

In The Matter Of:

*Therese Pruitt, etc., et al. v.
Mahesh Ochaney, M.D.*

*Keith B. Armitage, M.D.
May 24, 2004*

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[1] IN THE CIRCUIT COURT FOR BALTIMORE CITY
[2]
[3]
[4] THERESE PRUITT, etc,
[5] et al.,
[6] Plaintiffs,
[7] -vs- CASE NO. 24-C-03-006098
[8] MAHESH OCHANAY, M.D.,
[9] Defendant.
[10]
[11] Deposition of KEITH B. ARMITAGE, M.D., taken
[12] as if upon cross-examination before Linda A.
[13] Astuto, a Registered Merit Reporter and Notary
[14] Public within and for the State of Ohio, at the
[15] University Hospitals of Cleveland, 11100 Euclid
[16] Avenue, Cleveland, Ohio, at 9:00 a.m. on Monday,
[17] May 24, 2004, pursuant to notice and/or
[18] stipulations of counsel, on behalf of the
[19] Defendant in this cause.
[20]
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On behalf of the Defendant.

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[1] KEITH B. ARMITAGE, M.D., of lawful age,
[2] called by the Defendant for the purpose of
[3] cross-examination, as provided by the Rules of
[4] Civil Procedure, being by me first duly sworn, as
[5] hereinafter certified, deposed and said as
[6] follows:
[7] CROSS-EXAMINATION OF KEITH B. ARMITAGE, M.D.
[8] BY MR. MORTER:
[9] Q: Good morning. My name is Bob Morter on behalf of
[10] Dr. Ochaney.
[11] Have you had your deposition taken before?
[12] A: I have.
[13] Q: How many occasions?
[14] A: I really haven't kept track. I'd say, you know,
[15] between, you know, 30 and 70 or somewhere in
[16] there.
[17] Q: Okay. And you're familiar with the ground rules,
[18] I assume?
[19] A: Yes.
[20] Q: I've been provided, previously provided by Miss
[21] DiFranco with a copy of your curriculum vitae.
[22] The one that I have, on the very last page it
[23] ends with your presentations in 2003, the last
[24] one being Case Studies of Infection in
[25] Adolescents and Elderly presented in Sanibel

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[1] Island, Florida.
[2] Have you updated your CV recently or is this
[3] the most up-to-date version?
[4] A: There's a more up-to-date version. I have one in
[5] my hand that was from March, 2004. There's a few
[6] more things on it.
[7] MR. MORTER: Madam Court Reporter,
[8] can you mark that as Dr. Armitage Exhibit
[9] No. 1, please, and append it to the
[10] deposition transcript.
[11]
[12] (Thereupon, Defendant's Armitage Exhibit 1,
[13] the Curriculum Vitae of Keith B. Armitage,
[14] M.D., was marked for purposes of
[15] identification.)
[16]
[17] Q: Relative to your curriculum vitae, are there any
[18] publications or presentations that you've done
[19] that you believe are particularly relevant to the
[20] issues in this case?
[21] A: There's a chapter I wrote on, in a book called
[22] Experts Guide to Common Infectious Diseases on
[23] enteropathogens. I think it dealt with bacterial
[24] infections.
[25] There's a few presentations that deal with C.

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[1] diff, Case Studies in Infectious Diarrhea, Case
[2] Discussions in Infectious Diarrhea. That's from
[3] 1995. We covered C. diff.
[4] Q: And that's a book chapter?
[5] A: That's a presentation.
[6] Q: Okay.
[7] A: The book chapter was, I think, the only article.
[8] Q: That's the Experts Guide to the Management —
[9] A: Experts Guide to Management of Common Infectious
[10] Diseases.
[11] Q: That's with you and Dr. Salata or you and Dr.
[12] Colecraft?
[13] A: Salata.
[14] Q: Okay.
[15] A: And I think that's it.
[16] Q: Did you say that was it?
[17] A: Yes. Of things that are referenced on my CV, I
[18] think that's it.
[19] Q: And could you point me to the presentation you
[20] had reference before, you said 1995?
[21] A: You know what, I'm sorry, it's 1996. It's the
[22] last one under 1996.
[23] Q: Case Discussions in Infectious Diarrhea?
[24] A: Right.
[25] Q: Do you have any materials from that Case

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[1] Discussions in Infectious Diarrhea presentation?
[2] A: I think I do.
[3] MR. MORTER: Tina, could I ask you
[4] to hopefully gather that while you're there
[5] and provide me with copies?
[6] MS. DiFRANCO: Sure. I'll be
[7] happy to. If Dr. Armitage can put his
[8] hands on it relatively —
[9] MR. MORTER: That's what I was
[10] thinking.
[11] A: That one is so old, I think it is actually in
[12] printed form, not something on my computer. I
[13] think I probably can.
[14] MS. DiFRANCO: Will you look for
[15] it?
[16] THE WITNESS: I think I know where
[17] it is. Shocking.
[18] MR. MORTER: Can you hold on one
[19] second, please?
[20]
[21] (Thereupon, a discussion was had off the
[22] record.)
[23]
[24] Q: I'm sorry about that. So the way we stand, we're
[25] not certain whether we have that Case Discussions

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[1] in Infectious Diarrhea but we'll look?
[2] A: I'm pretty sure we can find it.
[3] Q: Thank you. And I believe you said you thought
[4] you had given some treatment to C. diff colitis
[5] in that presentation?
[6] A: I know in that presentation I think we did a C.
[7] diff case. So it's really a case discussion.
[8] That's the way we teach in these settings.
[9] Q: Do you recall anything about that case?
[10] A: No.
[11] Q: I think your CV probably sets out your education
[12] and training in some detail.
[13] Why don't you just give me a nutshell from
[14] your graduation from college and then on forward
[15] to the present.
[16] A: Well, I went to medical school in Colorado. Then
[17] I came here, in 1986 here to Cleveland Case
[18] Western Reserve University and did the initial
[19] three years of internal medicine, two years of
[20] infectious diseases. I was a chief resident for
[21] a year and then joined the faculty at Case
[22] Western and the staff of University Hospitals and
[23] the Cleveland VA in 1992 and I've been here since
[24] then.
[25] Q: Okay.

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[1] A: And I have a couple roles in the medical school
[2] in the Department of Medicine. I've been the
[3] residency training director since '92 and the
[4] vice-chairman for education since, I think '99
[5] and I divide my time between, permanently between
[6] education and clinical care. So it's probably
[7] about 75 percent clinical care and about 25
[8] percent worth of education, administration.

[9] Q: And is part of that educational time subsumed
[10] within your clinical care, that is training
[11] residents, interns and the like?

[12] A: There is overlap in the clinical care obviously.

[13] Q: I assume you're licensed to practice in Ohio?

[14] A: Correct.

[15] Q: Any other states?

[16] A: No.

[17] Q: Have you ever been so licensed in any other
[18] state?

[19] A: No.

[20] Q: Relative to your licensure, I assume you've had
[21] no adverse actions, those being suspension,
[22] revocation, restrictions, et cetera?

[23] A: Correct.

[24] Q: You're board certified in internal medicine and
[25] infectious diseases, correct?

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[1] A: Correct.

[2] Q: When did you become board certified in internal
[3] medicine?

