white count. There is usually point tenderness near the appendix; and if it is inflamed enough and pointing outwards toward the front of the body, there may be peritoneal signs, including rebound.

Q Okay. Let me just go through this with you for a second. First of all, do you agree with me that -- and I'm going to use the

word hallmark, and if you don't like it, we can work with a word you do like -- but the hallmark of an appendiceal illness -- we'll call it appendicitis, not necessarily the perforation itself, but classic appendicitis -- is right lower quadrant pain? Would you agree with that?

A Correct.

Q Okay. Did Mr. Baldwin demonstrate or exhibit right lower quadrant pain in the first and primary hospitalization of August 27th, 1990?

A Yes.

Q Okay. Now, that in and of itself frequently leads people to the presumptive diagnosis of appendicitis, does it not?

A Correct.

Q Okay. The other things may or may not be there; in other words, low temperature is not always necessarily found in a person with an appendiceal illness. Is that an accurate statement of medicine?

A Correct.

Q Mildly elevated white counts, likewise, are not necessarily always found in a person with an appendiceal illness, correct?

A Correct.
Q Okay. Now, when you talk about point tenderness, are you talking about McBurney's point or just generalized point tenderness?
A Either would apply but localized tenderness.
Q Okay. Would you agree with me that the hospital records that were provided to you regarding the August 1990 hospitalization document McBurney point tenderness?
A I believe one of the accounts does, but I don't remember which person used that term.
Q If I suggest to you that the emergency room physician who first examined him --
A I --
Q -- defines it that way, does that refresh your memory of what the records contain?
A Yes.
Q You don't have to agree. I'm just trying to make it faster for you.
A Yes, I remembered one of the three physicians used that term. And since I'm looking at Reardon's and the surgeon's, it has to be the emergency room doctor. But go ahead. We'll presume that that's the doctor that --
Q We'll presume it until you prove me wrong.

A Yes.
Q How's that --
A That's correct.
Q -- until you find otherwise? But I -- my recollection is that it's the emergency room doctor.

All right. Do you agree with me that Dr. Reardon documents in the course of the hospitalization, that three-day hospitalization of August of 1990, that there is rebound tenderness found in this patient?
A He said that in his first exam, that is correct.
Q Now, when you say first exam, what day are you looking at; the 27th?
A I'll double-check that.
Q That's fine.
A I'm looking at a discharge summary. Then I see Gallagher's exam. Gallagher did not use the term McBurney's point, by the way.
Q You're right. Actually, Dr. Reardon used it.
A It is actually in Reardon's -- here it is. Yes, it is Reardon's exam. And he notes soft right lower quadrant -- or is soft with right lower quadrant tenderness to palpation at

approximately McBurney's point with mild rebound. Yes, August 27th.

Q August 27th. Okay. Do you see the place in the note where on the 28th at 5:55 in the afternoon that likewise Dr. Reardon documents rebound tenderness?

A Yes.

Q Okay. So it is still persistent and present on his examination at about five minutes of six on the evening of the 28th, correct?

A That is correct.

Q All right. Let me ask you this, Doctor. I'm certain that since you've agreed to testify in this matter -- oh, by the way -- I'm sorry, I should ask this first. Have you written a report?

A I have not.

Q You have not. And you were not asked to write a report, correct?

A That is correct.

Q All right. Obviously, once again, since you've agreed to testify, you've had some time to evaluate and analyze the issues in this matter. Why wasn't a diagnosis of appendicitis made in the August of 1990

hospitalization?

MR. SKIVER: Objection. Go ahead, Doctor.

THE WITNESS: I -- I think it's multifactorial. It's interesting to look at the progress note you just called my attention to, with Reardon noting rebound at 5:55 p.m. And I presume since it still says 8-28, that the surgeon Sogocio is writing his note five minutes later noting no rebound with good bowel sounds.

