DIRECT-EXAMINATION

BY MR. POWER:
Q. Good morning.
A. Good morning.
Q. Can you please state your full name for the record?
A. I'm Henry Danko.
Q. And are you a physician licensed to practice medicine in the state of Illinois?
A. Yes, I am.
Q. Can you tell us a little bit about your educational background starting with your undergraduate degree?
A. I studied at Northwestern University, I got a bachelor's degree in biology. Then I went down to the University of Illinois in Champagne, Urbana and got a master's degree in physiology and biophysics.
Q. When did you finish your master's?
A. In 1973.
Q. And then what did you do?
A. Then I enrolled in Rush Medical College here in Chicago and graduated in 1976.
Q. And when you completed your medical school training at Rush, what did you do then?
A. I completed a residency training there for three years from 1976 to 1979.
Q. And what was your residency training in?
A. Internal medicine.
Q. Can you tell us what internal medicine is?
A. Well, it's the care of the adult starting at about age 16 or 18, depending when the patient breaks away from their pediatrician.
We do everything for the care of the adult that does not require surgery, obstetrics or psychiatry. We really do everything else.
Q. Does it include the area of geriatric medicine?
A. Yes, it does.
Q. And does it include the area of managing diabetics?
A. Yes, it does.
Q. Either with the use of oral or insulin by shot?
A. That's correct.
Q. Now, Doctor, when you completed your residency training at Rush, did you receive any additional qualifications or certifications?
A. I worked three years at the Bowman Geriatric Facility at Rush. That qualified me to take the qualifying exam for a certificate that was given both by the Board of Internal Medicine and the Family Practice Board. They gave it jointly.
That was the first exam ever given in the area of geriatrics. I took that exam and I passed it.
Q. Before completing your geriatric medicine added qualification exam, did you take the board certification exam for internal medicine?
A. Yes, I did.

Q. Can you tell me, first of all, what it. means to be board certified in internal medicine?
A. In order to take the exam, first you must be board eligible, you must complete an accredited recognized training program and do it satisfactorily, as I fortunately did.
And then you sit for a two-day exam covering about every single field in internal medicine in the greatest depth I've ever seen and walked out of that exam as though two vacuum cleaners were attached to your ears. They want to know everything that you know.
Q. And did you pass the board certification exam?
A. I did.
Q. And, Doctor, what are the - strike that.
After you became board certified, you practiced at Rush University?
A. yes.
Q. And, Doctor, with respect to your board certification, what relevance did it have to your staff privileges?
A. To retain staff privileges after the initial appointment, physicians have to pass their board exam to prove their competence.
Q. Doctor, I think you started to tell us about the geriatric medicine added qualification.
Is there a board certification for geriatric medicine?
A. It's exactly as I described. It's not a full board exam as we have in the various establishments of specialties.
There's some kind of a diplomatic to-do between the Internal Medicine Board and the Family Practice Board.
So they decided to give the exam jointly. And the certificate still reads as added qualification in geriatric medicine.
Q. Is that the highest level of added certification you received for purposes of geriatric medicine?
A. Yes.
Q. and you received that when?
A. 1988.
Q. Doctor, in addition to receiving these qualifications and certifications and practicing medicine, did you also have additional responsibilities in your professional life?
A. Quite a few.
Q. Can you tell us about them?
A. Yeah. I guess my biggest responsibility to date is teaching at Rush Medical College. I've been teaching since I finished my own training and I've taught first- and second-year students, I've done some work with third-year students.
And then on a daily basis my interaction with the residents who practice at Rush-Presbyterian-St. Luke's Hospital which is also a teaching experience.
I've taught the first- and second-year students in a course that's entitled Clinical Concepts and Skills and then Physical Diagnosis the following year.

And essentially we're teaching the students in this course how to examine patients, how to talk to patients, how to come up with diagnostic schemes, how to formulate ideas of disease of treatment from interacting with the patient in the office.
Q. Are you still an assistant professor at the Rush Medical College?
A. Yes, I am.
Q. Doctor, in addition to teaching at Rush, do you also hold committee memberships at Rush?
A. I'm on several committees. It's sort of expected of us to volunteer. If we don't volunteer, the chairman of the committee will call up and ask you to volunteer.
I think the longest-serving committee I've been on now is the Pharmacy and Therapeutics Committee where we meet monthly to discuss new medications, old medications, replacement of medications.
I'm on the subcommittee for that committee to discuss what's in the pipeline, what's coming up from the drug companies that's not even been discussed yet either in the hospital or in Wall Street.
I'm also on a committee now that will look at promotion of faculty members. I think those are the two active committees I'm serving on currently.
Q. I'm sorry?
A. Those are the only two that I'm actively serving on now.
Q. Doctor, were you involved in the end of life issues committee?
A. Yes, I was.
Q. Can you tell us what that committee dealt with?
A. It's very difficult for physicians to deal with the end of life. There's really no formal training in medical school, as least when I went. I think now there are some formalized teachings. The hospital grappled with it back in the late ‘70s or early ‘80s. I forget when that committee met. And we tried to come up with guidelines to help physicians deal with patients who were dying, how to deal with family members, how to talk with them, what kind of documents we had to generate or sign in order to comply with the law and comply with morals and ethics.
Q. Were one of the documents that you dealt with commonly referred to as a DNR order?
A. The DNR order had always been there. It was matter of how to get there.
Q. Can you, first of all, tell us what a DNR order is?
A. A DNR order stands for Do Not Resuscitate. In itself it seems straight forward, but it also has many nuances, what is resuscitation.
Generally when a patient's condition is terminal or pre-terminal, when further action would be deemed futile, it would be cruel to try to keep the patient alive at that point.
And if there's a clear understanding among all the treating physicians or at least a consensus, if there's an understanding with the family members that further actions will really not do any good, nurses are involved also of course in this decision making, then we can come to an agreement that should the patient suffer either a respiratory arrest or a cardiac arrest, that no heroic measures would be instituted. We would let the patient die a natural death.

The nuances of course include, you know, what is resuscitation. When a patient comes in with a very low blood pressure, badly dehydrated or bled very profusely, then we talk about fluid resuscitation, do you pour in massive amounts of fluid in a patient like that.
We talk about intubation if the patient is not breathing well, do you want to put a tube into that patient's airway and mechanically ventilate the patient. That is a form of resuscitation.
So when we talk about DNR, Do Not Resuscitate, sometimes we add to that do not intubate, sometimes we add do not use blood pressure-raising medications, depressors and family members will occasionally lead us to also say don't put any feeding tubes in, don't use any more IV fluids, just let the patient do whatever the patient can.
Q. In this case there was no evidence - strike that.
You would not include don't give insulin as something that would be applicable to a DNR, correct?
A. No absolutely.
Q. And you wouldn't talk about not feeding a patient as part of a DNR order, correct?
A. If the family members requested no feeding to take place other than oral feeding, that we not put feeding tubes in either through the nose or through the stomach surgically, then of course.
Q. There's no evidence of that in this case, right?
A. I think Mrs. Carter did ask that no feeding tube go in initially.
Q. Eventually there was a feeding tube put in?
A. Eventually there was, yes.
Q. And that was on the 23rd or 24th of February?
A. I believe so.
Q. Now, Doctor, you also served on the Infectious Disease and Sepsis Control Committee between 1982 and 1987?
A. Yes.
Q. Can you tell me what that committee dealt with?
A. We were looking at patterns of infections particularly in the hospital to see whether we had any problems with infectious control, really for outbreaks of specific types of infections on various units.
We had a clustering of staph infections or tuberculosis outbreak, just to make sure that those who take care of patients were not doing harm.
Q. Now, Doctor, in addition to those appointments, you were also a member and are a member of certain associations, professional associations?
A. Yeah, the AMA and the Illinois Society of Medicine and the Chicago Society of Medicine, all the usual, the American Geriatric Society.
Q. And, Doctor, were you - strike that. Are you currently - strike that. Were you the medical director of Hospice of Illinois between 1997 and 1999?
A. Yes, I was.
Q. Can you tell me, first of all, what Hospice of Illinois is?

A. Hospice of Illinois is a for-profit group that takes care of patients who are deemed hospice appropriate, patients whose physicians and family agrees that the life expectancy is six months or less.
Hospice care is provided for by the Medicare Act, it's paid for by Medicare. And essentially it's a humane way of approaching a dying patient. It's taking care of all their needs, all their physical needs, take care of all their symptoms, their fears, pain, nausea, shortness of breath, alleviating all symptoms of their illness, but trying to avoid needless hospitalizations, needless procedures, things that would possibly prolong their lives but at the cost of their comfort.
Q. Doctor, in your opinion was
Mr. Carter hospice qualified as of January 13th, 1995?
MR. SHAPIRO: Objection, Rule 213.
THE COURT: Sustained.
BY MR. POWER:
Q. Now, sir, I asked you to review certain - strike that.
In your actual care and treatment of patients, you have interacted with patients since you finished your residency training?
A. Yes.
Q. And can you tell me are you a part-time clinician or a full-time clinician? Can you tell me on average how many patients you see?
A. I'm a full-time clinician. I have a solo practice. I'm all alone in my office.
I'll see between 10 to 20 patients a day in the office and an average of four, five patients in the hospital per day. I also have a small group of patients at one nursing home right now.
Q. Can you tell us generally what the makeup of the patient population is between the geriatrics versus adults?
A. My practice started off as largely geriatrics when I finished my training, but now with the advent of managed care, all the contracts that the hospital and I have had to sign with insurance companies, they're sending me younger patients as well.
So probably the mix has gotten younger in the last three or four years. My patients will range from 16 to - I think I have a 95-year-old right now in my practice.
Q. Doctor, have you had experience in treating nursing home patients who are diabetic?
A. Yes.
Q. Can you tell me on average how often you see that type of patient in your practice?
A. You know, the onset of diabetes grows with age. In the young population, I got about 5 percent. Classically it was 5 percent. Recently it's actually gone up to well over 6 percent now.
Once we approach age 70, you have about 50 percent incidence of diabetes. By the time the patient reaches the age of 80, you're well over 60 to 70 percent. So it's a very frequent occurrence.
Q. Doctor, have you had experience in treating diabetics who are bedridden in nursing homes?

A. Yes.
Q. Can you tell me how often that has occurred in your practice?
A. Not that often. The bedridden patient, once they become bedridden, their life expectancy drops off dramatically.
Q. Doctor, are there special concerns with geriatric patients who are diabetics?
A. The usual concern. They have an accelerated rate of onset of disease. I think I described earlier in my deposition the fact that diabetes can be seen as an acceleration of all aging processes.
In the diabetic, we see the onset of heart attacks sooner, strokes come on sooner, kidney failure certainly comes on sooner, cataracts occur at a younger age in diabetics. It really is an accelerated aging.
So treating any diabetic, you know, we look for these diseases much sooner. A 40-year-old diabetic with chest pain, we take that very seriously as opposed to an ordinary patient - a 40-year-old patient with chest pain is very unlikely to be heart disease, but a diabetic, you know, too many times it is heart disease.
Q. Doctor, with respect to diabetes, what effect does it have on the patient's microvascular system?
A. The microvasculature, the arterioles, not the arteries, but the arterioles are affected primarily. They are obstructed, they are stenosed.
And that is one of the leading factors in the disease process in diabetes is that the arterioles when they become obstructed will manifest themselves as eye disease, kidney disease, the skin will break down very easily.
There's very little blood supply to fatty tissue to start with and when the arterioles of fatty disease break down, there's just a breakdown of tissue there.
Q. Now, Doctor, I want to stop you for a second. You said not arteries but arterioles. Can you tell me what the difference is?
A. The arteries are the large vessels where we can actually feel a pulse, put a finger over your own radial artery, that's an artery.
When it gets smaller, when it branches down again, you really don't feel the pulse anymore, when it becomes small enough, we call them arterioles.
Q. Now, Doctor, do the effects of diabetes generally develop acutely and quickly, or does it develop over time?
A. No, it's a slow onset. It's a gradual erosion of functions.
Q. And can you tell me why that is?
A. The changes in the blood supply, the changes in the nerve function, the peripheral nerves. It all occurs very gradually with the ravages of diabetes.
Q. Now, Doctor, did I ask you to become involved in this case and review records and certain depositions and provide me with your opinions?
A. Yes.
Q. And you are charging me for your time, you have charged me for your time to do that?
A. I will.