[4] A: 1989.

[5] Q: Did you pass that exam on your first attempt?

[6] A: Yes.

[7] Q: And then thereafter when did you become board
[8] certified in infectious diseases?

[9] A: 1994.

[10] Q: And did you pass that exam on your first attempt?

[11] A: Yes.

[12] Q: Tell me a little bit about your clinical
[13] practice.

[14] Are you 100 percent infectious diseases or do
[15] you practice both internal medicine and
[16] infectious diseases or perhaps some other
[17] subspecialty?

[18] A: It's pretty much evenly divided between
[19] infectious diseases and internal medicine. So
[20] I'm sure you're familiar with people who work at
[21] teaching hospitals, our practice patterns really
[22] are kind of episodic. So one month we might
[23] attend inpatient infectious disease consultation
[24] service or an inpatient infectious disease ward
[25] team. I have at least three half days a week in

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[1] outpatient hospitals. It involves both internal
[2] medicine and infectious diseases and a half day a
[3] week supervising residents at the Urgent Care
[4] Center at the Cleveland VA. That's in addition
[5] to my inpatient activities.

[6] Q: Do you maintain a private office practice or are
[7] all of your patients seen in conjunction with
[8] Case Western?

[9] A: Well, the internal medicine physicians who work
[10] here at the hospital are a private group, an
[11] entity that is not owned by Case Western or the
[12] hospital.

[13] So I guess it's organized, I don't know all
[14] these details, it's a non-profit corporation, 200
[15] physician group. In that way I guess it's
[16] private. The only office I have here is at the
[17] hospital but I see patients as a private doctor.

[18] Q: Got it. What's the name of that group? I think
[19] you may have told me and I let it just slip by
[20] me.

[21] A: I didn't. I believe, these things are changing
[22] because we're reorganizing, University
[23] Physicians, Inc., I believe.

[24] Q: And do you hold any positions with University
[25] Physicians, Inc.?

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[1] A: No.

[2] Q: So you're an employee, correct?

[3] A: Yeah. I think I'm an employee. It's
[4] complicated. I'm an employee of Case Western.
[5] My paycheck comes from Case Western but I think
[6] the money for my paycheck comes from University
[7] Physicians, Inc.

[8] Q: I got you. What type of patient population do
[9] you deal with? Do you do adults only or do you
[10] do pediatric and adult work? How does that break
[11] down?

[12] A: I do adults only.

[13] Q: And do you have any subspecialties within your
[14] specialty?

[15] A: No. I don't do much HIV work just because I'm
[16] so, there's other people here who really
[17] specialize in that in our institution and so I
[18] don't consider myself an expert in HIV. I
[19] consider myself a generalist infectious disease
[20] physician. There are some areas where I think I
[21] do more than others, pneumonia, bone and joint
[22] and diarrhea.

[23] Q: Are you able to estimate for me the percentage of
[24] time you spend attending hospital patients versus
[25] attending patients in clinic?

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[1] A: You know, it's varies from month-to-month. So,
[2] you know, I guess over a year, roughly 50/50.
[3] Q: Okay. I think you told me about 25 percent of
[4] your time you spend in education and
[5] administration, is that correct?
[6] A: Correct.
[7] Q: And I assume the education component, you're
[8] talking about grand rounds and didactic lectures?
[9] A: Yeah. And having to do with the educational
[10] programs, running the educational programs in the
[11] Department of Medicine.
[12] Q: Okay. What percentage of that 25 would you
[13] estimate that you spend in your administrative
[14] activity?
[15] A: I don't know. Maybe a third.
[16] Q: Okay.
[17] A: There's a lot of overlap there.
[18] Q: Got it. At which hospitals are you privileged to
[19] practice?
[20] A: At University Hospitals of Cleveland and the
[21] Cleveland VA Medical Center.
[22] Q: How many hospitals are there affiliated with the
[23] university?
[24] A: Around 20.
[25] Q: Okay. The VA. Relative to any privilege that

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[1] you've held to practice in any hospital, I assume
[2] there have been no adverse actions, revocations,
[3] restrictions, et cetera?
[4] A: There have not.
[5] Q: There's one thing on your CV I want to ask you
[6] about on the first page under education and
[7] training, 2003, Academic Alliance for Internal
[8] Medicine, Merck Executive Leadership Program,
[9] tell me a while bit about what that program was.
[10] A: The Academic Alliance for Internal Medicine is a
[11] professional group for people that are active
[12] chairmen, division chairs, program directors,
[13] administrators, clerkships, I guess through an
[14] arrangement that's somehow supported by Merck,
[15] they put on a week long course every year for
[16] people who have leadership positions in
[17] departments of medicine and I applied to
[18] participate in the course and I participated last
[19] year.
[20] Q: Is it fair to summarize it as like a management
[21] training, that type of thing?
[22] A: Yeah. It has to do with, I guess there's three,
[23] there's three parts of it. Leadership skills in
[24] general, healthcare finance and some on
[25] marketing. The healthcare finance was, I

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[1] thought, the major part, at least the part that I
[2] found the most interesting.
[3] Q: I notice something on the CV, I can't put my
[4] fingertips on it right now, having to do, you
[5] mentioned it in response to the previous question
[6] about clerkships.
[7] Do you have a clerkship program there at Case
[8] Western?
[9] A: Of course.
[10] Q: What does that entail?
[11] A: Well, traditionally the third year medical school
[12] student spends time rotating through various
[13] clinical services and those are called the core
[14] clerkships and we, of course, have a core
[15] clerkship for third year students from Case
[16] Western.
[17] Q: And that's a precursor to the rotations that
[18] these folks will expect when they move into
[19] residency?
[20] A: Right. It's a core part of, it's a core part of
[21] medical school.
[22] Q: Do you have any research interests?
[23] A: Yeah, I guess a couple areas. I was involved
[24] with pneumonia and pneumonia care path here but
[25] now it's probably more medical education than

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[1] clinical care, although I do participate in
[2] studies, but the way my time is divided between
[3] clinical care and other responsibilities I don't
[4] have a lot of time for research.
[5] Q: And when you're talking about medical education,
[6] are you meaning the content and the methodology
[7] as far as how to go about teaching medical
[8] students and residents?
[9] A: Correct.
[10] Q: Estimate for me approximately how many patients
[11] you personally have treated for C. difficile
[12] colitis.
[13] A: Boy. That's going to be tough because it's
[14] pretty common. I treat patients with C. diff
[15] colitis both as a primary, you know, physician in
[16] the inpatient or outpatient setting and I also
[17] get consulted on cases and maybe 20 or more a
[18] year for the last 15 years. I've seen a lot of
[19] C. diffs. It's an interest of mine.
[20] Q: We can agree that C. difficile colitis cannot be
[21] diagnosed radiologically, is that correct?
[22] A: That is not correct. There are, when patients
[23] truly have full-blown pseudomembranous colitis, a
[24] CAT Scan is pretty pathognomonic. Having said
[25] that, it's not a usual way of diagnosing it and

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[1] in this case there wasn't pseudomembranes but
[2] there is an appearance on CAT Scans of full-blown
[3] pseudomembranous colitis that really can't be
[4] anything else.
[5] Q: I think what you're telling me is as a general
[6] rule, one just simply just can't take a CT Scan
[7] of the abdomen and pelvis, take a look at it and
[8] say this patient has C. diff colitis without
[9] more —
[10] A: You can certainly interpret a clinical CAT Scan.
[11] A diffuse colitis is highly suggestive of C.
[12] diff.
[13] Q: And if there is a gold standard, what is the gold
[14] standard for defining and diagnosing C. difficile
[15] colitis?
[16] A: Well, there's really three ways you can diagnose
[17] C. diff. You can, in the case of
[18] pseudomembranes, you can diagnose it on a CAT
[19] Scan. You can diagnose it endoscopically as
[20] pseudomembranes or you can isolate the organism
[21] or the toxin in the stool.
[22] Q: Relative to a stool assay, in order to make the
[23] diagnosis of C. difficile colitis, you would need
[24] a finding of the toxin, is that correct?
[25] A: That is not correct.