And I think that's telling, that a surgeon at that point did not think it a classical abdominal exam, with pain in both lower quadrants, good bowel sounds. It was not your abdomen that is shutting down characteristic of peritonitis.

And so the -- the features of the case were very soft and not characteristic of acute appendicitis so that's why the diagnosis wasn't made then or in the multiple other admissions to various emergency rooms, hospitals, and doctors' offices.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q Let me ask you a couple of questions since you

just -- I have them in order, but when you say things, it makes me think of what else I actually need to cover.

Do you have any criticism of any of the doctors or medical facilities' care and treatment of this patient prior to the hospitalization where the colectomy was actually performed?

A No.

Q So you won't be offering any testimony against the emergency room doctors at any of these facilities at trial?

A No.

Q All right, Now, I gather that what I just heard you say -- and we were going to talk about that because, in fact, immediately following Dr. Reardon's examination there is, in fact, a note from Dr. Sogocio, right, and that's the note you just alluded to --

A Yes.

Q -- that his particular abdominal examination didn't precisely reveal the same as the one five minutes prior by Dr. Reardon; would you agree with that?

A Correct.

Q At least in terms of what is documented, right?
A Correct.
Q Okay. Now, at this point Mr. Baldwin had been in the facility for 17, 18 hours, I think --
A Okay.
Q -- somewhere. I can't remember the exact admission time on the evening previous. What was the purpose for them giving him IV fluids up to that point in time?
A I'm not sure why they -- he had no fever, nausea, vomiting or diarrhea. He might have been kept NPO at that point. We could look at the orders.
Q Sure.
A I don't know whether I can easily find orders in here, but --
Q You should yell at your lawyer.
A But he -- I don't know. That may have been the case. I -- I don't see the orders this second so I can't comment for sure.
Q Well, let me ask you this. A person comes in, and they've got a very -- I'm going to call it an acute abdomen, acute abdominal pain, correct?

MR. SKIVER: Objection.

THE WITNESS: I don't think those are synonymous. Acute abdomen has a fairly specific medical definition, and even the surgeon's examination would be contradictory to that diagnosis.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q We'll say acute abdominal pain. Would you agree that that was the presenting admitting symptom?

A No. It was subacute. He had had it for a number of days.

Q And you gathered that from the history, correct?

A Even per Dr. Gallagher's note it says, increasingly severe over the last six days. So that's not very acute. That's many days of duration.

Q Okay. I don't want to fight with you over how we state things, but the reason he was admitted to the hospital is that he had unrelenting abdominal pain; would you agree with that?

A That is correct.

Q Okay. Now, given that that's how he

presented, does that give you an idea of why they gave him IV fluids?

A Well, Dr. Reardon in his impression said possible dehydration, you know, and so that's fairly standard, you know, treatment.

Q Okay. What medications were given to this patient prior to those examinations on the 28th by Drs. Reardon and Sogocio?

A I think I'd have to find a med chart in here.

Q All right.

A But he certainly was discharged on doxycycline, I know that.

Q Do you --

A And he may have gotten another drug during the hospitalization. I would just have to find the orders which I don't have quite handy.

Q I'll tell you what. I'll let you trust me, and I'm going to read some things, and --

A Fine.

Q -- we'll do it hypothetically, I guess, since you can't see them.

If, given the presenting set of symptoms, Dr. Reardon had written an order for the patient to receive Demerol, you would

think that was medically advisable or not? Do you have any problem with Dr. Reardon having written an order for a shot of Demerol?

A It would depend on what he thought the most likely diagnosis was whether it was appropriate or not.

Q Well, what do you think that he was thinking the diagnoses were, based upon your familiarity with the records?

MR. SKIVER: Objection as to what he thinks Dr. Reardon was thinking.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q What does the record demonstrate to you Dr. Reardon was entertaining as a diagnosis in this case?

A He said right lower quadrant abdominal pain, rule out gastro versus appendicitis possibly masked by antibiotics versus adenitis. So that's what he was thinking.