Q. And, Doctor, can you tell me what your fees are with respect to your involvement in reviewing the records, in providing a deposition and testifying at trial?
A. Reviewing records, my fee is $250 an hour, and for both depositions and for court testimony, it's $500 an hour.
Q. Now, Doctor, can you tell us what records you reviewed in this case before developing the opinions with respect to the care and treatment rendered to Mr. Carter during the time frame at issue?
A. I looked primarily at his admission at Imperial Nursing Home from February 1st to February 20th.
I looked at his record at Ingalls Hospital. I think he was transferred from Imperial to Ingalls. I looked back at the records -
Q. That would be the February 20th admission?
A. February 20th to I think March 17th.
Q. Right.
A. I looked back at his Ingalls admission in January, late January, I think it was the 19th and also when he was Imperial for a few days before that, January 13th through the 18th.
And then you asked me to look at the depositions of several physicians.
Q. Did you also look at the Glenwood Terrace Nursing Home records and the St. James hospitalization from September 1984?
A. Yes, I did.
Q. And you looked at the deposition of my client, Dr. Azaran?
A. Yes, I did.
Q. And you looked at the deposition of Dr. Fine?
A. Dr. Fine's also, yes.
Q. And you also looked at the deposition of Traci Foster but didn't come to opinions as to who was right and who was wrong as to the events surrounding February 1, is that fair?
A. That's correct. And also a deposition of Dr. Sing I believe.
Q. And Dr. Santos?
A. And Dr. Santos, yes.
Q. Now, Doctor, can you tell me approximately how much time you spent reviewing all those materials before developing an opinion in this case?
A. I think about 12 hours.
Q. And, Doctor, after reviewing all of those records, did you arrive at an opinion as to whether Dr. Azaran complied with or deviated from the standard of care between his first involvement of January 13th, 1995, and the end of his involvement in this case February 1, 1995 - excuse me, February 20th, 1995?
A. Yes, I did.
Q. Now, Doctor, we'll talk about those opinions in a minute.
Is hyperglycemia and hypoglycemia known issues with respect to diabetes?
A. Yes, they are.

Q. Can you tell me what the difference is and potentially how the complication are associated with each and every one of those conditions?
A. Hyperglycemia, a high blood sugar, can lead to many pertubations, disturbances in the normal functioning of the human body.
If it is extraordinarily high, you can have as osmotic diuresis. That's the first thing that a patient will notice. An osmotic diuresis is a profuse production of urine. The kidney is supposed to return sugar from the bloodstream after it filters it back into the bloodstream. But when confronted with a very high blood sugar, some of it spills in the urine and the kidney is unable to retrieve all of it and the sugar will take water with it so that the patient will produce a very large volume of urine, they will urinate excessively and generally also develop a thirst and that's usually the first presentation of diabetes.
If the patient is allowed to drink naturally, they will function normally for a given time. If for any reason fluid is withheld, then the disturbance will lead to dehydration and loss of blood pressure, kidney failure and then cascading, going onward from there.
There are many, many other manifestations of hyperglycemia. When the blood sugar gets high, the pancreas is then stimulated to produce more insulin.
If the pancreas can produce insulin, it's a Type II diabetes, then you'll set the condition of a high insulin level also known as hyperinsulinemia. The high circulated insulin level itself is also harmful to the body.
Q. How's that?
A. It appears that the higher the insulin level is, the more nerve damage occurs and perhaps even more blood vessel damage occurs.
So the reaction of the body to the high glucose level which is by producing more insulin is also deleterious.
Some of the newer treatments we have today which were not available in 1995 - .
Q. Let's just talk about the 1995 treatments, Doctor.
And if I could ask you to keep your voice up a little bit. I'm having a little trouble hearing you and I want to make sure that I can hear everything you have to say.
Doctor, I cut you off. You didn't talk about hypoglycemia.
A. Hypoglycemia is a low blood sugar. When the sugar drops too low and, again, body tissues are going to be disturbed, primarily muscle tissue which uses the majority of our glucose or metabolism for energy, so there will be a weakness.
If the hypoglycemia is allowed to go further, then even the brain will start to malfunction. The brain is the only tissue in the body that actually does not need insulin in order to utilize glucose. Every other tissue does.
It's a protective mechanism. So that if there's a very low blood sugar, the body naturally shuts down its own insulin production and so that the muscles don't get either insulin or sugar, but the brain gets whatever sugar is left over.
Q. Can hypoglycemia or does it have any risks associated with it including death?
A. Oh, absolutely.

Q. Now, Doctor, are diabetics at risk generally for any problems in addition to the general population if they're bedridden?
A. Well, they're at risk whether they're bedridden or not.
Q. I guess maybe it's a poorly-worded question.
With a bedridden patient, what additional risks do diabetics have in the general population with respect to the development of bed sores or other complications?
A. Okay. In general, diabetics are predisposed to infection and they're predisposed to vascular insufficiency.
Put that kind of a patient at bed, at bed rest who's somebody who just cannot move about himself, now you're dealing with lungs are not expanding, so you're dealing with a risk for pneumonia, you're dealing with bed sores, the pressure of the body itself compresses the blood vessels, squeezes the blood out and does not allow blood flow in the compressed area.
If the patient has any mental problems or neurologic problems or is drugged or tied to a bed, if the patient cannot move or cannot feel the pain, as happens with diabetics, their nerves malfunction so they don't feel pain the way most of us do, then you are at great risk for bed sores.
Patients like that, it's almost impossible to prevent - all the mechanisms we have in place today still don't prevent bed sores. You have compression of these blood vessels, blood is not getting through there.
The ischemic tissue, the tissue that's not getting oxygen will break down when a patient is moved by the nursing staff, by family members, under their own volition.
The shearing forces of the body rubbing against the bed or bed clothes or against the side rail can cause tissue damage and because of their poor vasculature, they just won't heal.
Q. When you say their poor vasculature, what do you mean?
A. The blood supply is diminished because the blood vessels are so narrow.
Q. And what does the diminished blood supply, what effect does that have on the ability of the body to heal once it develops a bed sore?
A. It makes it almost impossible to heal.
Q. Now, Doctor, are the bedridden diabetics at risk for any additional problems? I think you mentioned pneumonia and bed sores.
If you add to that an in-dwelling Foley catheter to a bedridden patient, what additional risks are attendant to that Foley catheter?
A. Clearly having any instrument inside the body predisposes that part of the body to infection.
If you break the barrier between the outside and the inside, whether it's with an IV line or a Foley catheter in the bladder, the diabetic because of their nerve problems and neuropathy will also lose control of their bladder a lot sooner.
So they are unable to void voluntarily and empty completely. So they are much more likely to require a Foley catheter, an in-dwelling catheter of the bladder. And, again, that's an avenue for infection.

Colonization of the bladder, the presence of bacteria in the bladder is universal when the catheter is used.
Infection where the body is not responding to an overwhelming presence of bacteria with white count with a fever, that is a consequence that comes later.
Q. Doctor, are you telling me that everyone who has a Foley has bacteria in their system?
A. Pretty much, yes, in their bladder. I don't know what you mean by system.
Q. I'm sorry, in their bladder?
A. Yes.
Q. And that's regardless of whether or not they're infected?
A. Correct.
Q. Can you explain that to us?
A. Our bodies are colonized all over with bacteria, but we don't consider ourselves infected. Our hands have bacteria, our mouths, every mucous membrane has bacteria. Our colon is full of bacteria.
The urine of a patient with a catheter in is going to have bacteria in it. Our stomach has bacteria. Our small bowel has a beneficial bacteria we cannot live without.
Q. Doctor, in reviewing Mr. Carter's case, what did you discover about his medical condition before January 13th, 1995?
A. Before January 13th, I believe he was a man with severe Alzheimer's disease. The description was that he was not communicative, his speech was really gibberish, he was hard to direct and redirect by the nurses at the nursing home.
He started somewhere around that time having problems with his gait, I believe he started stopping, he was losing balance or stooping forward to regain some balance.
And I think shortly thereafter he began to fall. There was actually a history of falls before then. I remember reading something about nurses wanting to put safety devices on Mr. Carter. There was some passage that the wife didn't want him tied down, but the nurses were afraid of him falling, but there were several falls before that and subsequent to that also.
Q. And eventually did he suffer a stroke?
A. It appears he suffered a stroke, yes, probably more than one, but at least one.
Q. Was that about December 10th or December 14th, 1994?
A. December or January.
Q. Was that the December admission to St. James Hospital?
A. Yes, I believe so.
Q. Doctor, from the time he suffered a stroke until January 13th, did the records reveal that he had suffered any urinary tract infections?
A. I believe there was at least one incident recorded of what's called urosepsis, infection of the bladder.
Q. And what's the difference between a urinary tract infection and urosepsis?
A. Urosepsis is really used a little too loosely by most young physicians I come in contact with.

Urosepsis really implies that the individual is quite ill, the high fevers, profuse sweating, you know, frequent uncontrolled urination, a painful urination sometimes associated with a high white count, a drop in blood pressure.
A urinary tract infection as many of us have had experience with either personally or family members, a little burning when you urinate, frequent urination, nighttime urination, three days of pills and it's cleared up.
Q. And was there any evidence of pneumonia between December 10th and January 13th?
A. I don't remember that.
Q. Now, Doctor, was Mr. Carter dehydrated at all during his admission to St. James Hospital?
MR. SHAPIRO: Objection, irrelevant.
THE COURT: Overruled.
THE WITNESS: I don't remember dehydration.
BY MR. POWER:
Q. And, Doctor, with respect to the status of his vasculature, did it appear to you based on the notes that his vasculature was compromised in December of 1994?
MR. SHAPIRO: Objection, leading.
THE COURT: Sustained.
BY MR. POWER:
Q. What did you notice, if anything, about the status of his vasculature between December 10th, 1994, and January 13th, 1995?
A. I think he already had skin breakdown on his buttocks, so I would assume from that he's already had vascular compromise.
He also was described as having Alzheimer's disease. I don't know how rigorously that diagnosis was arrived at.
Reading these records over the three, four-month period there was a decline in his mental function and it appeared to me at least in this little snapshot of this man's life appeared to be a step-wise progression.
Alzheimer's disease, the diminution of cognitive function, it's a very gradual downhill course in a dementing process that is caused by multiple strokes.
We see more of a step-wise where there's a sudden drop off and a leveling and then another sudden drop off versus a slow -
MR. SHAPIRO: Your Honor, objection, Rule 213.
THE COURT: I'll sustain it as to the narrative summation.
BY MR. POWER:
Q. Doctor, how would you characterize his Alzheimer's as of December 1994?
A. In December of 1994, Mr. Carter was not given credit for speaking. He was already described as having lost weight. His gait was compromised, he was falling.
So he was already an advanced case of dementia. Again, I don't know that he had true Alzheimer's, but he had a dementing process.

Q. Doctor, based on your review of the December 1994 St. James Hospital records, did he also have spinal stenosis or something that happened to his neck?
A. Yes. After one of his falls when he developed weakness in both legs, there was an investigation of his cervical spine and there was some evidence that he had stenosis of the spine, the bone had encroached upon the spinal cord, there was some disks out of place also that were also compressing the cord. So there were several reasons for him to develop weakness at that point.
Q. From the time he was diagnosed with this bone compressing the cord, did you ever see any evidence that he was able to walk again?
A. No, I did not.
Q. Now, Doctor, what did you notice, if anything, about his diabetes management during that admission?
A. It really did not seem very remarkable. His sugars were kept under relatively good control, the ones that I saw and I don't remember specifically, but there was just nothing extraordinary.
He was being treated with a long-acting insulin, the NPH insulin and there was just nothing remarkable about it.
Q. During that admission, did he also receive some Humulin R sliding scale?
A. Yes.
Q. And, Doctor, based on your review of the chart, despite those medications, did he develop the problems that we just talked about?
MR. SHAPIRO: Objection, leading.
THE COURT: Sustained.
BY MR. POWER:
Q. What problems did he develop during that admission despite the fact that he was on N and R?
MR. SHAPIRO: I just object to what admission we're talking about.
THE COURT: Sustained.
BY MR. POWER:
Q. Dispute being on Humulin N and Humulin R, what problems did Mr. Carter develop, if any, during the December 10, 1994, admission to St. James?
A. Well, his ulcers got worse. I believe he needed more debridement. There was some mention of some redness and dryness of his heels which would qualify him as a Stage I decubitus ulcers of his heels.
His mental status, just, you know, did not improve. It gradually worsened. He had at some point been self-feeding and then needed help being fed. So despite being treated, there was still some evidence of deterioration.
Q. Now, Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether Mr. Carter suffered any of these problems as a result of his diabetes and the problems we talked about before January 13th, 1995?
A. 1 wouldn't know.