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[1] Q: How do you go about defining it or diagnosing C.
[2] difficile colitis based upon a stool assay?
[3] A: Well, I'm not sure the second question is tied to
[4] the first question, but if I can just explain.
[5] C. diff colitis is very often a clinical
[6] diagnosis. So a patient who has been on
[7] antibiotics, who has diarrhea, depending upon the
[8] other findings, can be highly suggestive of C.
[9] difficile colitis. So the toxin can sometimes
[10] give additional information and is the most
[11] common lab test used. But the diagnosis can be
[12] made quite confidently on the basis of clinical
[13] grounds. The assay of toxins are imperfect.
[14] There are technical issues with the assay.
[15] So quite frequently we treat patients with C.
[16] diff colitis with a negative assay when the
[17] clinical picture is so clear.
[18] Q: So is the assay for the toxin not specific enough
[19] for someone to place reliance upon it in making a
[20] diagnosis of C. difficile colitis?
[21] A: Well, it's specific but not sensitive. Those are
[22] medical terms. So sensitivity means the ability
[23] to detect something and specificity means if you
[24] detect it, how accurate is it. A positive test
[25] is fairly accurate but a negative test isn't very

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[1] sensitive.
[2] Q: And that's irrespective of how many times you do
[3] an assay or does the sensitivity increase
[4] proportionally with the number of assays that one
[5] does?
[6] A: It would increase somewhat.
[7] Q: I'm going to shift gears just a little bit just
[8] to get a flavor for your expert work.
[9] When did you first begin reviewing cases in
[10] the medical/legal context?
[11] A: I believe it was around 1996.
[12] Q: Currently approximately how many cases do you
[13] have under review for litigation purposes?
[14] A: That's a hard one to answer because there's cases
[15] that I'm sent material on that I never hear about
[16] them. Active cases, four or five.
[17] Q: Are you able to estimate for me how many cases
[18] you're sent for review on an annual basis?
[19] A: Probably around 20. Maybe a little more than 20.
[20] Q: And how long have you been at the level of
[21] receiving approximately 20 cases per year in your
[22] medical/legal review activities?
[23] A: Probably the last three or four years.
[24] Q: Have you testified in trial?
[25] A: Yes, I have.

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[1] Q: How many times?
[2] A: Probably about 10 or 11 times.
[3] Q: And when was the last time?
[4] A: Last time was once this year so far.
[5] Q: And where was that case pending?
[6] A: That was in Ohio.
[7] Q: You testified for the plaintiff or the defendant
[8] in that case?
[9] A: That case was for the plaintiff.
[10] Q: How does your work break down for plaintiffs
[11] versus healthcare providers?
[12] A: 60 percent for defense or healthcare providers
[13] and 40 percent for plaintiffs.
[14] Q: And in what states have you accepted
[15] medical/legal work, from what states?
[16] A: Well, the majority of cases are from Ohio but
[17] also Illinois, West Virginia. I believe this is
[18] the first case I've ever been involved in from
[19] Maryland.
[20] Q: Do you know how Miss DiFranco or someone from her
[21] office came to contact you?
[22] A: I do not recall.
[23] Q: Have you ever provided expert review and
[24] testimony in a case with issues similar to the
[25] ones that we're discussing today?

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[1] A: I have.
[2] Q: On how many occasions?
[3] A: I can give at least one.
[4] Q: Tell me a little bit about that case.
[5] A: Well, I was a defense expert and there was an
[6] eight hour delay in treating C. diff and the
[7] allegation, and the patient ended up dying and
[8] the allegation was the eight hour delay directly
[9] lead to the patient's death and I was asked to
[10] review that case.
[11] Q: And you defended it on the basis that if indeed
[12] there was an eight hour delay, then that would
[13] have had no effect on the patient's outcome?
[14] A: Well, the patient had a sudden cardiac arrest
[15] which I don't think was necessarily related to
[16] the colitis. But I didn't think eight hours was
[17] critical in this patient's illness.
[18] Q: Did you go to trial in that case or was that
[19] deposition testimony?
[20] A: No trial.
[21] Q: So you did give a deposition in that case?
[22] A: I think there was a deposition.
[23] Q: And where was that case pending? Ohio or
[24] elsewhere?
[25] A: In Ohio.

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[1] Q: Any other C. difficile cases that come to mind?
[2] A: None that come to mind.
[3] Q: Doctor, have you ever been the subject of a claim
[4] for medical negligence?
[5] A: No, I have not.
[6] Q: Take me through your fee schedule, records
[7] review, deposition time and trial testimony.
[8] A: For records review, it's \$250 an hour. For
[9] deposition it's \$350 an hour and for trial
[10] testimony it's \$1,250 per half day.
[11] Q: Could you estimate for me what percentage of your
[12] annual income is derived from your activities in
[13] medical negligence cases?
[14] A: Probably 10 or 15 percent.
[15] Q: Up to the time of your deposition but not
[16] including it, are you able to tell me how much
[17] time you spent in the review of materials in your
[18] deposition preparation for this case?
[19] A: Total time in this case is probably between four
[20] and six hours.
[21] Q: Do the materials that you have there with you
[22] indicate when it was you were first contacted
[23] with regard to reviewing this matter on behalf of
[24] Mr. Brown's estate?
[25] A: Well, I have two letters from the firm Cook &

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[1] DiFranco, one dated November 17th and one dated
[2] April 28th, 2004. November 17th, 2003 was their
[3] first letter. So I would say I was probably
[4] contacted in the weeks before that.
[5] Q: By telephone?
[6] A: I imagine.
[7] Q: With the letter of November 17th, 2003, were
[8] medical records enclosed?
[9] A: There were.
[10] Q: Would you chronicle for me what was included in
[11] that first contact letter?
[12] A: It's St. Agnes Hospital records, the office
[13] records of Dr. Ochaney, the Charlestown Home
[14] Health Care notes, the North Arundel Hospital
[15] admission and University Hospital of Maryland
[16] admission.
[17] Q: Did that come to you in a binder?
[18] A: Yes, it did.
[19] Q: Since that time have you received additional
[20] records?
[21] A: Yes, I have.
[22] Q: Would you tell me about those records, where did
[23] they come from, et cetera?
[24] A: The only other thing I received was the
[25] deposition transcript of Dr. Ochaney.