Q And in which of those scenarios would a shot of Demerol be inappropriate?

MR. SKIVER: Objection. It presumes it is inappropriate in one of those scenarios. Go ahead.

THE WITNESS: The use of narcotics

in acute surgical abdomen is to be done with great discretion and with reservation.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q And the reasoning? Would you like to tell me the reasoning or do you want me to suggest it? I'm sorry. Tell me why.

A Well, it can sometimes mask the symptoms of acute appendicitis.

Q It's a pretty well-known fact, isn't it, in terms of medical practitioners, to expect that they would know that, right?

A That is correct.

Q Sure. What is -- and I can never pronounce the word, and that's why I'm a lawyer and you're a doctor; well, there's more reasons, I'm sure -- Phenergan -- I can never say it -- P-h-e-n-e-r-g-a-n?

A That was given with the Demerol. It potentiates the effect of the Demerol and can be an antiemetic.

Q Right. A primary purpose for that, in combination, is the control of nausea, isn't it?

A I think it's given as often to potentiate the effect of the narcotic.

Q Okay. Now, you indicated that you -- I think you indicated, but I'm not sitting there so it's a little harder to remember exactly what you say, that he didn't have any nausea or vomiting; is that what you were indicating?

A I believe the record states that.

Q Did you read all of the nurses' notes?

A No.

Q Would you think that nurses' notes were a good source to find out what a patient's level or ability to actually eat is?

A Yes.

Q And so you may be actually missing some information if you've never seen the nurses' notes; would you agree with that?

A If I haven't seen the nurses' notes, I am missing that information.

Q Okay. What does the ability to eat or not eat have to do with making the diagnosis of appendicitis?

MR. SKIVER: At what point in time?

THE WITNESS: That would be pretty nonspecific in that loss of appetite could be characteristic of gastroenteritis, mesentery adenitis or appendicitis.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q So that the record is clear, you are stating that, appetite or no appetite, nausea or vomiting are pretty nonspecific factors in determining whether or not someone is having appendicitis?

A Correct.

Q Okay. And I agree with that, but I just want that to be nice and clear on the record.

Okay. A 50-milligram shot of Demerol, how long do you expect the pain -- I call it pain efficacy, but that's just my term for it -- how long do you expect it to control abdominal pain?

A Probably, if not inordinately intense, two to four hours.

Q All right. Fair enough. And it's variable from individual to individual, correct?

A Yes.

Q Let's talk about mesenteric adenitis. Why don't you tell me what your definition of mesenteric adenitis is.

A Well, literally it means that there's some inflammation of the tissue and -- lymphatic tissue of the mesentery infected by viruses.

Q How is the diagnosis of mesenteric adenitis made?
A It is made, I think, commonly as a presumptive diagnosis excluding others.
Q When you say a presumptive diagnosis, so that I'm not confused, would you agree with me that you really don't know if someone has mesenteric adenitis until you open the abdomen?
A I think to a -- that is commonly true. I presume with some of our modern imaging studies that you could get a more precise idea of whether those areas are swollen or involved with MRIs and CAT scans. But in general it would be made presumptively or at operation.
Q Right. Dr. Winston, would you agree with me then, I guess, on this point. A CAT scan -- let's just deal with the issue of CAT scan or MRI -- both of those diagnostic tools aid and assist in identifying structures in the abdomen better than an x-ray, of course. You'd agree with that, I think.
A Yes.
Q Okay. And as it relates to mesenteric adenitis versus an appendicitis, a CAT scan

is a good tool to actually see what structures seem to be inflamed or swollen, correct?

A It may assist you.

Q May assist?

A Yes.

Q Okay. And in this case no one ordered a CAT scan of this person's abdomen, correct?

A Correct.

Q And so when this diagnosis of mesenteric adenitis is made in this case, it, like appendicitis, is presumptive only because no one has opened his stomach, correct?

A Correct.

Q All right. There are no hallmarks that make this clearly the disease of mesenteric adenitis, are there?