Q. Well, from your review of the records between December 10th, 1994, and January 13th, 1995, do you have an opinion as to whether Mr. Carter suffered any of the above problems that we just talked about as a result of his diabetes?
MR. SHAPIRO: Objection, asked and answered. He said he didn't know.
THE COURT: Overruled. BY MR. POWER:
Q. Go ahead.
A. It appears that these problems continued despite being treated adequately for diabetes.
Q. Did you - strike that.
Doctor, can you tell me generally what relevance does food intake have for the need for insulin whether it's long-acting or short-act ing?
A. You know, food will contain carbohydrates, starch, sugar, all the same substance essentially and as that's absorbed into the bloodstream, we would need insulin in order to move it from the bloodstream into the tissues. We cannot move it out of the bloodstream without insulin.
So as food is absorbed, as the starches are broken down into the individual glucose molecules, we need insulin to utilize it.
Q. And, Doctor, if food intake is decreased in the absence of any other problems, what does that do to the need for insulin?
A. Well, then you have to reduce either the production of insulin within the *pancreas* or the administration of insulin.
Q. Doctor, what can occur if too much insulin is in the body when food intake is low?
A. Then the individual becomes hypoglycemic, the blood glucose drops, the nerve tissues, muscle tissue and eventually brain tissues can begin to starve.
Q. Doctor, there's been some discussion about Type I or Type II diabetes.
Can you, first of all, tell us what a Type I diabetic is?
A. Type I diabetic tends to be a younger patient, as young as ten years old, even younger. These people have essentially a complete shutdown of production of insulin in their pancreas. They must have insulin to survive. Without it, they won't live.
Type II diabetes is a much more common form of diabetes that we see in the adult. The onset tends to be in the third, fourth, fifth decade of life and then just continues on and accelerates after that.
Type II diabetics have either an insufficient production of insulin in their pancreas or their tissue where the insulin acts to allow glucose into the tissue as a resistance to the effect of the insulin. It's insulin resistant.
If you think of insulin as a key to a lock, then Type I is not enough keys or no keys being produced and Type II, there are not enough keys and their locks are rusty.
Q. Doctor, is a Type II diabetic in your opinion someone who is insulin dependent?
A. Not insulin dependent per say. There are some Type II diabetics who are better treated with insulin, but they do survive without it.

They do produce their own insulin and if you can stimulate either more production of insulin from their pancreas through one group of medication or can reduce the resistance to the insulin with another group of medication, then they should not need supplemental insulin.
Q. Doctor, did you arrive to an opinion to a reasonable degree of medical certainty as to which classification Mr. Carter fell in?
A. He clearly falls as a Type II.
Q. In your opinion, was he insulin dependent as a lifeline to sustain life?
A. No, I don't believe so.
Q. What do you base that on?
A. I believe that he went without insulin from the 1st of February to the 20th of February at Imperial and he survived.
Q. Doctor, if he was a Type I diabetic, would he have been able to survive?
A. Oh, absolutely not.
Q. Now, Doctor, I'd like to turn your attention to the January 13th to January 18th admission to Imperial, which I believe you have in front of you.
A. Yes, sir.
Q. And simply refer to the discharge transfer sheet to Ingalls.
First of all, was Mr. Carter on Humulin N 22 units while he was at Imperial between January 13th and January 18th?
A. May I look at the record?
Q. Sure. Take your time.
A. Yes, he was.
Q. And can you tell us the stage he was in at the time of the transfer from Imperial to Ingalls at the end of that short admission?
A. Mr. Carter had fever of unknown origin, he had had that CVA and I believe that was the reason for the admission, the fever.
Q. Was it your understanding that he was diagnosed as having a urinary tract infection in the hospitalization at Ingalls after the January 18th transfer to Ingalls?
A. Yes, sir.
Q. And, Doctor, did that occur when he was on or off Humulin N?
A. He was on Humulin N at the time.
Q. Doctor, do you have an opinion to a reasonable degree of medical certainty whether 22 units of Humulin N was appropriate to manage his diabetes at that time between the 13th and the 18th?
A. It appeared to have been appropriate.
Q. Now, Doctor, to a reasonable degree of medical certainty - you were aware that Dr. Azaran was Mr. Carter's treating physician during that January 13th admission?
A. Yes.
Q. Do you have an opinion to a reasonable degree of medical certainty as to whether Dr. Azaran complied with the standard of care in continuing the admitting orders to Imperial for Humulin and 22 units during that admission?

A. I believe he complied with all the standards, sure.
Q. Doctor, once he was transferred to Ingalls on N, if you look next to the February 1 transfer sheet back to Ingalls or - excuse me, back to Imperial.
If I can direct your attention to Defendant's Group Exhibit 1. It should be the Imperial Nursing Home records from the February 1 admission.
A. Okay.
Q. And I'd ask you to look at the transfer sheet.
A. Okay.
Q. Which I believe is stamped at Page 140 and 142.
A. Yes, I have it.
Q. What did you note with respect to the type of insulin and coverage he was on when he came back to Imperial on February 1?
MR. SHAPIRO: Objection to the question, what he was on.
THE COURT: Sustained.
BY MR. POWER:
Q. What type of insulin or blood glucose monitoring orders were in effect on February 1 at the time of transfer from Ingalls to Imperial?
MR. SHAPIRO: Objection, it's to time frame and fact.
THE COURT: Sustained.
BY MR. POWER:
Q. On February 1, based on that transfer order, can you tell me what orders were in effect for insulin coverage for Mr. Carter at the time of his transfer?
MR. SHAPIRO: Objection.
THE COURT: Sustained.
BY MR. POWER:
Q. Doctor, can you tell me what you noted, if anything, about the transfer sheet with respect to the discussion of insulin coverage or blood glucose monitoring on that sheet on Page 142?
A. On Page 142, the insulin has been changed to insulin R, the faster-acting insulin and monitoring has now been ordered to be done four days a time, once before each meal and once before bedtime.
Q. And, Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether that order on February 1 complied with the standard of care for the management of Mr. Carter's diabetes on February 1 when he was admitted to Imperial?
MR. SHAPIRO: Objection. It's not an order. The form of the question.
THE COURT: Overruled.
THE WITNESS: I believe it's quite adequate, yes.
BY MR. POWER:
Q. And, Doctor, had those orders been carried out the entire admission to Imperial, do you have an opinion to a reasonable degree of medical certainty if those were the orders and

those were instituted whether Dr. Azaran complied with the standard of care for the management of the diabetes during that admission?
A. Yes, he would have.
Q. Doctor, what, if any, orders did he have with respect to diet based on the transfer sheet?
A. The diet that was ordered on the transfer sheet was a puree diet with a low sodium content and low salt content.
Q. And, Doctor, based upon the physician's order sheet from February 1, what information did you obtain with respect to the calorie counts and the type of feeding that was to be instituted for Mr. Carter at Imperial during that admission?
A. Dr. Azaran ordered a calorie count to be measured.
Q. And was that - when was that ordered?
A. February 1.
Q. And, Doctor, can you tell us, and I believe it's in front of you, what did the calorie count show for his intake when he was readmitted to Imperial for the days that the calorie count would be done?
A. Do you know offhand what page that's on?
Q. I don't believe you're going to find it on the numerical pages. I believe it's -
MR. POWER: If I may have a moment, your Honor.
BY MR. POWER:
Q. I would direct your attention to Page 194.
A. Page 194. For day one, Mr. Carter consumed close to 800 calories the first day, close to a thousand calories the second day, on the third day he has an incomplete record but for two meals, about 800 calories for two meals out of the three.
Q. Now, Doctor, based upon the oral things that are referenced in the calorie counts, do you have an opinion as to a reasonable degree of medical certainty whether the treatment with Humulin R -and blood glucose monitoring and four meals a day before bedtime was appropriate for that admission?
MR. SHAPIRO: Objection, Rule 213.
THE COURT: Sidebar please.
(Whereupon, the following proceedings were had in chambers outside the presence and hearing of the jury:)
THE COURT: Will you read the question please?
(Whereupon, the record was read as requested.)
MR. SHAPIRO: Your Honor, my objection is that he never explored the basis of his opinion on the calorie counts.
MR. POWER: Judge, he said he looked at the entire chart and his clinical situation - it's based on his entire clinical condition at that nursing home based on these very records that Mr. Carter's blood glucose monitoring four times a day and Humulin R was appropriate.
It was disclosed. He went into it in his dep, he just went into it on direct. I mean it's already in evidence that this is the clinical factual scenario he was faced with during this admission when he said Humulin R was appropriate.

MR. SHAPIRO: Judge, the problem is he's already been asked the question whether management, the way Dr. Azaran gave him Humulin R and blood glucose four times a day was appropriate, he said it was.
Now, he's asking another question and now he's asking whether that management was appropriate on the basis of the calorie counts. That was never disclosed. This is a whole new theory that the defense has come up with at the time of trial that there was some change in the management based on these calorie counts.
At the time of his deposition, and I'll show this on cross-examination, Dr. Danko's opinion from reading Dr. Azaran's deposition was that he intended the patient to be on Humulin N, plus the Humulin R.
So this whole concept of calorie counts was never disclosed, he certainly never disclosed that as being the basis of his opinion.
Now, this objection of defense counsel is that now that there's reduced calorie counts, it's a whole different ballgame and that's just something that was never disclosed, never discussed at his deposition under Rule 213.
THE COURT: Is there an opinion with regard to the calorie counts in addition to the Humulin R and the blood glucose monitoring?
MR. POWER: Did he specifically refer to calorie counts?
THE COURT: You're asking for a specific opinion.
MR. POWER: Actually, Judge, it's almost in light of this, he said yes, not that is this a new basis. This is one of the critical factual items that he looked at. He said he looked at the entire chart.
He said there was no clinical change in this man's condition, that I will get into toward the end of my direct-exam, and that Humulin R in the like of this clinical scenario day by day was appropriate for this patient.
I guess what Mr. Shapiro is now saying is that I can't ask him anything about basically the clinical condition because Mr. Shapiro didn't talk to him about what the clinical condition was that he faced on a day-to-day basis.
I agree that I have to disclose opinions. My opinion was based on the clinical condition of this patient during this admission.
THE COURT: Read the question back please.
(Whereupon, the record was read as requested.)
THE COURT: And has he given an opinion with that as a basis?
MR. POWER: Specifically -
MR. SHAPIRO: Sorry, Counsel, no.
THE COURT: The objection is sustained.
(Whereupon, proceedings were held in open court.)
THE COURT: The objection is sustained.
BY MR. POWER:
Q. Doctor, would you agree with me that there would be no circumstance that you believe would be appropriate where you can discontinue insulin and monitoring on Mr. Carter?

A. I would agree, yes.
Q. And if Dr. Azaran did so, you believe he deviated from the standard of care, is that fair?
A. Yes.
Q. Is there any evidence based on your review of Dr. Azaran's testimony that he believes that he discontinued monitoring?
MR. SHAPIRO: Objection. He's asking to comment on the witness' testimony.
THE COURT: Would you read the question back please?
(Whereupon, the record was read as requested.)
THE COURT: Sustained as to the form of the question.
BY MR. POWER:
Q. Doctor, based on your review of Dr. Azaran's testimony, what did he testify to as to whether he continued or discontinued the blood glucose monitoring plus the Humulin R sliding scale?
A. In Dr. Azaran's deposition, he repeatedly stated that he wanted to continue the insulin treatment and monitoring that was ongoing at Ingalls Hospital.
Q. Doctor, I'd like to talk about the clinical condition of the patient regardless of whether the insulin was given or not given.
Did you find any evidence of clinical deterioration between February 1 and February 20?
A. I believe that the feeding became more difficult. I think the nurses were having a harder time with him as far as being less communicative. He was essentially vegetating in bed. There was several references that he was alert but not responding.
Q. Doctor, you're aware that Dr. Azaran saw the patient on the 16th for decubitus ulcers?
A. Correct.
Q. Doctor, do you have an opinion as to a reasonable degree of certainty as to whether Dr. Azaran needed to review the entire chart for that visit?
A. He was called in to see a specific problem. He had just seen the patient two weeks earlier. So no, I don't believe a full examination and a full review of the chart was warranted at that point.
Q. And, Doctor, if he failed to review the entire chart, did he comply with the standard of care when he dealt with the decubitus ulcers?
A. No, he did not fail to comply.
Q. I'm sorry. My question was, did he comply with the standard of care if he did not review the entire chart on the 16th when he dealt with decubitus ulcers? Bad question.
On the 16th, based on his limited review to focus on the ulcers, did he comply with the standard of care?
A. Yes, I believe he did.
Q. Now, Doctor, do you have an opinion as to a reasonable degree of medical certainty as to why this patient was transferred on February 20, 1995, from Imperial to Ingalls?
A. The nurses became alarmed when his blood glucose monitoring showed to be excessively high. This followed a half a day or a day of his taking in even less foods than previously, so the nurses were alerted to a change in his condition.