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[1] Q: And that's the only deposition transcript you've
[2] reviewed to date?
[3] A: That's correct.
[4] Q: I assume you've not reviewed any radiology films?
[5] A: I have not.
[6] Q: And we talked briefly off the record before we
[7] got started, you said you had taken some notes on
[8] the back of a couple of letters, correct?
[9] A: Well, there's two letters from Miss DiFranco and
[10] there's some scribbling on the back of those
[11] letters. I'd be happy to copy front and back for
[12] you if you'd like.
[13] Q: That would be great. And those are the letters
[14] of November, 2003 and February, 2004?
[15] A: April, 2004.
[16] Q: April of 2004. Okay. Relative to the medical
[17] records that you reviewed, did you annotate or
[18] write on the medical records or did you simply
[19] take whatever notes you were going to take on
[20] that separate piece of paper we were talking
[21] about?
[22] A: I did not write on the records.
[23] Q: You're familiar with the medical/legal litigation
[24] process. Basically there are several areas in
[25] which expert witnesses are asked to testify.

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- [1] I assume you'll be offering standard of care
[2] opinions, correct?
[3] A: Correct.
[4] Q: And causation opinions?
[5] A: Correct.
[6] Q: Any other areas in which you will be rendering
[7] expert testimony?
[8] A: Not that I'm aware of. I don't know what other
[9] areas there were than those two.
[10] Q: Okay. Have you reviewed any medical literature,
[11] be it textbooks, Internet, treatises, peer review
[12] literature in conjunction with your review of
[13] this case?
[14] A: Not specifically for this case. I've done quite
[15] a bit of teaching about C. diff and I have read
[16] widely about it.
[17] Q: And when you teach with regard to C. diff, are
[18] there any particular materials upon which you
[19] rely?
[20] A: No.
[21] Q: And did you consult with any other physicians or
[22] peers relative to your review of this particular
[23] case?
[24] A: No.
[25] Q: You said you had the records from Mr. Brown's

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- [1] admission to St. Agnes Hospital.
[2] I believe it was during that time that Dr.
[3] Ochaney first encountered Mr. Brown, correct?
[4] A: Correct.
[5] Q: Did you have any problems with Dr. Ochaney's
[6] management of this patient from November 23rd
[7] through November 29th, 2001 at St. Agnes
[8] Hospital?
[9] A: No.
[10] Q: I assume you hold an opinion that Dr. Ochaney
[11] deviated from the standard of care with regard to
[12] some treatment of his of Mr. Brown, is that
[13] correct?
[14] A: That's correct.
[15] Q: Take me through your standard of care opinions as
[16] they relate to Dr. Ochaney and then I'll follow
[17] up with you accordingly.
[18] A: Okay. I guess there was three separate occasions
[19] or dates when I thought the standard of care
[20] issue came into play.
[21] On December 10th I think, on December 10th
[22] the patient presented to Dr. Ochaney with, quote,
[23] unquote, burst of liquid stools, uncontrolled
[24] since discharge. Again this is a patient who had
[25] been in the hospital on broad spectrum

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- [1] antibiotics, was discharged on broad spectrum
[2] antibiotics. I think his chief complaint at that
[3] visit was diarrhea.
[4] So I think the standard of care called for
[5] the physician to consider C. diff at that point
[6] and either do testing or provide empiric therapy
[7] given the clinical context of again someone who
[8] had been in the hospital, people pick up C. diff
[9] in the hospital, they pick up the bug, who have,
[10] been on antibiotics, discharged on antibiotics,
[11] who is complaining of lots of diarrhea, that's
[12] number one. Should I keep going?
[13] Q: Before you leave that, why don't you provide me
[14] with the basis for your opinion to the extent you
[15] haven't already. If you tell me that's
[16] everything, that's fine. But if you have a
[17] further basis for that opinion, I'd appreciate
[18] hearing it.
[19] A: I just expect an internist who is taking care of
[20] a patient who has recently been hospitalized,
[21] been given broad spectrum antibiotics, who
[22] presents with a chief complaint of diarrhea or
[23] significant complaint of diarrhea to think about
[24] C. diff and to either provide empiric therapy or
[25] testing for it. And that's probably it in a

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- [1] nutshell.
[2] Q: And before we leave that, that date, is it any
[3] diarrhea that raises the concern or does it have
[4] to be, you know, chronic or consistent diarrhea?
[5] Is there a way to quantify that or is that based
[6] pretty much on the physician's critical judgment
[7] when he encountered the patient and takes the
[8] history?
[9] A: Well, any change in stools or any diarrhea after
[10] hospitalization on broad spectrum antibiotics and
[11] discharged on antibiotics should raise the
[12] suspicion for C. diff.
[13] Q: Okay. Have we fairly covered all of your
[14] opinions as they relate to December 10th, 2001?
[15] A: I believe we have.
[16] Q: Let's move on to the next date.
[17] A: Next date is December 14th and I believe that
[18] there's a family member phone call who actually
[19] asked about C. diff at that date and again there
[20] wasn't any action taken regarding either therapy
[21] or diagnosis of C. diff and there was a
[22] prescription for Imodium and again I think the
[23] standard of care would call for an investigation
[24] and/or empiric therapy and for not giving
[25] Imodium.

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[1] Q: And I want to make sure that I understand your
[2] opinion as it relates both to December 10th and
[3] December 14th. The standard of care, I believe
[4] what I hear you telling me is the physician has a
[5] choice in order to comply with the standard of
[6] care.

[7] You could either do C. diff testing or you
[8] can institute empiric therapy, is that correct?

[9] A: Correct.

[10] Q: Now if one were to employ C. diff testing, and
[11] when you're talking about testing, what
[12] specifically are you referring to?

[13] A: In that case I would ask the patient and family
[14] to provide a stool sample and would probably
[15] order one of the toxin assays.

[16] Q: All right. Now if one performed a toxin assay
[17] for C. diff and the result was negative, what if
[18] anything would the standard of care require based
[19] on that finding?

[20] A: Well, if the patient's symptoms persisted or
[21] worsened, the standard of care would require
[22] empiric therapy or timely consultation.

[23] Q: And when you say consultation, are you referring
[24] to referral to an infectious disease specialist
[25] or gastroenterologist or both?

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[1] A: Probably both.

[2] Q: You mentioned a prescription for Imodium.
[3] Is it your belief that that is a deviation
[4] from the standard of care?

[5] A: I think if it is an isolated action, no. But in
[6] the context of not recognizing what's going on
[7] with this patient it was.

[8]

[9] (Thereupon, a recess was had.)

[10]

[11] Q: Just to summarize where we left off, you said the
[12] Imodium as an isolated incident would not be a
[13] violation, but I believe in this context you
[14] would have to assign a deviation from the
[15] standard of care by Dr. Ochaney prescribing
[16] Imodium in response to the phone call on December
[17] 14th, 2001, is that fair?

[18] A: Yeah. You know, a specific phone call about C.
[19] diff in a patient who was hospitalized on broad
[20] spectrum antibiotics, discharged on antibiotics
[21] and Prednisone and not, prescribing Imodium
[22] without thinking about C. diff or taking any
[23] appropriate action is a deviation.

[24] Q: And why would it be a violation of the standard
[25] of care in this context for Dr. Ochaney to have

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[1] prescribed the Imodium?