A No.

Q Okay. Fair enough. Let's talk about antibiotics that this patient may have or did, in fact, receive prior to being admitted in the hospital on August 27th. Were you provided with the records from the treatment center where Mr. Baldwin was seen just prior to coming to Flower Memorial Hospital?

A I don't think I was.

MR. SKIVER: You mean Westec?

MS. TAYLOR-KOLIS: Yes.

THE WITNESS: Maybe I do have Westec, but --

MR. SKIVER: Actually, I think he was provided with the records that you provided us with.

THE WITNESS: Okay. So I did find this record from 8-25 where he was given Entex and erythromycin with a diagnosis of viral syndrome and bronchitis, yes.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q How does the prior administration of erythromycin interfere with the ability to make a medical diagnosis of appendicitis?

A I don't think necessarily erythromycin is a good example. Its spectrum isn't particularly good for gut flora.

But in general antibiotics may cool down appendicitis and make it less acute.

Q And that's something you would factor in when you're examining a person who has abdominal pain who you know has been on an antibiotic, correct?

A Yes.

Q How would that same antibiotic affect mesenteric adenitis?

MR. SKIVER: Which antibiotic? Are we talking about erythromycin?

MS. TAYLOR-KOLIS: We're talking about what he had. Not any other thing. We're talking about what's charted in the Westec records.

MR. SKIVER: Okay. Because the doctor's last comment was in general about antibiotics, not about erythromycin.

MS. TAYLOR-KOLIS: I understood what he said.

MR. SKIVER: Okay.

MS. TAYLOR-KOLIS: But I'm asking him the same situation with mesenteric adenitis.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q How would taking erythromycin affect that diagnosis?

A It wouldn't affect it.

Q Okay. Good enough. Let me see. Doctor, do I gather that it's going to be your testimony at trial that from August 27th, 1990 all the way up to the date of the colectomy, which I

believe is October llth, 1992, that it was not medically -- I don't want to use the word improved. Let me start the question again.

Will it be your testimony at trial that from August 27th, 1990 through October llth, 1992 no one could have made the diagnosis of appendicitis?

A That's a hard one, "could have".

Q Okay.

A Yes, I think people could have with further testing if they had had good reason to do that.

I'd like to turn it around. I don't think --

Q I could ask the question better --

MR. SKIVER: Well, let him finish his answer.

THE WITNESS: I don't think there was violation of standard of care by this series of doctors in emergency rooms and offices and hospitals in failing to diagnose in that he was very atypical, and he probably had a constellation of gastrointestinal symptoms that were unrelated to his appendicitis as well with much upper abdominal

pain, which would be atypical for a walled-off appendicitis in responding to H2 blockers.

So could have it been diagnosed with operation at any time? Possibly. Could a CAT scan have seen a small walled-off cavity at some point? Yes. But I have no way of knowing when. I have no idea how you would document when this appendix ruptured in this series of subacute attacks he had.

BY MS. TAYLOR-KOLIS, CONTINUING:

Q Is it preferable to remove a person's appendix before or after it perforates?

A Before.

Q Sure. Okay. And you don't think that he perforated in August of 1990?

A As I have testified, I don't think you can say.

Q Well, do you think that it perforated just before the colectomy in October?

A I don't think it perforated just at that point because there was evidence of chronic inflammation.

Q Let me ask you this. When a person has abdominal pain and they're indicating to health care practitioners, be it nurses

or doctors, that the quality or intensity of that pain is changed with position, does that suggest anything to you?

A In general, with most conditions, when you change position, it usually suggests that it's musculoskeletal and not visceral or internal at all. When someone is infected with abscess and has inflammation extending to the outside of the abdomen, there may be a positional component.

Q Yeah. Let me reask that because I got lost in your answer, and perhaps I didn't include it properly in my question. A person presents with right lower quadrant pain, okay? That's where the pain is.

A Yes.