Q. And when the BGM came back HHH, was the patient then transferred?
A. Yes, he was.
Q. Doctor, do you have an opinion to a reasonable degree of medical certainty as to why the blood glucose reading was HHH in Mr. Carter on February 20th, 1995?
A. He had developed an infection again and very typically when a diabetic develops an infection, the blood glucose rises precipitously.
Q. Doctor, in your opinion to a reasonable degree of medical certainty, was the patient's admission to the hospital due to the infection?
A. Yes, it was.
Q. And can you tell me the basis for that?
A. With the diabetes that badly out of control due to infection, you have to treat the infection aggressively.
Q. Doctor, he had a urinary tract infection on admission?
A. Yes.
Q. And was that urinary tract infection treated by Dr. Santos?
A. I believe it was, yes.
Q. Do you have an opinion to a reasonable degree of medical certainty as to whether the urinary tract infection was either caused by or exacerbated by the hyperglycemia that was seen on February 20th, 1995?
A. I don't think it was caused by or exacerbated by the hyperglycemia. I think the converse would be true, that the hyperglycemia was caused by the urinary infection.
Q. Can you tell me the basis for that opinion?
A. It's really a daily occurrence in diabetics whether they develop a urinary sepsis, a pneumonia or just a cold.
Typically, a patient will call and tell me that they're not eating, they've got a cold, a sore throat, they've lost their appetite, what should they do with their insulin.
And I advise them to stay with it because, if anything, they're going to need more that day. The stress on the body of an infection actually causes more sugar to be released from stored supplies.
We've got some sugar stored in our muscles, some stored in our liver. You can create sugar for fasting. And under the stress of an infection, our blood sugars will rise.
And so my advice to my patients is to take their insulin. I don't raise it because I don't know how far to raise it at that point. So I tell them to stay the course.
Q. Doctor, this patient had the hyperosmolar hyperglycemic state on admission to Ingalls?
A. I believe he did, yes.
Q. Do you have an opinion to a reasonable degree of medical certainty as to the cause of the HHS?
A. He was hyperosmolar because his sugar had risen. He was also hyperosmolar because he a mild dehydration and his blood urea nitrogen had risen. You know, those will raise the blood to osmolarity level.
Q. On admission to Ingalls, do you know how long the HHS was present?

A. I calculated that through the 25th. It began to diminish on the 25th.
Q. Doctor, on admission to Ingalls, did you note lower lobe abnormality found by the physicians?
A. There was a left lower lobe abnormality described that Dr. Santos attributed to atelectasis which is a compression of the lung tissue so that it's more prominent on X-ray.
And I believe there's also an abnormality of a pneumothorax on that side. There was some air leak between the lung and the chest wall on that side. The pneumothorax can cause an atelectasis.
Q. Clinically, did you see any change in his condition due to the pneumonia?
A. There was no evidence on admission that I could see from the chart that Mr. Carter had pneumonia, he was not short of breath, he was not described as being short of breath, he wasn't coughing profusely.
So there didn't seem to be evidence as reported in the chart of a pneumonia at that time.
Q. Doctor, with respect to the urinary tract infection, that was found on admission?
A. Yes, it was. The urine cultures grew out significant numbers of a urinary pathogen and Dr. Santos instituted measures to treat it.
Q. Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether the infection that was found at Ingalls on February 20th was a new infection, an acute infection or a chronic one?
A. I believe it was a new infection. He had previously been treated for a urinary infection and I believe a different organism was grown at that time.
I don't recall offhand which one, but it was not the Providencia that was grown out on the 20th of February.
Q. What effect, if any, did the finding of neutrophils have on your opinion that it was acute versus chronic?
A. He had an elevated white blood count. The neutrophil count was high upon admission and subsequently came down so it looked like a new onset of infection.
Q. I'm sorry, a new onset -
A. A new onset of infection.
Q. What would you normally expect to see with neutrophils if it was a chronic infection?
A. Well, it wouldn't really be elevated to begin with. Chronic infections tend to be rather indolent and so you would see a baseline white count whether above normal or not and then it wouldn't necessarily change if the treatment wasn't effective.
Q. Doctor, you know there is some reference to a nontransmural MI and myocardial infarction- in the Ingalls records?
A. Yes, I saw that.
Q. Do you have opinion within a reasonable degree of medical certainty as to whether one actually occurred?
A. I'd be hard pressed to conclude that a MI occurred.
Q. Can you tell us why?
A. Well -

MR. SHAPIRO: Objection, Rule 213.
THE COURT: Sidebar.
In fact, ladies and gentlemen, take a recess for a few minutes.
(Whereupon, a short recess was taken.)
(Whereupon, the following proceedings were had in chambers outside the presence and hearing of the jury:)
MR. SHAPIRO: Judge, in his deposition when asked if the patient had a myocardial infarction, Dr. Danko said I would be very hard pressed to say yes or no on this matter.
Now, he says that - now he says in court that he would be hard pressed to say that he had a myocardial infarction, which to me is attempting to say that he didn't have one.
MR. POWER: If you read his entire answer instead of just the first sentence, you can see where he says I know there's an elevated myocardial band determined at the hospital, but there was no clinical evidence recorded. Nobody recorded a low blood pressure or unusual heartbeat, the EKG didn't change. So basing strictly on the MB band of a slightly elevated CPK is very hard to do to diagnose an MI.
That's exactly what he'll testify to today.
THE COURT: The objection is overruled.
(Whereupon, proceedings were had in open court.)
THE COURT: You may be seated. The objection is overruled.
MR. POWER: Your Honor, may I have the last question read back so that the witness could testify as to -
THE COURT: Could you read the last question and answer, if there was one.
(Whereupon, the record was read as requested.)
THE COURT: You may answer the question.
THE WITNESS: The only evidence that there was any cardiac event on the chart was an elevation of Mr. Carter's CPK. That's a blood test, creatinine phosphokinase.
And that's enzymes released from muscle when it's damaged. Heart muscle releases a slightly different band that we call myocardial band or the MB band.
When that's measured, it gives us an indication of whether there's been any significant heart damage or not.
At best it's been an unreliable test. In Mr. Carter's case, the elevation was not really significant.
BY MR. POWER:
Q. Doctor, was there any evidence of low blood pressure or an unusual heartbeat?
A. There was nothing recorded to make me think that there was any heart malfunction at all with either an abnormal heartbeat which can go along with a heart attack nor a drop in blood pressure, and I think they did an echocardiogram on that same day looking for heart dysfunction.
And in the echocardiogram, the main measure that we're looking for is how efficient is the heart, the left ventricle of the heart as it's ejecting blood.

Normal is between 50 and 70 percent. Mr. Carter's ejection fracture was measured at actually 80 percent. So there really was no indication of any heart dysfunction.
Q. Doctor, with respect to the issue of dehydration, you would acknowledge that Mr. Carter did come in dehydrated?
A. There were a couple of indications that he was dehydrated, even though his blood pressure never fall as a result of it.
His BUN, the blood urea nitrogen, was elevated and that indicates that there was some kidney dysfunction secondary to a drop in circulating volume.
And his urine output, I believe the last day at Imperial was down to 500 cc's, if I recall correctly.
So there was a lower output. The blood test showed a little bit of kidney dysfunction at that point, so yes.
Q. So, Doctor, what effect, if anything, did his long-standing vascular disease have on the BUN value?
A. In diabetics, the larger blood vessels now come into play, the macrovasculature along with the microvasculature we talked about earlier.
So they have less of a reserve in the long run over the decades that they have their disease, they have a much lower reserve so they don't withstand loss of volume as well as the non-diabetic patients would.
Q. And, Doctor, do you have an opinion as to whether the BUN elevation given the fact that Mr. Carter was a diabetic was a significant elevation
A. It really wasn't. Most patients at age 85 with diabetes, I would expect them to have a higher BUN to start with.
But in his case, he had had a normal BUN before this incident. And after he was rehydrated two or three days later, his BUN was right back down to normal again.
Q. Now, Doctor, do you have an opinion as to a reasonable degree of medical certainty as to what you would expect to see clinically in Mr. Carter if his blood sugars were elevated at 5 or 600 for a long time?
A. He would have had the hyperosmolar diuresis I described earlier, his kidneys would have been unable to retain the glucose that was filtered out of the blood so that the urine would have been excessively rich in glucose and he would have made excessive amounts of urine.
He would have had a polyuria, his Foley bag would have filled up very quickly and very often would have to be emptied. His blood pressure would clearly have fallen.
He would have gone into kidney failure and he probably couldn't survive two, three weeks of blood glucose at either 500 or higher.
Q. Did you see any evidence of those types of problems develop in Mr. Carter while he was at Imperial?
A. No, there was nothing in the chart to indicate that.
Q. Doctor, did you - or what, if any, characteristic odor would you expect to find in the patient who had high blood sugars for an extended period of time?
A. I don't know that there's a characteristic odor that goes along with a high sugar.

The urine can become malodorous if it's very concentrated. So later on when you become dehydrated, there would be.
If you're dealing with a Type I diabetic, when they become ketonic, when their body starts to create ketones now in order to feed itself, the ketones have a very distinctive fruity smell and people at the bedside will notice that immediately.
But that's a Type I diabetic. It wouldn't apply here to Mr. Carter.
Q. Now, Doctor, do you have *an* opinion - or strike that.
The records reflect that Mr. Carter began to suffer a right lower lobe pneumonia and defective decubitus ulcers after February 27th.
Do you have an opinion to a reasonable degree of medical certainty as to whether those problems are related to the hyperglycemia on 2/20/95?
A. I don't believe they are related. The hyperglycemia was corrected and days later he developed these problems.
You know, reading this chart, if he had not had the urinary tract infection on the 20th, he probably would have developed a pneumonia on the 27th and been hospitalized regardless.
Q. And that's the right lower lobe?
A. The right lower lobe pneumonia, correct.
MR. POWER: Actually, Doctor, I have no more questions for you. Thank you.
THE COURT: Is there any cross-examination?
MR. SHAPIRO: Yes, there is.

CROSS-EXAMINATION

BY MR. SHAPIRO:

Q. Good morning, Dr. Danko.
A. Good morning, Mr. Shapiro.
Q. Is it true that you have no particular specialized training or expertise in diabetes?
A. That's correct.
Q. Those medical people who are specialists in diabetes are called endocrinologists, correct?
A. Yes.
Q. And you're not trained in that field, correct?
A. No, sir.
Q. And when you told counsel that you teach at Rush Medical College, am I correct that that is only one day a month?
A. During this part of the year, it's only one day a month. During the other quarters, it's once a week.
Q. Your curriculum vitae lists no research. You're not involved in medical research?
A. No. I'm not.
Q. No lectures listed in your curriculum vitae?
A. I had given the medical students lectures on pharmacology several years ago, but the course director who invited me to give those lectures no longer is the course director so I haven't been invited to do so.

Q. And no lectures to your peers, other doctors, correct?
A. There have been cases where I have given lectures but that's usually informal settings at dinners where I'm invited to talk about certain changes in medications but nothing formal.
Q. And no list of publications, any referee medical journals or textbooks, correct?
A. That's correct.
Q. And when you told counsel that having patients who are diabetics in nursing homes was a very frequent occurrence, isn't it correct that, for example, at the present time you only have three patients total in nursing homes?
A. That's correct.
Q. Now, is it correct that you have been reviewing medical/legal files for lawyers for 20 years?
A. correct.
Q. And you've testified in court exclusively for defense, correct?
A. Well, I actually made a mistake when I said that on my deposition.
The very first time I testified in court was on behalf of the plaintiff, so I apologize for my mistake.
Q. When you testified before, you considered yourself to be representing the defense, correct?
A. In the cases where I represented the defense, yes.
Q. And you've also given various depositions, most of those have been for the defense too, correct?
A. The majority of my calls for help with charts have come from defense attorneys.
Q. Now, I think you said you charge 250 an hour for review and $500 an hour for depositions and trial. And I think you said you had about 12 hours and that was before your deposition, correct?
A. That's correct.
Q. Then how much time did you spend preparing for and giving your deposition?
A. Including the deposition?
Q. Yes, sir.
A. Up to this moment in time, up to trial date?
Q. Up through the deposition.
A. Up through and including the deposition?
Q. Yes, sir.
A. Probably 14 hours.
Q. So that was another 14 hours?
A. No, not - I thought it was inclusive. I'm not understanding your question.
Q. So now you're giving us - you said about 12 hours before you furnished opinions to Mr. Power, correct?
A. Correct.
Q. Then you had to give a deposition on August 10th, correct?
A. Correct.