[2] A: Well, I have seen people prescribe Imodium along
[3] with specific therapy for C. diff or along with
[4] the workup for C. diff. I would not give Imodium
[5] and I don't think in general it's a good idea.
[6] But I think the isolated act of giving Imodium,
[7] to me, as an isolated action isn't significant
[8] compared to putting in context of the overall
[9] approach to this patient.

[10] Q: You are losing me just a little bit.

[11] Is it a problem with the Imodium in this case
[12] or not?

[13] A: There is in the sense it reflects not working up
[14] the patient for C. diff and not taking any
[15] further actions.

[16] Q: Would Imodium be contraindicated in a patient in
[17] whom one suspected C. difficile colitis? I think
[18] you said no.

[19] A: I think most people would not give Imodium to
[20] someone with C. diff and certainly I would never
[21] give it unless I was giving anti-C. diff therapy.
[22] I'm not aware of any literature that specifically
[23] says or has shown it to be harmful, however.

[24] Q: So the fact, and this is going to touch on
[25] causation a little bit, but the fact that the

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[1] patient was prescribed Imodium and assuming that
[2] he took the Imodium, you couldn't relate that to
[3] any harm to the patient, is that fair?

[4] A: I would not specifically make the Imodium a major
[5] issue, no.

[6] Q: Okay.

[7] A: What I would make a major issue is the next date,
[8] which I guess we're coming to.

[9] Q: All right. Have we fairly covered December 14th,
[10] 2001?

[11] A: We have.

[12] Q: All right. Why don't you go ahead with the next
[13] date.

[14] A: On December 17th I believe the doctor prescribed
[15] Augmentin and I consider this, I guess I would
[16] almost call it an egregious violation of standard
[17] of care.

[18] What happened on December 10th and 14th, I
[19] would expect a reasonable and prudent internal
[20] medicine doctor to think about C. diff or do the
[21] things I talked about. I think giving someone
[22] Augmentin, which is a major, major offender when
[23] it comes to the normal bowel flora, giving
[24] Augmentin to this patient in this context who has
[25] had these repeated complaints of diarrhea where

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[1] there should have been a concern about C. diff, I
[2] think that's, you know, just a huge error.
[3] Q: And why is that?
[4] A: Well, Augmentin, you know, if you look at all
[5] oral antibiotics that cause C. diff, Augmentin is
[6] one of the worst. It may be the worst in that it
[7] is used more than other drugs like clindamycin
[8] and to prescribe Augmentin, you know, to a
[9] patient in whom you should be concerned about
[10] ongoing C. diff without doing anything for the C.
[11] diff is a major error.
[12] Q: I assume that you hold the opinion that this
[13] patient, Mr. Brown, in fact suffered from C.
[14] difficile colitis, correct?
[15] A: In my opinion there is no question.
[16] Q: And when in your opinion did Mr. Brown contract
[17] C. difficile colitis?
[18] A: Well, it's really important that we get our terms
[19] right for my opinion. Because there's C. diff
[20] diarrhea, C. diff colitis and C. diff
[21] pseudomembranes colitis.
[22] I think he had C. diff diarrhea at least from
[23] the 10th on. The colitis, you know, the true
[24] colitis probably occurred later, more towards or
[25] around the time of the 17th.

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[1] But, you know, C. diff is a very
[2] heterogeneous disease. Some have mild, some have
[3] severe diarrhea. I would expect an internist to
[4] know it is heterogeneous.
[5] Q: I believe you told me earlier there is no
[6] evidence that he ever had pseudomembranous
[7] colitis as a result of C. difficile, is that
[8] fair?
[9] A: That's fair.
[10] Q: And you're aware that the Augmentin was
[11] prescribed for an infected ankle, is that right?
[12] A: Well, I'm aware that one of the home nurses I
[13] think called the doctor and said there was some
[14] redness over the malleolus.
[15] Again if I was getting a phone call like
[16] that, I would think this might be just as likely
[17] a stasis change than an infection. But it was
[18] related to a phone call from a visiting nurse,
[19] not examination by a physician.
[20] And my recollection was when he was admitted
[21] a few days later there wasn't any mention of
[22] cellulitis, although I'd have to look at the
[23] records to be 100 percent sure.
[24] Q: So is your criticism on the 17th the type of
[25] antibiotic or is it the prescription of any

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[1] antibiotic?
[2] A: Well, Augmentin is particularly bad. Again there
[3] are antibiotics that you could use to treat
[4] cellulitis that are not associated with C. diff
[5] but I think any antibiotic at that time in a
[6] patient with ongoing and specific concerns about
[7] C. diff and ongoing, you know, bursts of liquid
[8] stools, I think any antibiotic in that setting
[9] without thinking about C. diff is inappropriate.
[10] Q: All right.
[11]
[12] (Thereupon, a recess was had.)
[13]
[14] MR. MORTER: We're back on the
[15] record.
[16] Q: Doctor, was there anything else relative to
[17] December 17th, 2001 as it relates to your
[18] standard of care opinions and the bases thereof
[19] that we've not talked about?
[20] A: No.
[21] Q: All right. Are there any other, do you have any
[22] other standard of care opinions as it relates to
[23] Dr. Ochaney?
[24] A: The only other question I have, and this is based
[25] upon maybe incomplete information at this time,

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[1] other phone calls from the family to the office
[2] about diarrhea?
[3] Q: Okay.
[4] A: But I haven't read the family's depositions and
[5] so if there were more phone calls, and I'm not
[6] saying there were, if there were more phone calls
[7] about diarrhea, I would also cite those phone
[8] calls as concerns.
[9] Q: Based on the information you have at this point,
[10] you'd not be able to assign any deviation from
[11] the standard of care?
[12] A: That's correct.
[13] MS. DiFRANCO: To any other phone
[14] calls other than the ones you've already
[15] discussed.
[16] A: Right.
[17] Q: Doctor, if you're ultimately provided with the
[18] family depositions and you have opinions based
[19] thereon that rise to a level of deviation from
[20] the standard of care, I'd ask that you let Miss
[21] DiFranco know so we can take a short deposition
[22] to flush those out. Is that fair?
[23] A: Sure.
[24] Q: Thank you. Assuming Dr. Ochaney had referred Mr.
[25] Brown to a gastroenterologist on December 10th,

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[1] 2001, would that have complied with the standard
[2] of care as it related to the patient's complaints
[3] of diarrhea?

[4] A: No.

[5] Q: Why not?

[6] A: Well, I would expect an internist to know or
[7] recognize the clinical situation in which you
[8] would suspect C. diff and if he picked up the
[9] phone and said can you see this patient tomorrow
[10] it would have helped.

[11] But I think C. diff is something that an
[12] internist should recognize and know how to either
[13] work up or treat.

[14] Q: Okay. Before we leave the standard of care area,
[15] the notes that you have on the back of those two
[16] letters, could you simply read them into the
[17] record and in doing so reference which notes
[18] appear on which, you know, the back of which
[19] letter so I'll know when I look at them.

[20] A: Okay. The first letter is the letter of November
[21] 17th, 2003. These are just jottings that don't
[22] have any specific significance as to any
[23] opinions. I just sort of did it just to
[24] concentrate, jot things down as I go.