Q Okay. Abdominal. And they relate to you that -- the doctor that the intensity of that pain is changed with positional changes. Does that mean anything to you?

A Yes. Quite often positional changes are associated with diseases of the skeleton, not internally. In other words, it would commonly lead you away from the internal visceral organs.

Q Okay. I think I understand your answer.

MS. TAYLOR-KOLIS: I don't have any further questions for you. I look forward to meeting you at trial.

I will be ordering a transcript of your testimony so your attorney should advise you -- or the two of you can make a decision whether you'd like to read the questions and answers or whether you wish to waive that right.

MR. SKIVER: He will review it, Donna.

MS. TAYLOR-KOLIS: Okay. That's fine.

MR. SKIVER: By the way, Donna, for the record, I'm not his attorney.

MS. TAYLOR-KOLIS: The attorney for the physician. Sorry.

MR. SKIVER: That's all right.

MS. TAYLOR-KOLIS: I will clarify that.

(Deposition concluded at 1:15 p.m.)

* * *

CERTIFICATE OF NOTARY PUBLIC

STATE OF MICHIGAN)
) SS.
COUNTY OF WASHTENAW)

I, Glenda J. Hall, Certified Shorthand Reporter and Notary Public in and for the State of Michigan, do hereby certify that the witness whose attached deposition was taken before me in the above cause was first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth; that the testimony contained herein was by me reduced to writing in the presence of the witness by means of Stenography; afterwards transcribed by means of computer-aided transcription; and that the deposition is a true and complete transcript of the testimony given by the witness to the best of my ability.

I further certify I am not connected by blood or marriage with any of the parties, their attorneys or agents; that I am not an employee of either of them; and that I am not interested, directly or indirectly, in the matter of controversy.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Notarial Seal this 14th day of October, 1997.

Glenda J. Hall

Glenda J. Hall, CSR-2910, RPR-CP
Notary Public, Jackson County, Michigan
Acting in Washtenaw County
My Commission Expires **10-18-99**

CURRICULUM VITAE

DAVID M. WINSTON, M.D.
BIRTHDATE: 2/12/45

EDUCATION:
Midland High School 1959 - 1963
Central Michigan University 1963 - 1967
University of Michigan Medical School 1967 - 1971

GRADUATE MEDICAL TRAINING:
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BOARD CERTIFICATION:
American Board of Internal Medicine 1974
American Board of Internal Medicine, Geriatric Medicine, 1990

PRESENT OCCUPATION:
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OFFICIAL POSITIONS:
President - Associates in Internal Medicine
Founder 1986, Medical Director, Blue Care Network - Med Group, Inc.
(Multi-specialty HMO group)
Member, Board of Directors, Vice President and Secretary -
Integrated Health Associates, P.C.
Member, Blue Care Network Board of Directors
Member, Executive Committee, Blue Care Network Board of Directors
Member, Blue Care Network Medical Directors Advisory Council
Chairman, Medical Services Committee, Blue Care Network, South East
Member, Michigan Geriatrics Society
Member, Executive Board, Huron Valley Physicians Association 1988 - 1993
(550 Doctor Independent Practice Association)
Member, Executive Board Allegiance Corporation 1991 - 1993
Chief of Medicine, Chelsea Community Hospital 1982 - 1986

TEACHING POSITIONS:
Clinical Instructor of Internal Medicine, University of Michigan
Medical School, Ann Arbor, MI

COMMITTEES:
Chairman, Emergency Medicine Committee (SJMH) 1987 - 1991
Member, Lab Radiology Committee (SJMH) 1988 - 1992
Member, Blue Care Network Market & Product Committee 1991 - 1993

CORPORATE APPOINTMENTS:
Company Physician, National Sanitation Foundation, Ann Arbor, MI
Medical Advisor, Washtenaw Community College
Medical Advisor, TriMas Corporation

ASSOCIATIONS:
Member of the American Medical Association
Member of the American College of Physicians
Member of the American College of Physician Executives