Q. And you had to prepare for that deposition?
A. That preparation was the full 12 hours I talked about. Up to the deposition, I spent 12 hours on the case.
Q. And then how many hours did you spend in the deposition?
A. I believe that was a two-hour meeting.
Q. And then how much time have you spent in between the deposition up to today?
A. Oh, maybe another eight to 10 hours.
Q. And how did you do your billing for this trial, from the time you leave your house or sitting in the courtroom, how does that work?
A. From the time I'm sitting in the courtroom. I wouldn't - I don't ever charge travel time.
Q. Doctor, is it correct that diabetes interferes with the body's ability to fight infection?
A. Oh, we've known that for a long time, yes.
Q. Now, will you agree that Dr. Saharan did not order Humulin N and if he asked Traci Foster, as she testified, to discontinue the blood glucose monitoring and the Humulin R that he would have committed malpractice?
A. Yes.
Q. Now, you agree that from your review of the records, Dr. Azaran never ordered Humulin N, correct?
MR. POWER: Objection as to the time frame.
THE COURT: Sustained.
BY MR. SHAPIRO:
Q. During the admission from February 1st to February 20th at Imperial from your review of the records, will you agree that Dr. Azaran never ordered Humulin N?
A. That's correct.
Q. Now, I take it then that your opinion that Dr. Azaran complied with the standard of care is based solely on the assumption that he ordered blood glucose monitoring and sliding scale Humulin R insulin, correct?
A. Yes.
Q. Am I also correct that in your review of the records, you saw no record that during the admission of February 1st to February 20th that Dr. Azaran ever ordered blood glucose monitoring before meals and before bedtime and sliding scale Humulin R insulin?
A. I believe I saw a telephone order to that effect.
Q. You saw a telephone order to give blood glucose monitoring and sliding scale Humulin R?
A. Yes. And then I believe there's a controversy over who wrote the discontinue notation on the top of those orders.
Q. Can you show me where an order is that doesn't say to discontinue that?
A. No, sir.
Q. So there is no such order, correct?
MR. POWER: Objection.
THE COURT: Sustained.
BY MR. SHAPIRO:

Q. You didn't see an order in the chart saying give blood glucose monitoring, give sliding scale insulin for the February 1st admission to Imperial, did you?
MR. POWER: Objection.
THE COURT: Overruled.
THE WITNESS: Okay.
BY MR. SHAPIRO:
Q. Yes?
A. Yes.
Q. Now, would you agree that even if such an order had been given, that the standard of care would require the doctor to check the blood glucose readings to see if the patient was getting Humulin R, whether he was constantly getting Humulin R to see whether he needed to have any medications changed, diet changed, et cetera?
MR. POWER: Objection as to time frame.
THE COURT: Sustained.
BY MR. SHAPIRO:
Q. Would you agree with me that if assuming for the question that Dr. Azaran had ordered simply blood glucose monitoring and Humulin R, that it would have been his responsibility on a periodic basis during that admission to check the results of the blood glucose to see if the patient was receiving - whether his blood glucose was out of the control, whether he was receiving frequent injections of Humulin R or not?
MR. POWER: Objection, compound form and time frame.
THE COURT: Overruled.
THE WITNESS: The physician's responsibility is shared with nursing responsibility. These are orders given to the nurses to monitor the sugars.
BY MR. SHAPIRO:
Q. Excuse me, Doctor. I'm not asking you about the nurses. I'm asking you just about Dr. Azaran.
Did he have a responsibility to check the blood glucose levels to see whether or not the nurses had to frequently give the patient Humulin R?
A. It would depend on his comfort level with the nurses.
If he was not comfortable with them, then yes, he would check to see what they were monitoring and what they were giving.
If these were nurses he knew, if these are nurses that I know and in the case of my patients, I would rely on them if I found them reliable nurses.
Q. Well, Doctor, regardless of the reliability of the nurses, assuming that they did the blood - assuming that they ordered it and that they did it and they had to give the patient Humulin R, wouldn't the doctor need to know how often the patient was receiving the Humulin R so that he could make adjustments to the medication, if necessary?
A. Yes.
MR. POWER: Objection to form and time frame.
THE COURT: Overruled.

THE WITNESS: Yes.
BY MR. SHAPIRO:
Q. And did you see any evidence in the record that Dr. Azaran in the whole 20 days when Mr. Carter was there ever check with the nurses to find out how much Humulin R was being given to the patient on a daily basis?
A. No.
Q. Now, Doctor, as I understand it, as part of your preparation for this case, you were given and you reviewed the deposition transcripts of Dr. Azaran, correct?
A. Yes.
Q. And when you read those depositions, I take it that you formed understandings about the facts in this case that then became part of the basis of your opinion, correct?
A. Yes.
Q. And would you agree with me that they - and you read both of Dr. Azaran's depositions, correct?
A. No, I think I only had one. I think I had Part 2.
Q. Based upon reading Dr. Azaran's deposition, was it your understanding that Dr. Azaran intended to give Mr. Carter Humulin N when he came into the nursing home between February 1st and February 20th?
MR. POWER: Objection as to relevance, his understanding as to Dr. Azaran's -
THE COURT: Overruled.
THE WITNESS: Dr. Azaran in his deposition stated he wanted to continue the insulin treatment that he had already in place at Ingalls prior to the admission.
BY MR. SHAPIRO:
Q. Okay. Doctor, was it your understanding as to Dr. Azaran's intent with respect to providing this patient with Humulin N that Dr. Azaran was under the impression that the Humulin N was to be given?
A. In his deposition, Dr. Azaran kept repeating that he wanted to continue the insulin that Mr. Carter had been receiving.
I don't recall specifically him saying N or R, but he wanted to continue the insulin treatment.
Q. Doctor, do you recall giving a deposition in this case?
A. Yes.
Q. On August 10th, just a few weeks ago?
A. Uh-huh.
Q. Do you recall the following question being asked of you on Page 25 of that deposition at Line 19?
“Question: What is your understanding as to Dr. Azaran's intent with respect to providing this patient with Humulin N?
Answer: My understanding is that he was under the impression that the Humulin N was to be given.”
MR. POWER: Objection, not impeaching as to time frame.
THE COURT: Overruled.

BY MR. SHAPIRO:

Q. Was that question asked of you and did you give that answer?

A. Yes.

Q. And would you agree with me that if it was Dr. Azaran's intention to give Humulin N to this patient and he neglected to order it, that that would be a violation of the standard of care?

A. If it was his intention to give Humulin N, then yes.

Q. Doctor, I believe that you told counsel on - strike that.

Doctor, let me just ask you this flat out. Would you agree that it was probably a combination of the lack of insulin and the developing uterine tract infection that caused Mr. Carter's hyperosmolar hyperglycemic state?

A. It would be a combination of those events, yes.

Q. Will you also admit that with respect to Mr. Carter's dehydration, that it was probably worsened by the lack of insulin given to him while he was at imperial between February 1st and February 20th?

A. Yes, I would.

Q. Would you also agree that in order to rehydrate Mr. Carter, that the doctors at Ingalls had to pass the central line which then caused a pneumothorax?

A. Yes.

Q. Now, you also testified when counsel asked you that when Dr. Azaran saw the patient on February 16th that it was for the purpose of only examining the decubitus ulcer, do you remember that?

A. Yes, I do.

Q. Where does it say that in the medical records?

A. That's all he did was look at the decubitus ulcer.

Q. Do you have Dr. Azaran's note for that day?

A. Not offhand. I believe all he did was write an order to change the treatment.

Q. Can you turn to Page 160 of the Imperial Nursing Home records for the February 1st admission.

A. Yes.

Q. That's Defendant's Group Exhibit No. 1.

A. I have it.

Q. That's Dr. Azaran's note for the February 16th visit, correct?

A. Well, it's not signed by him so I'm not certain.

Q. Assuming that Dr. Azaran has testified that's his note and that's his name of course at the top of it, that note say anything that this was a limited visit or that Dr. Azaran was only called in to just look at the decubitus ulcer, correct?

A. Correct.

Q. In fact, at that visit as reflected by this note, Dr. Azaran assessed the patient's ability to communicate, correct?

A. Correct.

Q. He assessed his status with respect to being in distress or not?

A. Correct.
Q. He assessed his temperature?
A. Correct.
Q. He assessed his lungs?
A. Yes.
Q. He assessed his cardiac function?
A. Yes.
Q. And he made a note that he was going to check his blood count, correct?
A. Yes.
Q. Now, you also testified I believe that you didn't believe that this patient had pneumonia when he came into the hospital, correct?
A. That's correct.
Q. If we could take a look at the Ingalls admission records from February 20th, that admission.
A. Yes, sir.
Q. And specifically calling your attention to Page 211 which is the emergency room record.
A. I have it.
Q. And do you see the note under radiology, Doctor?
A. Yes, I do.
Q. And isn't it a fact that in the emergency room that he assessed the patient as having a left lower lobe pneumonitis?
A. I believe it says infiltrate.
Q. A left lower lobe infiltrate is pneumonia, correct?
A. No, sir.
Q. A left lower lobe infiltrate has got nothing to do with pneumonia?
A. A pneumonia is one possible cause of an infiltrate.
Q. So it's one possible cause of pneumonia or a symptom of pneumonia, correct?
A. An infiltrate is one possible finding on an X-ray that could be caused by pneumonia. It can be caused by several things.
Q. Well, I'd like to call your attention to Page 215 of the records.
A. Same admission?
Q. Yes. And that is the admitting history and physical examination done by Mr. Winter.
A. I see it.
Q. That is the patient's attending physician, correct?
A. Yes, sir.
Q. And is it a fact that this doctor having gone through the entire history and. physical, that his impression for this patient includes left lower lobe pneumonia by X-ray?
A. That's what he concludes.
Q. And he saw the patient, you didn't, correct?
A. That's correct.
Q. Doctor, can you also turn to Page 220 of the chart.

A. I have it.
Q. That is the consultation note of Dr. Hodgihau (phonetic)?
A. Yes.
Q. He's one of the attending cardiologists for this patient?
A. Yes, sir.
Q. He did a consultation on February 23rd, 1995, correct?
A. Yes.
Q. And he indicates in his review of the patient that the last chest X-ray revealed presence of pneumonia in the left lower lobe, correct?
A. That's what he writes.
Q. And then in his conclusions and recommendations, his No. 5 conclusion is pneumonia of the left lower lobe, correct?
A. That's correct.
Q. Now, I believe you also, while we're sticking with Dr. Hodgihau who's a cardiologist on this case, I believe you said that you would be hard pressed to say that there was evidence of myocardial infarction, correct?
A. Correct.
Q. Would it also be fair to say that you would be hard pressed to say that there wasn't evidence of myocardial infarction?
A. No.
Q. Let me ask you this way, Doctor.
Would it be fair to say that you would be very hard pressed to say yes or no on this matter of myocardial infarction?
A. The evidence here is very flimsy for a myocardial infarction. If I had to choose, it would be easier to choose no, there was not. There was no EKG evidence, there was no physiologic evidence at the bedside that was recorded here. The echocardiogram shows a supernormal functioning of the ventricle.
There is just no evidence of it. This one elevated MB and the whole CPK is elevated because of this other muscle that's being damaged, that's very weak evidence. We don't use it anymore today. It was so unreliable, we dropped it.
Q. Doctor, isn't it a fact that Dr. Hodgihau who is the cardiologist on this case listed in his No. 4 conclusion for this patient quote acute nontransmural myocardial infarction?
A. He did list that, yes.
Q. And using the term acute, that means something that just happened, correct?
A. That's correct.
Q. And is it also correct that not only did Dr. Hodgihau, the cardiologist on the case, diagnose acute nontransmural myocardial infarction, but then he went ahead and treated the patient for myocardial infarction, correct?
A. Yes.
MR. SHAPIRO: That's all I have. Thank you.
THE COURT: Any redirect-examination?

MR. POWER: Yes, your Honor.