[25] 11/23/01 to 11/29, I think it says Cefoxitin

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[1] IV 10 slash Z. Decrease 02. Daughter nurse.
[2] '79, diabetes, neuropathy, COPD. NQWWS.
[3] Steroids. DC'd Levaquin. 12/10, Ochaney.
[4] Depression. Diarrhea. Colonoscopy. 12/17,
[5] 12/14, Lomotil. I can't read that. Some of it I
[6] can't read. 12/17, Augmentin. Infection, left
[7] malleolus. 12/19, diarrhea. Question going back
[8] to primary M.D. 12/21, IV Flagyl. Wolf consult.
[9] Severe somewhat chronic persistent diarrhea.
[10] White cell count, 27,000. That's it for the
[11] first letter.

[12] The next letter says med school Bombay. IM
[13] St. Agnes. Private practice 1991. 11/23/01,
[14] admitted under him, new patient. Shortness of
[15] breath, chest pain. NSSTWI. Possible consult.
[16] GI for tarry stools. ETD, gastritis. Cefoxitin.
[17] DC Levaquin, Prednisone. I can't read that. GI
[18] colonoscopy. 11/29, he called Grobotney, PMD.
[19] 12/7, home care call. 12/10, office visit.
[20] Burst of liquid stool. I can't read that.
[21] Question depression. Something I can't read.
[22] Possible plan, see GD as planned. Chief
[23] complaint, diarrhea. Something I can't read.
[24] Question not taking Levaquin. 12/14, family
[25] called, re C. diff. See GI, gave Imodium.

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[1] 12/17, Augmentin. Question cellulitis. Usual
[2] fever, pain. Lomotil makes C. diff worse. ✓

[3] That's the last note. I believe that last
[4] statement was again something that the doctor
[5] said in his deposition.

[6] Q: Okay. When we were talking about the standard of
[7] care violations, I don't have in my notes that
[8] you mentioned anything about Lomotil.

[9] Do you have any opinions relative to the
[10] administration of Lomotil?

[11] A: Well, my global opinions would be the same as we
[12] talked about for Imodium.

[13] Q: And would your causation opinion as it related to
[14] Lomotil be the same as it was as to Imodium?

[15] A: Yes.

[16] Q: All right. Before we move then into your
[17] causation opinions, do you have an opinion as to
[18] what the cause of Mr. Brown's death was?


[19] A: Complications from C. diff colitis.

[20] Q: What's the basis for that opinion?

[21] A: Well, he was admitted to, let me look at the
[22] records here, he was admitted to North Arundel
[23] Hospital December 24th and transferred to
[24] Maryland and just had a continued downhill course
[25] related to his C. diff colitis.

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[1] Q: And what complications from C. diff colitis do
[2] you identify which caused the patient's death?

[3] A: Well, C. diff colitis causes sort of a systemic
[4] inflammatory response, it causes your nutrition
[5] to go south, it causes exacerbation of other
[6] medical problems and, in his case, it led to a
[7] surgery which further weakened him. 

[8] Q: All right. What evidence is there in the
[9] Maryland records or the North Arundel records
[10] relative to systemic inflammatory response?

[11] A: Well, a very high white count.


[12] Q: Anything else?

[13] A: His serum albumin continued to drop.

[14] Q: Is that related to inflammatory problems or is
[15] that the nutritional problem you referenced?

[16] A: That would be both.

[17] Q: Okay. Any other parameters there reflecting
[18] problems with inflammatory response or
[19] nutritional problems?

[20] A: Those are the main ones. I think that Mr. Brown
[21] had some frailty and the C. diff colitis just
[22] created a stress to his system that led to a
[23] downhill course. 

[24] Q: I assume the appropriate treatment for C.
[25] difficile colitis is oral Vancomycin, is that

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[1] correct?
[2] A: Well, there's three basic treatments. IV or oral
[3] Flagyl or oral Vancomycin. Oral Vancomycin is
[4] somewhat expensive and sometimes hard to find.
[5] So most often people use oral metronidazole or if
[6] the patient has nausea or vomiting or can't take
[7] oral, intravenous.
[8] Q: Is it fair to say the oral route is more
[9] efficacious than IV?
[10] A: I would say without question for Vancomycin. I'm
[11] not sure that is true for metronidazole.
[12] Q: Which is Flagyl?
[13] A: Right.
[14] Q: I believe you told me earlier that the
[15] sensitivity of the C. difficile stool assay
[16] increases with repeated testing, is that a fair
[17] statement?
[18] A: It can in some cases.
[19] Q: How do you explain the finding on, I count four
[20] separate assays where the toxin result is
[21] negative?
[22] A: Which hospitalization are you talking about?
[23] Q: I've got a stool assay done at North Arundel
[24] Hospital where the C. difficile antigen is
[25] positive and the toxin is negative and that at

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[1] the University of Maryland Hospital, I believe
[2] beginning on December 25th and then thereafter
[3] three separate stool assays are done, all of
[4] which come back negative for the toxin.
[5] A: Yeah. You know, there's different toxins and
[6] there's different assays and all the assays, you
[7] know, lack really high sensitivity. There's also
[8] the issue about the time Mr. Brown went to the
[9] University of Maryland where he had been on
[10] therapy for a while which cuts down on the
[11] sensitivity.
[12] You know, it's well-known among people who
[13] have an interest in C. diff that sometimes the
[14] toxin assay is negative in patients who have
[15] pseudomembranous colitis. I've seen many
[16] patients and the toxin always says, it is not the
[17] be all and end all in making the diagnosis.
[18] There is very strong evidence in this patient,
[19] which I'm sure you'll ask me about, pointing to
[20] C. diff.
[21] Q: Why don't you take me through, you're exactly
[22] right, I do want to know exactly what it is about
[23] this patient that leads you to the opinion that
[24] he unquestionably had C. difficile diarrhea and
[25] then C. difficile colitis.

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[1] A: Well, the clinical context, you know, is highly
[2] suggestive of C. diff. that is someone who is in
[3] the hospital and C. diff is a spore forming
[4] gram-positive rod. The spores are pretty hardy.
[5] Unfortunately it's not uncommon to find the
[6] spores in a hospital environment. So people who
[7] haven't been previously colonized with C. diff
[8] pick it up in the hospital and at the same time
[9] they're in a hospital getting, picking up the
[10] spores and getting colonized with C. diff,
[11] they're put on broad spectrum antibiotics that
[12] wipe out the normal flora.
[13] So in the context of this patient being
[14] somewhat elderly, being in the hospital, on broad
[15] spectrum antibiotics and then developing
[16] diarrhea, I think if you look at those findings
[17] and ask what their positive predictive value for
[18] this diarrhea being associated with C. diff is
[19] extremely high.
[20] And the patient goes on, this diarrhea that
[21] gets worse on Augmentin, when he comes into the
[22] North Arundel Hospital on the 21st he has a white
[23] count during the hospitalization that's around
[24] 27,000, 28,000. Leukocytosis is one of the
[25] hallmarks of C. diff colitis. There is very few

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[1] infectious processes that cause that high of a
[2] white blood count. It is almost like a
[3] leukemoid. There's been literature on this, the
[4] higher the white count in a patient like this,
[5] again the stronger the positive predictive value
[6] is for C. diff colitis, particularly in the
[7] absence of any other reason to have a high white
[8] count.
[9] All the physicians at North Arundel thought,
[10] you know, without question that this person had
[11] C. diff colitis. The CAT Scans showed diffuse
[12] colitis.
[13] The only other alternative diagnosis that
[14] might cause this would be ischemic colitis but
[15] the clinical course is not consistent with
[16] ischemic colitis, the presentation isn't, the
[17] endoscopic findings weren't consistent with
[18] ischemic colitis.
[19] So there's no question in my mind that the
[20] patient had C. diff.
[21] Q: Would there be any other inflammatory bowel
[22] problems that would produce the type of result
[23] that you've just referenced to me other than
[24] ischemic colitis?
[25] A: You know, a plain colitis in a patient with a

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[1] 28,000 white count who has been on antibiotics,
[2] recently been in the hospital, I can't think of
[3] any other condition that would cause a plain
[4] colitis that presents that way other than
[5] ischemic colitis.