REDIRECT-EXAMINATION

BY MR. POWER:

Q. Doctor, you told Mr. Shapiro that currently you have approximately three patients in the nursing home. Can you tell me on an average how many patients are in the nursing home?

A. Before this year, probably five, six, seven at any given time.

I've limited my practice now to one single nursing home, so I no longer follow all my patients as they're distributed to very geographical locations. I really tried to cut it down.

Q. Now, Doctor, you indicated that when you're retained by the defense, you represent the defense.

Does that affect your opinions in any way with regard to whether somebody complied with or deviated from the standard of care?

A. No. I've been critical of defense efforts in the past.

Q. In fact, I think you told us that you testified for the plaintiff in the past?

A. Yes.

Q. And in that case, were you critical of the. defense efforts?

MR. SHAPIRO: Objection, your Honor, irrelevant.

THE COURT: With regard to that question, the objection is sustained.

BY MR. POWER:

Q. When you were retained by the plaintiff, did you have a problem criticizing the physician if in fact you felt it was warranted?

A. No, not at all.

Q. Now, Doctor, do you limit your availability to either the defendants or plaintiffs for reviewing records and giving your opinions?

A. Not consciously, no.

Q. Doctor, we talked about this order on February 1 and whether you actually ever saw an order for blood glucose monitoring and Humulin R.

What is your understanding with respect to whether that order was on the chart and later modified with a DC?

MR. SHAPIRO: Objection, no foundation.

THE COURT: Sustained.

BY MR. POWER:

Q. Doctor, did you review the deposition of Dr. Azaran's nurse, Traci Foster, with respect to whether the BGM monitoring and Humulin R were on the chart for any period of time before the DC was added?

A. Yes, I did.

Q. And what did you learn with respect to whether there was an order in place before the DC was placed on the chart?

MR. SHAPIRO: Objection, Rule 213.

THE COURT: Overruled.

THE WITNESS: From my understanding, there was an order to perform the blood glucose monitoring and there was an order for regular insulin.

BY MR. POWER:

Q. And that's at some later date depending on whoever you believe DC was added?

A. Right.

Q. I'm sorry, at some later time?

A. Right.

Q. Now, Doctor, you were asked about a physician's responsibility to review the admitting. orders - excuse me, the blood glucose monitoring orders and the levels.

Doctor, was Dr. Azaran within the standard of care on February 1 to February 20, 1995, if during that time frame he did not ask the nurses for the chart to review them to determine the blood glucose levels during that time frame?

A. As I told Mr. Shapiro, it depends on Dr. Azaran's comfort level with his nurses.

If he hasn't worked with them before and he found them reliable, then asking them to monitor the glucose is an appropriate thing to do.

And typically it's the nurse that calls the physician and says I'm giving insulin four times a day, the sugars are high.

This is taxing on my time to have to administer this often or it's uncomfortable for the patient to receive this so many times.

If one is comfortable with one's nurses, you rely on them. It is after all a nursing home, not a doctoring home.

Q. Now, Doctor, Mr. Shapiro directed you to Page 25 of your deposition where there was a discussion about Dr. Azaran's intent with respect to providing the patient with Humulin N.

I'd like to take a look at Page 25 of the questions before and after that.

A. Okay.

Q. When he talked to you about the questions with respect to Humulin H, did he ever ask you whether the Humulin N was related to the February 1 time frame? It was a general question.

MR. SHAPIRO: Objection.

THE COURT: Sustained.

BY MR. POWER:

Q. Doctor, do you recall when you - specifically on Page 25, Doctor, were you asked the following question and did you also give the following answers?

“What is your understanding as to Dr. Azaran's intent with respect to providing this patient with Humulin N?

THE COURT: A little slower.

MR. SHAPIRO: Thank you.

BY MR. POWER:

Q. “What is your understanding of Dr. Azaran's intent with respect to providing the patient with Humulin N? Answer: My understanding is that he was under the impression that the Humulin N was to be given. Question: And -

MR. SHAPIRO: Objection to this being read.
THE COURT: Overruled.
BY MR. POWER:
Q. And if a physician believes that Humulin N is supposed to be given for a patient and neglects to write the order for that, is that a violation of the standard of care?
MR. SHAPIRO: Objection.
THE COURT: Overruled.
MR. POWER: Answer: It depends on whose responsibility it is to write that order. When my patients are transferred from the hospital to a nursing home, the residents from the hospital write those orders. When my patients are transferred specifically to me from Rush to the Bowman Center, the geriatric facility that we have at Rush, it's the residents who write the orders. Whether it's the nurses -
THE COURT: Now, with regard to those questions and answers being asked, the objection will be sustained.
The jury will disregard those questions asked and answers given in the deposition.
BY MR. POWER:
Q. Doctor, were you ever asked whether the Humulin N ordered was directly pertaining to the February 1, 1995, time frame?
A. No.
Q. Doctor, Mr. Shapiro asked you to look at the physician's progress notes for Dr. Azaran on February 16th.
I'd like to direct you to Page 152 of the Imperial Nursing Home records, which I believe are the physician's orders for the 16th.
A. I'm sorry. Mine start with 153.
Q. I'm sorry. It would be 152. I've given you my Page 152.
A. Thank you.
Q. Doctor, have you had a chance to look at that?
A. Yes.
Q. Was Dr. Azaran's order on February 16th an order covering multiple issues that deal with a singleissue?
A. His orders deal only with the decubitus ulcer.
Q. Doctor, have you reviewed Dr. Azaran's deposition with respect to his intention for that visit?
A. I probably did, but I honestly don't remember it, sorry.
Q. Fair enough.
Now, Doctor, you were asked to look at several pages from the Ingalls chart with respect to the diagnosis of pneumonia.
What I'd like you to turn to is Page 255 of the Ingalls chart from the February 20th admission which is Plaintiff's Group Exhibit 16, specifically to the note from Dr. Santos, the infectious disease consultant.
A. I have it.

Q. What did the infectious disease consultant place on the chart with respect to whether it was pneumonia or infiltrate?
A. Dr. Santos' opinion was that the left lower lobe infiltrate equals atelectasis.
Q. Can you tell me what atelectasis is?
A. Atelectasis is a compression of the lung which will lead to an X-ray finding of an infiltrate.
Q. Does it have anything to do with pneumonia?
A. No.
Q. Now, Doctor, with respect to relying on a cardiologist's interpretation of pneumonia versus an infectious disease's interpretation of whether there is or isn't pneumonia, which would be reliable?
A. I don't know either one of these gentlemen, but I think the general perception is that an infectious disease specialist will be a little more attune to infectious disease processes.
Q. Doctor, with respect to the cardiologist's discussion on the MI, were there any clinical changes before or after the cardiologist treated with Cardizem to this patient during the February to 20th, 1995, admission?
A. I don't think so.
Q. What effect did that have on your opinion that the patient probably did not sustain a MI?
A. It didn't change my opinion.
MR. POWER: Thanks. I have no more questions.
THE COURT: Is there any recross-examination?
MR. SHAPIRO: Yes, just briefly, Judge.

RECROSS-EXAMINATION

BY MR. SHAPIRO:
Q. In terms of whose interpretation is better, Doctor, isn't it a fact that cardiologists routinely review chest X-rays, don't they?
MR. POWER: Objection as to generalizations.
THE COURT: Overruled.
THE WITNESS: Cardiologists do review chest X-rays, yes.
BY MR. SHAPIRO:
Q. Doctor, with respect to what your assumption was with respect to Dr. Azaran's order for the Humulin N, isn't it a fact that in forming the opinion about Dr. Azaran's intention that you relied on in giving your opinions -
MR. POWER: Objection, beyond the scope.
THE COURT: Overruled.
BY MR. SHAPIRO:
Q. - that you relied upon the following deposition testimony from Dr. Azaran at Page 114? “Question: I guess I'm just asking this question. Was it your assumption when Mr. Carter entered Imperial on February 1st that his orders already in place were for daily Humulin N and then blood glucose monitoring with additional Humulin R as needed? Answer: That's correct.” Isn't that what you were referring to regarding Dr. Azaran's testimony?
MR. POWER: Objection, not impeaching.

THE COURT: Overruled.
THE WITNESS: I probably would rely on that, yes.
BY MR. SHAPIRO:
Q. And, Doctor, also with respect to the February 16th order, do you still have those in front of you, which is Page 152 of Defendant's Exhibit No. 1 for identification purposes - no, wait - I'm sorry, yeah, Defendant's 1 which is the Imperial Nursing Home records.
Those refer to the orders that were written on February 16th by Dr. Azaran?
A. Yes.
Q. And I believe that you told Mr. Power that the orders that day that he wrote were solely with respect to the decubitus ulcers, do you remember telling him that a few minutes ago?
A. Yes.
Q. That's not true, is it?
A. There's an order above that for stopping Tylenol.
Q. That's got nothing to do with decubitus ulcers, correct?
A. I don't believe so.
Q. With respect to the fact that the doctor doesn't write orders with respect to other aspects of the patient's care, that doesn't mean that the doctor didn't have an obligation to review the patient's chart on a patient that he hadn't seen for 16 days in order to see how the patient was doing in the nursing home, does it, Doctor?
A. I don't know what Dr. Azaran's responsibilities that day were.
Generally we see patients on a 3.0-day basis. This would not have been his monthly visit. I think the standard of care that I was brought up in in his all the nursing homes I practiced in, and I've been in at least a dozen of them, was that monthly you review your records.
You leaf through the nurse's notes, you leaf through the laboratories, check the patient's weight, see if there's been a temperature in between. That's a monthly event.
If he is called in to see this problem and it's two weeks after the patient was admitted, I don't know that I would have done that, I would have leafed through the whole chart.
Q. Doctor, as far as we know, that was the monthly visit for this patient, correct?
MR. POWER: Objection.
THE COURT: Overruled.
THE WITNESS: I don't think two weeks makes a month.
BY MR. SHAPIRO:
Q. I understand that, Doctor.
But the doctor comes in at least on a once-a-month basis. That's a visit within the month, correct?
A. Well, this would have been the second visit of that month, would it not?
Q. Well, he didn't see him on February 1st. So that would have been the only visit the entire 20 days he was in the nursing home, correct?
A. That's correct.
Q. And he did not limit his examination of the patient at that time solely to decubitus ulcers, did he?

A. That's correct.
MR. SHAPIRO: That's all I have. Thank you.
THE COURT: Is there any re-reredirect?
MR. POWER: No, your Honor.
THE COURT: Thank you, sir.
(Whereupon, the witness was excused.)
THE COURT: If you'll just remain for a moment.
Ladies and gentlemen, we're going to break now for lunch. I would ask that you be back here at 1:30. That would give you about an hour and a half for lunch.
Do not discuss this case with anybody, not amongst yourselves, your family, your friends, not with anybody until all the evidence in this cause has been concluded, the attorneys make their closing arguments and I instruct you as to the law to be applied to this case.
Have a nice lunch. We'll see you at 1:30. (Whereupon, the jury was dismissed for lunch.)
(Whereupon, the following proceedings were had in chambers outside the presence and hearing of the jury:)
THE COURT: The defense was going to have the clean copy of their No. 1 which was their 1501.
MR. POWER: I do, your Honor.
THE COURT: And I've already ruled on that, that was refused.
MR. POWER: Right.
THE COURT: Okay. And also you were going to be doing a clean copy of your No. 2 which was the 36.01.
MR. POWER: Yes, your Honor.
THE COURT: And that instruction will be given.
Did the defense have any other instructions they were offering?
MR. POWER: No, your Honor.
THE COURT: And the plaintiff was redoing their No. 10 which was the 12.05 instruction.
MR. SHAPIRO: Yes, we have that.
THE COURT: And their No. 9 which was the 1204. Which do you want to -
MR. SHAPIRO: We'll start with Plaintiff's 9.
THE COURT: This would be Plaintiff's Instruction No. 9A, LIPID No. 12.04 with both the first and second paragraphs.
Is there any objection?
MR. POWER: No, not with this modification.
THE COURT: It will be given.
MR. SHAPIRO: And then I have 10A.
THE COURT: And Plaintiff's Instruction No. 10A, which is IPI 12.05 with both the first and second paragraphs. Is there any objection?
MR. POWER: No objection to the modification.
THE COURT: It will be given.
And the plaintiff was also redoing their No. 18 which was the verdict form A.

MR. SHAPIRO: I'm sorry, what was the number, Judge?
THE COURT: It would be 18A.
MR. POWER: This is a little different than what we discussed to begin with, your Honor, and I don't think it follows the form A from IPI books.
It's my understanding you're supposed to leave in that first paragraph, we assess the damages in the sum of X and then itemized as follows.
THE COURT: Well, but they - assess damages as follows and then they have the elements and they have a total, so it serves the same purpose.
Are you objecting to it?
MR. POWER: I am. I think they should follow the IPI form unless there's some reason to modify it.
THE COURT: Well, in its form it's close. enough. The elements are the same with what they're telling the jury, if they find in Verdict Form A for the plaintiff that they're assessing damages, very different elements and you give a total which is going to be given over objection.
Any other instructions being offered?
MR. SHAPIRO: No, sir.
MR. POWER: No, your Honor.
THE COURT: Okay. That concludes the instruction conference.
MR. SHAPIRO: Thank you.
(Whereupon, which were all the proceedings had in this cause on this date.)
REPORT OF PROCEEDINGS at the trial of the above-entitled cause before the Honorable IRWIN J. SOLGANICK, Judge of said Court, on the 5th day of September, 2001, at the hour of 1:30 o'clock p.m
REPORTED BY: KIMBERLY A. OTTO, CSR
LICENSE NO.: 084-003713
(Whereupon, the following proceedings were held in open court.)
THE COURT: Counsel, you may call your next witness.
MR. POWER: Thank you, your Honor. At this time I would like to call Mr. Carl Skrabacz. THE COURT: Sir, would you come up here, please. Will you please raise your right hand to be sworn.
(Witness sworn.)
You may be seated. While testifying, sir, will you please keep your voice up so all the jurors, the court reporter, the attorneys and I can hear you?
THE WITNESS: Yes.
THE COURT: You may proceed.
CARL SKRABACZ, called as a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT-EXAMINATION

BY MR. POWER:

Q. For the record, could you tell the ladies and gentlemen of the jury your name?

A. My name is Carl Skrabacz.
Q. Mr. Skrabacz, you are currently the CEO of Jacobs Healthcare Systems?
A. That is correct.
Q. Can you tell us what Jacobs Healthcare Systems is?
A. We are a pharmacy that services long-term care facilities exclusively, nursing homes.
Q. Did your pharmacy service the Imperial Nursing Home of Hazelcrest in February of 1995?
A. Yes, we did.
Q. In February of 1995 you were the COO or the chief operating officer of that corporation?
A. That is correct.
Q. Can you tell me what your job was at that time with respect to the knowledge of the policies and the procedures at that institution?
A. I was instrumental in developing the policies and procedures and in carrying them out and knew all of the interworkings of the company.
Q. On February 1 - Strike that.
Did you bring records with you that reference the Jacobs Healthcare interaction with Imperial of Hazelcrest for Mr. Carter?
A. Yes, I did.
Q. I believe we previously entered into the record Plaintiff's Exhibit No. 6, which are paginated in numbered pages for those original records.
Please feel free to either look at the originals or the numbers paged at any time.
Sir, before coming here, did you review those records to familiarize yourself with your company's involvement with Mr. Paul Carter during February of 1995?
A. Yes, I did.
Q. I want to take a step back before we actually talk about this case in particular.
Tell me what system was in place for the Imperial orders to be submitted to Jacobs so that you could fill those pharmacy orders back in February of 1995?
A. Okay. Orders could be received by us in any one of three ways. Nurses could telephone us and call orders in, speak with a representative in the pharmacy and give them the order verbally over the telephone.
The other method that we could utilize was an actual pick up of the orders. When our driver delivered medications to the nursing home, he would ask for orders to be taken back to the pharmacy which were to be filled; so that was the second means by which we could get orders.
Lastly, orders could potentially be faxed to us.
Q. Was there a policy in place or a procedure in place at the Jacobs Pharmacy for certain forms to be used if orders were going to be faxed to your facility?
A. That is correct. We have a standardized form that was used for either orders, new orders or for reorders of medication.
Q. Doctor, were those forms circulated to Imperial in Hazelcrest before February 1 of 1995?
A. Before?
Q. Sure. In other words, were they already there?

A. Yes, they were.
Q. Sir, you brought with you all of your original records from Jacobs Healthcare Pharmacy. Did you find any evidence when reviewing your business records that Jacobs Healthcare Pharmacy ever received a faxed order on February 1, 1995 from the Imperial of Hazelcrest with respect to any orders pertaining to Mr. Paul Carter?
A. I did not find any faxed orders on any date in the orders that I looked through, so the answer is no.
Q. Would that review of records included the entire February admission for Paul Carter?
A. Yes.
Q. Now, sir, if you received a fax order, tell me what the policy and procedure was at Jacobs with respect to maintaining that fax order if you later received the actual hard copy or the original?
A. Okay. All orders that were received by us either faxed or phoned or picked up were all stamped with a serialized number.
After processing the order the paperwork is combined - was and still is combined with a computer printout of that day's activity and the orders are filed alongside the computer printout day by day, nursing home by nursing home that I service.
Q. Sir, tell me when an order is received by phone what the procedure was at Jacobs in February of 1995 with respect to processing that phone order.
A. Very much the same as I just described. The phone order is stamped with a serialized number, given to the pharmacy technicians and the pharmacists to process, and after the day's business, it is joined together with the computer printout and filed in the pharmacy for future use reference.
Q. First a phone order - the blank order is received by the person receiving the phone call and it's filled out?
A. Filled out by one of my employees.
Q. When that form is filled out, how is it then that anybody in the warehouse knows how to pick up the drugs? In other words, does that form. go to processing -
A. That form would go to - okay.
After the order is written, the form is placed in a tray, if you will, that is then utilized by various technicians who will enter the order into the computer order system.
Then a label is generated, and the label is given to a pharmacist alongside the original order so that the pharmacist can verify that the technician did everything correctly on the order.
Once the pharmacist signs off on the label, the label and the order sheet go down to another group of technicians.
Those technicians will fill the order much the same as they would at a Walgreen's drugstore, albeit in a different system. We use a carded system rather than the little vial prescriptions and that order would then proceed to a pharmacist for further checking and authorization to be sent to the **nursing home**.
Then it will go on to packaging where it will be packaged and delivered to
the **nursing home** in question.

Q. Sir, back in February of 1995, were there normal times that you would send vans out to Imperial to deliver medications that were ordered throughout the day?
A. Yes, there was.
Q. Can you tell me what those normal delivery times were?
A. I believe that in 1995 we were delivering to Hazelcrest at - the run would leave my drugstore at 12:00 noon and at 8:00 o'clock at night.
Q. Were there published cutoffs for use at Imperial to have those orders transmitted to you so you could process them, fill them and get them on that noon or a.m. truck?
A. Yes. There was a one-hour cutoff time before the run would normally leave. So the cutoff would have been 11:00 o'clock and 7:00 o'clock.
Q. Now, sir, on February 1, 1995, your business records do reflect that you received some telephone orders with respect to Mr. Carter?
A. I'd have to check the date.
Q. I believe it's Page 7 of the Xeroxes that are in front of you which is Plaintiff's Group Exhibit 6?
A. Okay. I want to compare those to the original if you don't mind because the originals are a little bit clearer than the faxed copies.
Q. Sure.
A. Yes. February 1st we received nine orders on a telephone call from Hazelcrest, and that was scheduled for an 8:00 p.m. delivery at the time we received the call. So I would guess that the call came in between 11:00 and 7:00 o'clock at night.
Q. Now, sir, of those nine orders, are any of those orders for Humulin R?
A. There are no insulin orders here, none for Humulin.
Q. Based on your review of your records for the entire February admission, was there ever any order for Humulin or any order at all received for Paul Carter by Jacobs Healthcare Systems?
A. No, there was not.
Q. Based on your review of the record, these nine orders were the full extent of the orders received by Jacobs on February 1?
A. Yes, sir.
Q. Sir, if you received a phone call later than the normal cutoff time for a truck, was there. a procedure in place to take care of these emergency or stat orders?
A. Certainly.
Q. What did you communicate to Imperial with respect to the need for or the concern about making an extra run?
A. In the normal course of events, we probably do 30 to 40 stat deliveries a day depending on the time of month and the needs of my customers. There is no extra charge for these, and we encourage the **nursing homes** to call us if they need anything.
Q. Now, sir, in addition to the actual order form that you told us that there would be - somebody would type in or process the request into your daily activity report?

A. Well, the daily activity report is generated off of the same database that produces the labels that we utilize all day long.
So at the end of the day, we merely give the computer a command to aggregate all of the orders that were processed that day, and it produces what we call a shipping list for what we delivered that day.
Q. After you do the shipping list - Let me back up.
Obviously you bill for the drugs that you ship to the various patients at Imperial Hazelcrest?
A. Yes.
Q. That's how you stay in, business, right?
A. That's right.
Q. Between the daily activity report and the billing pertaining to Paul Carter, did you ever find any evidence for an order for insulin at any time during the February admission to Imperial?
A. I did not.
Q. Did you review the records for that purpose?
A. The one record I did not review was my bills that I sent, but I think I reviewed those at my deposition.
Q. Let me ask you a different way. It wouldn't make the bill if it didn't make the daily activity report?
A. I'm sorry?
Q. It wouldn't make the bill if it didn't make the daily activity report, correct?
A. That is correct.
Q. There was no evidence on the daily activity report that the insulin was ever ordered; is that fair?
A. Not on the daily activity report there wasn't. I'm seeing an insulin order on the bill however.
Q. On what date is that?
A. February • 13th.
Q. Can you tell me on the bill on February 13th when it indicates that the insulin was ordered?
A. I'm sorry?
Q. Can you tell me on February 13th - the request for insulin - can you tell me what date it was ordered from the bill?
A. The 13th.
Q. Is that the date it was actually ordered from the **nursing home** - Maybe I could help you out.
Is that the insulin that was ordered on January 13, 1995?
A. January 13th. Excuse me. That's January 13th. My mistake.
Q. No problem.
A. We're talking about February.
Q. Yes, sir.
A. Yes, we are. That's why I couldn't understand what was going on there.

In February, there is no Humulin ordered in February - no insulin ordered in February or billed.
Q. So you're familiar with the Jacobs Healthcare Systems physicians order sheet form?
A. Yes.
Q. I believe it's Page 22 in your Plaintiff's Exhibit 6. The Jacobs Healthcare physicians order sheet is a preprinted sheet that is supplied to your **nursing homes** by you?
A. Yes, sir.
Q. Is it a multipart form?
A. Yes, it is.
Q. Can you tell me what the parts are to the form?
A. There are two - we call it a physician order sheet. The first two pages, one of which is a NCR paper or a carbonized paper and that is sent back to the pharmacy once a month for editing.
The top copy is the copy that is retained by the **nursing home**, and the last part of the form is something called a medication administration record.
On the first of the month that is separated from the physician order sheet and used as a separate document.
Q. If I may, is the pharmacy copy of the physician's order sheet the yellow copy or the bottom copy of that document?
A. Yes.
Q. And the white copy is the copy that stays in the chart?
A. Yes.
Q. Now, if I understand you correctly, you said that these are kept in the **nursing home** until some predetermined time and then they're picked up by pharmacy?
A. Yes. Once a month we pick this form up so that we can edit it and print a new form for use on the following month.
Q. Then the following month all the things that would be handwritten in would come back typed?
A. That is correct.
Q. Sir, in November - in February of 1995, do you know when Imperial's pharmacy order sheets would have been picked up in the month?
A. Yes. It's generally towards the end of the month that we did their sheets. My guess would be it would probably be someplace after maybe the 25th or the 26th of the month.
Q. Based on the documentation that is noted on this sheet - and I'm looking at Page 22 of Plaintiff's Exhibit 6 - is there any evidence that Jacobs Pharmacy picked up the pharmacy order sheet, No. 22, before February 20, 1995 from Imperial of Hazelcrest?
A. Is there evidence that we picked it up before the 20th?
Q. Yes, sir.
A. I couldn't say that we did. The last entry on these sheets is on the 16th of February - a handwritten entry is on the 16th. So it would have to have been after the 16th that we picked it up.