[6] But if a patient presented with ischemic
[7] colitis with a white count of 28,000, initially
[8] those patients are going to die in the next day
[9] or two because if they have that much
[10] inflammation from ischemic colitis, they usually
[11] go on and get necroses. I don't know if I ever
[12] saw a patient with ischemic colitis present with
[13] a white count that high.

[14] But when patients do present with ischemic
[15] colitis, it is an acute presentation that gets
[16] worse rapidly. The clinical course is much more
[17] consistent with C. diff colitis, as were the CAT
[18] Scans. All the physicians who saw him
[19] contemporaneously before there was any litigation
[20] believed he had C. diff colitis.

[21] Q: Is pseudomembranous colitis the end stage of C.
[22] diff colitis or can it occur at any time?

[23] A: Well, it's really — C. diff colitis or the
[24] diseases associated with C. diff are a spectrum
[25] and C. diff colitis is one presentation and I

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[1] don't know if it's continuum or spectrum, it's
[2] just one presentation.

[3] Q: So there would be no difference in the bowel's
[4] ability to absorb nutrients as between a C. diff
[5] colitis that has not progressed to a
[6] pseudomembranous colitis?

[7] A: I guess I think in general that a pseudomembrane
[8] colitis is worse than C. diff colitis without
[9] pseudomembranes. We see plenty of really sick
[10] patients who don't have pseudomembranes.

[11] Q: If one is going to expire as a result of C. diff
[12] colitis, is one more likely to expire if one has
[13] pseudomembranous colitis versus
[14] non-pseudomembranous colitis?

[15] A: I don't know.

[16] Q: What could have accounted for the positive
[17] antigen finding at North Arundel and the negative
[18] toxin finding at North Arundel?

[19] A: Well, I think we already discussed this. I think
[20] the antigen proves that the patient had C. diff.
[21] The toxin assays are imperfect. There's
[22] different toxins, different subtypes of toxins,
[23] different strains of C. diff and the toxin assay
[24] didn't pick up the toxin.

[25] Q: So is it your testimony that if stool is assayed

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[1] for C. diff, a finding of a positive antigen
[2] equals the diagnosis of C. difficile diarrhea or
[3] C. difficile colitis?

[4] A: No, that's not what I'm saying.

[5] Q: Then I'm confused. Maybe you could help me
[6] square that away.

[7] A: Well, you can find C. diff in people who don't
[8] have disease. The finding of C. diff in someone
[9] who has been on antibiotics, been in the
[10] hospital, has a white count of 27,000 and is
[11] having very significant diarrhea and colitis is,
[12] you know, in my mind, diagnostic.

[13] The toxin assay, you know, is more specific
[14] for being associated with disease but the
[15] detection of C. diff in the stool in the right
[16] patient is also highly diagnostic.

[17] Q: So you're saying then the antigen can increase
[18] your suspicion about the disease provided that
[19] you're seeing other things clinically that would
[20] support that?

[21] A: That's correct.

[22] Q: Is there anything else relative to the cause of
[23] Mr. Brown's death that we've not talked about?

[24] A: Not that I can think of.

[25] Q: Is there any evidence on surgical pathology that

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[1] the patient had C. difficile colitis, surgery
[2] from the University of Maryland?

[3] A: Well, the pathology findings are completely
[4] consistent with C. diff colitis.

[5] Q: And what is that? What does one expect to see
[6] pathologically?

[7] A: It is a heterogeneous disease, acute
[8] inflammation, ulceration are completely
[9] consistent with C. diff.

[10] Q: Do you have any opinion as to whether or not this
[11] patient had a GI bleed at the time he was at the
[12] University of Maryland?

[13] A: I believe he did.

[14] Q: Do you have an opinion as to the cause of that?

[15] A: No.

[16] Q: Do you believe that the fact that the patient had
[17] a GI bleed while at Maryland contributed to his
[18] demise?

[19] A: No, it did not.

[20] Q: I assume you'll not be offered on any issues of
[21] life expectancy?

[22] A: Well, if I was asked about it I'd give an
[23] opinion.

[24] Q: What's your opinion?

[25] A: I would expect someone like this to live, you

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[1] know, at least five more years.

[2] Q: And what's the basis for that opinion?

[3] A: 17 years clinical experience.

[4] Q: Have you ever had any of your own patients
[5] succumb to C. difficile colitis?

[6] A: I have.

[7] Q: In what clinical circumstance?

[8] A: I mean I can think of some specific patients. I
[9] can think of a specific patient that was sent in
[10] from a nursing home with, much like Mr. Brown
[11] and, you know, the patient came in with a really
[12] high white count and diarrhea, had been in the
[13] hospital, had been on antibiotics and we
[14] suspected C. diff colitis, gave appropriate
[15] therapy and the patient continued to go downhill
[16] and died.

[17] This tends to occur more often in elderly
[18] patients. The disease tends to be more severe in
[19] general in elderly patients.

[20] Q: And that patient that you just described to me,
[21] was there a delay in diagnosis or delay in the
[22] implementation of therapy?

[23] A: I don't know. There was no delay on our part
[24] because we recognized on admission that this was
[25] C. diff colitis. She was transferred from a

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[1] skilled nursing unit. I don't know if there had
[2] been issues that should have raised the suspicion
[3] earlier or not.

[4] Q: Do you recall based on the history you were
[5] provided of how many days duration her diarrhea
[6] was?

[7] A: I don't recall.

[8] Q: Is it your opinion that had appropriate therapy
[9] been administered to Mr. Brown, that he would not
[10] have succumbed to this C. diff colitis?

[11] A: Well, I think there's two things that really put
[12] him over the edge. One was not instituting
[13] therapy. Augmentin, I think giving him Augmentin
[14] on the 17th was literally throwing fuel on the
[15] fire.

[16] Those two things, not giving therapy and then
[17] the addition of an antibiotic that further set up
[18] the right substrate for C. diff, I think those
[19] two things contributed to his death.

[20] Q: Do you have a sense from reviewing the medical
[21] record when the latest time in which therapy,
[22] appropriate therapy could have been instituted
[23] and averted the outcome?

[24] A: Well, I think if he had not been given Augmentin,
[25] you know, certainly around the 17th or 18th, in

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[1] the absence of Augmentin might have averted the
[2] outcome. I think once he was given Augmentin, I
[3] don't think any therapy after that, you know, was
[4] going to make any difference.