Q. Which page number are you referring to when you say that?
A. Page 23, the last handwritten entry by the RN is dated 2/16/95.
Q. Now, sir, based on your receipt of the documents from Imperial of Hazelcrest for orders that were initially given and then discontinued, what did your documentation usually contain when there was an order given and then later discontinued?
MR. SHAPIRO: Object.
THE COURT: Sustained.
BY MR. POWER:
Q. Was there a policy or procedure that your records followed with respect to how orders were completed and discontinued when it was received on behalf of Jacobs?
MR. SHAPIRO: Objection.
THE COURT: Sustained.
BY MR. POWER:
Q. Are you familiar with the custom and practice followed at Imperial with respect to orders that were received and later discontinued based upon the documentation of your business records?
A. Am I familiar with the procedures at Imperial?
Q. Yes.
A. for DCing an order?
Q. Yes, based upon the documents you received and are kept as part of your business records.
A. DCs are generally written on the physician order sheet. That's where they're documented. Usually the order itself, the verbal order from the physician, will be handwritten on the right-hand side of the sheet, and the items which they are actually discontinuing will be crossed off and marked DC for discontinued on the left-hand side of the sheet. That's pretty much the practice at most **nursing homes** that I'm servicing.
MR. POWER: I have no more questions for you, sir.
THE COURT: Is there any cross-examination?
MR. SHAPIRO: Yes, sir.

CROSS-EXAMINATION

BY MR. SHAPIRO:
Q. Now, Mr. Skrabacz, am I correct that whether a physician's order was faxed in or called in, if it was either faxed in or called in without - I'm sorry - if there had been an order for insulin without a DC on it, then your pharmacy would have shipped insulin to the **nursing home**, correct?
A. Yes.
Q. But you never did ship any insulin to the **nursing home**, correct?
A. Not in February.
Q. So that would be consistent with no order for insulin having been given, correct?
A. Yes, it would.
MR. POWER: Objection on the word “given.”

THE COURT: Overruled.
THE WITNESS: Being - not being delivered. I can't vouch for whether it was given or not.
BY MR. SHAPIRO:
Q. You never saw anything on a physician order sheet for February ordering insulin, did you?
A. You mean in retrospect?
Q. Right.
A. Not as an order, no.
Q. Similarly if there had been an order for a blood glucose monitoring that had not been discontinued, you would have shipped blood glucose monitoring kits?
A. No, we would not have.
Q. So you don't get involved with blood glucose kits?
A. The blood glucose strips are what we call a house stock item. They come in bottles of multiple doses and the house generally buys those and uses them on multiple patients. So when we ship them, we ship them as a bill to the house rather than to a patient. We don't know who they're going to be used for.
Q. Doctor, when you pick up the POS forms from the **nursing home** and you look at them after they've been picked up, is that in any way an audit to make sure that the orders that were on the POS form that you picked up were consistent with the orders that you had received and shipped?
A. Not when we pick it up. There's a different system in place to audit the chart against the actual orders that were shipped, and that would be done through my consultant pharmacists who visit the **nursing homes**. That's not done off-site.
Q. Now, Mr. Skrabacz, with respect to - and I believe you have your records that are marked Pages 21, 22 and 23 of Plaintiff's Group Exhibit No. 6 which are the Jacobs Healthcare records - do you have those in front of you?
A. Yes, I do.
Q. With respect to Page 21, that is the pharmacy copy?
A. The yellow copy that you have, yes. You have a copy of the yellow one, I believe.
Q. It says up in the right-hand corner, pharmacy copy, correct?
A. Yes.
Q. That form was picked up - according to the practice and procedure, was picked up by the pharmacy from the**nursing home** sometime before the physician signed it, correct?
A. Yes.
Q. So at the time that the form was filled out as a carbon copy before the physician signed it, it had this language already on it in the right-hand side, discontinue blood glucose monitoring, A, C and H's insulin as well as discontinue sliding scale insulin, correct?
A. That's correct.
Q. And there are some marks on there and on the medication orders. What do those marks indicate?
A. Are you talking about the red checkmarks?
Q. Right.

A. The red checkmarks were done - on my copy they're red. They were done by my editors at the pharmacy that indicate that they picked them up, if you will, and put them into the computer system. That there were changes from previous.
Q. So if there had not been a DC on the form and it just said sliding scale insulin, that would have been picked up as an order for insulin, correct?
A. It would have been picked up as an order to be put oh the physician order sheet.
Q. But that wasn't done, correct?
A. No.
Q. Now, with respect to the second page, and you indicated that you didn't know when that was picked up because showing you 22 of the pharmacy's records, the pharmacy copy -
A. Yes.
Q. The last notation that's written on the carbon copy is an order on February 13, right?
A. Yes, it is.
Q. And that order for February 13 says that on February 26, '95, give 5 milligrams of Valium and on 3/27 give something about Valium for a 1:30 p.m. procedure; is that right?
A. That's right.
Q. Somebody wrote on there that it was noted on February 13th of '95, correct?
A. Yes.
Q. Then this section on the lower right-hand corner on your pharmacy carbon copy is completely blank, correct?
A. The big square at the bottom?
Q. Right.
A. It has the note in the corner. The rest of it is blank.
Q. Right, and the doctor has not yet signed it, correct?
A. Yes. It's part of the same form that we had just discussed.
Q. Now, do you have Defendant's Group Exhibit No. 1 in front of you which are physicians order sheets chart copies?
Let me give you an extra copy of this so you can follow along with me.
A. Okay.
Q. By the way, one more question about Page 22: This pharmacy copy also has pharmacy orders over on the left-hand side, correct?
A. Yes.
Q. For blood glucose monitoring and for Humulin R insulin?
A. Yes.
Q. And it's got a DC written on it, correct?
A. Yes.
Q. So the pharmacy carbon copy has got that DC language on it at a point in time before Dr. Azaran has signed it, correct?
A. Yes.
Q. Now, if you could just go back for a minute to the chart copy for the **nursing home** and it's specifically Page 147.

A. I don't have a 147.
Q. I'm sorry. Check Imperial records from 2120. Let me just show you my copy. That will make it a little bit quicker. I'll show the jury.
Do you see on the chart copy, Doctor -
THE COURT: What's being shown to the witness, Counsel?
MR. SHAPIRO: This is Page 147 of the Imperial **Nursing Home** records for February 1st.
THE WITNESS: Okay.
BY MR. SHAPIRO:
Q. Doctor, on this chart copy there has now been an order added to the chart copy, correct?
A. It looks like.
Q. And that's an order dated February 20th for blood glucose monitoring every six hours, correct?
A. Um-humn.
Q. Is that a “yes”?
A. Yes.
MR. POWER: Your Honor, could we have a sidebar?
(Whereupon, the following proceedings were held out of the hearing and presence of the jury.)
MR. POWER: This clearly goes beyond the scope of direct. He's now going to start comparing parts of the chart that never made it to the pharmacy so this wouldn't have been part of his business records.
He's now going to I guess attempt to start comparing when things were done as compared to signatures which has nothing to do with this witness nor was it ever disclosed under 213 nor is there any basis for this witness to start talking about when signatures were placed on the chart since it's not dated.
All of this is clearly beyond the scope of direct and clearly beyond this witness's foundational abilities as to what occurred in the **nursing home** since it didn't make the business record.
MR. SHAPIRO: Counsel, specifically asked him when they picked up these copies and that he couldn't tell from the document when it was picked up.
well, I have the pharmacy copy showing this language isn't on it. I've got the chart copy showing that there was a notation made on February 20th, okay, which would clearly show that the pharmacy copy was picked up before February 20th.
MR. POWER: It means it was torn apart. It could mean a million things. It doesn't mean it was picked up.
THE COURT: Well, for that limited purpose I would allow the examination of the witness. The jury can draw whatever inferences from that that they wish. But it goes to an issue that was brought up on the direct examination of the witness. So I would allow it for that purpose only.
MR. POWER: I'm sorry, Judge, while we were walking out, I asked you a question that wasn't on the record.
My concern is that with respect to when Dr. Azaran signed this clearly is beyond this witness's foundational capabilities to talk about that, number one. Number two, it has nothing

to do with the limited purpose that you are asking about - with respect to when it was picked up.
THE COURT: The witness has already testified that Dr. Azaran has not signed the pharmacy copy so he has - he can't tell when the Doctor signed it.
The only purpose this examination would have was with regard to the picking up of the document, that is, he said he thought the regular procedures was around the 25th or the 26th and there was an entry that he had testified to that was made sometime and now there's a question that there is a copy made after that.
So the jury can infer that it may have been picked up prior to that last entry. That's all. That's the only purpose of the examination with this document with this witness.
(End of sidebar discussion.) (Whereupon, the following proceedings were held in open court.)
THE COURT: The objection is overruled. BY MR. SHAPIRO:
Q. Showing you Page 147 - we've got an extra copy now so we can look at it together - this is the chart copy, right, from Imperial?
A. It appears to be, yes.
Q. Now, this document - I think you said that these forms are carbon copies, correct?
A. Mine is a carbon, yes. It's NCR copy.
Q. So what it is written on the one would be identical to what is written on the other, correct?
A. Yes.
Q. But this form - the chart copy has now- got - that we see in this has got a new order added to it, correct?
A. Yes, it does. It has an order that the yellow copy did not have.
Q. This order is dated February 20 for blood glucose monitoring every six hours, correct?
A. Yes.
Q. And this form is signed by Dr. Azaran, correct?
MR. POWER: Objection, foundation.
THE COURT: Sustained.
BY MR. SHAPIRO:
Q. So if the chart copy has got a February 20th order on it and your form - your carbon copy doesn't have that February 20th order on it yet but it's got the last order being February 13th, would it be fair to say that the pharmacy picked up the carbon copy of the order sometime between February 13th and February 20th?
A. It would be fair to say.
Q. And in the pharmacy copy, it's already got the DC on it, doesn't it?
A. It has - Yes. It has the DC in the left-hand on the same page up in the left-hand corner.
Q. It's got DC on both of these forms, correct?
A. Pardon?
Q. It's got DC on the chart copy as well as the pharmacy copy?
A. Yes, it does.
Q. You said that there was a 7:00 p.m. published cutoff for the 8:00 o'clock run?

A. Yes, sir.
Q. But isn't it a fact that if an order was processed by 7:30 or even on occasion a quarter to 8:00, you would go ahead and include it on the 8:00 o'clock run?
A. Depending on the situation, we might recognize the fact that we need to add that order, yes, and put it in.
Q. If there was some reason it couldn't be made by then, you would just send it over on a separate run, correct?
A. If we had indication that it was needed quickly, we would make a stat on it, yes.
Q. There would be no extra charge to the **nursing home** for that, correct?
A. There would not.
Q. Now, just hypothetically, Mr. Skrabacz - By the way, on the orders that were called in on February 1st, they ordered nine different medications?
A. Yes.
Q. And if for some reason they forgot to order one of the medications and then it came the next morning and they realized that they didn't have that medication in-house but they had an order to give that medication to the patient, based on your experience, what would be the practice and procedure?
MR. POWER: Objection, foundation.
THE COURT: Sustained.
BY MR. SHAPIRO:
Q. Well, was your pharmacy open the next day?
A. Yes, sir.
Q. So they could just order it the next day if for some reason somebody didn't order it the night before?
MR. POWER: Objection, foundation.
THE COURT: Sustained.
BY MR. SHAPIRO:
Q. You were available at all times for the **nursing homes** for medications?
A. Yes.
Q. And as a matter of fact, didn't you even provide medication, insulin medication, for **nursing homes** to keep on hand for emergencies?
A. Yes.
MR. SHAPIRO: That's all I have. Thank you.
THE COURT: Any redirect?
MR. POWER: Yes, your Honor.

REDIRECT-EXAMINATION

BY MR. POWER:
Q. You were just shown the two documents with the note on it on the 20th and the one without the note on it on the 20th.
Sir, based on your business records, can you tell me whether that form was separated on the 13th, 14th, 15th, 16th, 17th, 18th, 19th or 20th two minutes before that note was entered?

A. Can I tell you if it was? It could have been. It could have been separated on any of those dates.
Q. As late as a minute before she wrote that 2/20 order?
A. Yes, sir.
MR. POWER: No more questions.
THE COURT: Recross examination?
MR. SHAPIRO: No.
THE COURT: Thank you, sir.
THE WITNESS: Should I take the exhibits with me?
THE COURT: Yes.
(Witness excused.)
THE COURT: Defense, call your next witness.
MR. POWER: Yes, your Honor. *fit* this time we will call Dr. Abdol Azaran.
THE COURT: Be seated. Again, identify yourself for the record.
THE WITNESS: Abdol Azaran.
THE COURT: And you have been sworn in this cause; is that correct?
THE WITNESS: Yes, sir.
THE COURT: You realize, sir, that you are still under oath?
THE WITNESS: Yes, sir.
THE COURT: Again, can you please keep your voice up so all of the jurors, the court reporter and the attorneys and I can hear you?
THE WITNESS: Sure.
THE COURT: You may proceed.