[5] Q: And why is that? I mean what is it about the
[6] Augmentin that rendered him not susceptible to
[7] the treatment that was instituted first at North
[8] Arundel Hospital?

[9] A: Well, C. diff can improve in the absence of
[10] specific therapy if the normal flora in the colon
[11] is allowed to re-establish itself and the
[12] severity of the disease is somewhat related to
[13] the degree of inhibition of the normal flora.

[14] So there are patients, usually younger
[15] patients who have diarrhea from C. diff, usually
[16] not full-blown colitis but just have diarrhea,
[17] for C. diff in young patients who are otherwise
[18] healthy where just time and stopping any
[19] offending antibiotics can lead to the
[20] re-establishment of the normal flora and
[21] resolution of the diarrhea.

[22] Further insults in patients who are already
[23] having diarrhea from C. diff, further insults to
[24] the normal flora, just to allow a rapid
[25] escalation of the pathologic process, they allow

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[1] C. diff to further replicate, multiply and cause
[2] illness.

[3] Q: But if that's occurring, why would you not see
[4] the presence of either the antigen or the toxin
[5] on subsequent stool assays at the University of
[6] Maryland?

[7] A: Well, I think we already discussed why the toxin
[8] wasn't detected. I don't believe they tested for
[9] the antigen at Maryland. There's a lot of
[10] reasons why I don't see the toxin in patients and
[11] I could repeat those if you like.

[12] Q: No. I heard you earlier. I just, in relation to
[13] your opinion about Augmentin, I was just trying
[14] to further clarify that.

[15] A: Well, you know, we know Mr. Brown had severe
[16] colitis in the context that we've already
[17] discussed and we've discussed why sometimes the
[18] toxin assay just doesn't detect it. Some strains
[19] produce toxins not detected by the assays.

[20] In my clinical practice I've seen plenty of
[21] patients whom we made a clinical diagnosis of C.
[22] diff and the assays were negative for the toxin.

[23] Q: In general what is the sensitivity of the stool
[24] assay for C. diff?

[25] A: I think in general it's 60 or 70 percent.

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[1] Q: By what factor, if any, would you increase that
[2] sensitivity in light of multiple assays?

[3] A: I couldn't give you a number but I would say if
[4] it's a toxin not picked up by the assay, then
[5] repeat specimens would not help. Repeat
[6] specimens are more helpful in patients who have
[7] perhaps a low level of assay or technical issues
[8] with the collection of the specimens.

[9] Q: How many different toxins are there for the C.
[10] diff bug?

[11] A: There's at least two.

[12] Q: And do most commercially available lab tests
[13] assay both of those toxins?

[14] A: I don't know if I would say most. Some do, some
[15] don't.

[16] Q: Doctor, as you're sitting there, are there any
[17] other areas that you and Miss DiFranco may have
[18] discussed relative to your opinions in this case
[19] that you and I have not talked about?

[20] A: I don't think so. I think we hit on, we hit on
[21] most of them.

[22] Q: So as it relates to the standard of care, you and
[23] I have covered all your standard of care
[24] opinions, is that fair?

[25] A: That's fair.

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[1] Q: As it relates to the cause of Mr. Brown's death,
[2] you and I have touched upon all of your causation
[3] opinions, is that fair?

[4] A: That's fair.

[5] Q: And as it relates to life expectancy, we have
[6] touched upon all of your opinions in that regard
[7] as well, is that fair?

[8] A: That's fair.

[9] Q: Would you just give me a couple of minutes to
[10] review my notes? I think I'm just about done.

[11] A: Sure.

[12] (Thereupon, a recess was had.)

[13] Q: Just a little thing in one area, I just wanted to
[14] pin this down with you before I let you go.

[15] As it relates to your opinions relative to
[16] Imodium and Lomotil, you are not going to testify
[17] that the prescription and the taking of those
[18] medications by the patient caused or contributed
[19] to the cause of Mr. Brown's death, is that fair?

[20] A: Yes. My opinion regarding Lomotil and Imodium is
[21] that I don't think they should be prescribed and
[22] most people don't, but I don't think the isolated
[23] prescription as a stand-alone event is a critical

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[1] criticism I have and most people, I think there's
[2] a general opinion that prescribing anti-motility
[3] agents in any kind of infectious colitis can lead
[4] to worse outcomes but I'm not aware of any
[5] specific literature that supports that for C.
[6] diff colitis and, therefore, I'm not going to
[7] offer that as a specific opinion.

[8] Q: I just wanted to clear that up, that you weren't
[9] going to be saying that those medications caused
[10] or contributed to the cause of Mr. Brown's death.

[11] A: No. I think the critical issue here was lack of
[12] appropriate therapy and the Augmentin was
[13] critical.

[14] Q: Okay. I think I understand that now.

[15] MR. MORTER: You have the right to
[16] read and sign your deposition or you can
[17] waive that.

[18] THE WITNESS: I'd just as soon
[19] waive but I'll ask Miss DiFranco.

[20] MS. DIFRANCO: That's fine.

[21] THE WITNESS: Who is nodding it's
[22] okay to waive.

[23] MR. MORTER: Those are all the
[24] questions I have. I thank you for your
[25] time and patience.

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[1] (Thereupon, Defendant's Armitage Exhibit 2,
[2] one page letter dated November 17, 2003
[3] addressed to Keith Armitage, M.D. from Tina
[4] DiFranco, was marked for purposes of
[5] identification.)

[6] (Thereupon, Defendant's Armitage Exhibit 3,
[7] one page letter dated April 28, 2004
[8] addressed to Keith Armitage, M.D. from Tina
[9] DiFranco, was marked for purposes of
[10] identification.)

[11] (The reading and signing of the
[12] deposition was expressly waived by the witness
[13] and by stipulation of counsel.)

[1]

[2] CERTIFICATE

[3]

[4] The State of Ohio,) SS:

County of Cuyahoga.)

[5]

I, Linda A. Astuto, a Notary Public within

[6] and for the State of Ohio, authorized to

administer oaths and to take and certify

[7] depositions, do hereby certify that the

above-named witness was by me, before the giving

[8] of their deposition, first duly sworn to testify

the truth, the whole truth, and nothing but the

[9] truth; that the deposition as above-set forth was

reduced to writing by me by means of stenotypy,

[10] and was later transcribed into typewriting under

my direction; that this is a true record of the

[11] testimony given by the witness; that said

deposition was taken at the aforementioned time,

[12] date and place, pursuant to notice or stipulation

of counsel; and that I am not a relative or

[13] employee or attorney of any of the parties, or a

relative or employee of such attorney, or

[14] financially interested in this action; that I am

not, nor is the court reporting firm with which I

[15] am affiliated, under a contract as defined in

Civil Rule 28(D).

[16]

IN WITNESS WHEREOF, I have hereunto set my

[17] hand and seal of office, at Cleveland, Ohio, this

_____ day of _____ A.D. 20 _____.

[18]

[19]

[20]

Linda A. Astuto, Notary Public, State of Ohio

[21] 1750 Midland Building, Cleveland, Ohio 44115

My commission expires October 25, 2007

[22]

[23]

4]

[25]

Lawyer's Notes

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Lawyer's Notes
