IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

MARY LOU ZIMMERMAN, et al.,
Plaintiffs,
-vs-
JUDGE BURNSIDE
CASE NO. 399411

THE CLEVELAND CLINIC FOUNDATION,
Defendant.

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Deposition of ROBIN K. AWRY, M.D., taken as if upon cross-examination before Laura L. Ware, a Notary Public within and for the State of Ohio, at The Cleveland Clinic Foundation, 9500 Euclid Avenue, Room S32, Cleveland, Ohio, at 2:35 p.m. on Monday, September 11, 2000, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Defendant.

EXHIBIT INDEX

ROBIN K. AWRY, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF ROBIN K. AERY, M.D.

BY MR. LINTON:

Q. Dr. Avery, we meet just a moment ago. My name is Bob Linton. Together Mark Ruf and I represent Mary Lou Zimmerman and her husband, Sherman Zimmerman, in a case that's been filed against The Cleveland Clinic Foundation. We're here today to take your deposition.

Have you ever had your deposition taken before7

A. Not in this case.

Q. Okay. I assumed that was the case, because one of us would have taken it.

A. Right.

Q. But how about in other cases?

A. Yes.

Q. Now, how many times have you been deposed?

A. Once. I'm sorry, twice if we count the car accident. I was a witness to a car accident.

Q. Let's exclude that.

A. One medical case.

Q. Was that in connection with your employment here at the Clinic7

A. No.

Q. What was your involvement in the other case?

A. I was a friend of the patient.

Q. So what was your involvement in that case?

A. Oh, the other case, a patient was admitted to Cleveland Clinic on the Kaiser service, which is a complex relationship here, and I came by as a friend and phoned his physicians and asked them to change hls antibiotics, although I was not his treating doctor, so ultimately that patient sued the Kaiser physicians and I ended up testifying, being deposed.

Q. In that case7

A. In that case.

Q. Was that a malpractice case filed by your friend against Kaiser?

A. Yes.

Q. Was the Clinic a named party in that case, to your knowledge?

A. It was initially but it was dropped.

Q. The case proceeded against Kaiser?

A. Correct.

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Q. What was the infectious disease issue in that case?
A. Can I just ask a question?
Q. Sure.
THE WITNESS: Am I allowed to answer this without breaking the confidentiality?
MS. DISILVIO: I don't want you to give the patient's name.
THE WITNESS: Yes.
MS. DISILVIO: You can just very generally tell Mr. Linton what the infectious disease issue was.
THE WITNESS: Yes.
Q. Let me be clear about this.
A. Yes.
Q. First of all, you were not a treating physician, you were just a friend?
A. Correct.
Q. And you offered, I assume, opinions in your capacity as an infectious disease expert?
A. Correct.
Q. That's what I'm getting at.
A. Well, they didn't ask me as an expert witness. It was more to determine the facts.
Q. I see, What was the name of your friend?
MS. DISILVIO: Objection. I'm not

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going to let her answer that.
MR. LINTON: Well, she gave a deposition in that case. On what basis would she not be permitted to identify the case caption in which she testified in?
MS. DISILVIO: I'll be happy to provide you the case caption, but I'm not going to let her give her friend's name on the record.
MR. LINTON: And the basis for that?
MS. DISILVIO: Because she feels uncomfortable about it, Bob.
THE WITNESS: Well, I just don't know if -- I mean, during that time that was going on I was told not to discuss it with anyone.
MS. DISILVIO: Is it still going on?
Q. Has the case been resolved?
A. That's the problem. I heard a rumor it was resolved, but I haven't seen anything in writing, so I think it's possible it may still be going on.
Q. Will you provide to Marilena at the end of the deposition the name of the case, as best you can remember?
A. Yes.
MS. DISILVIO And I will be happy to provide it to you.

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Q. All right. That's fine. All this was not at all to pry into your background, it's simply to make sure you understand the process we're doing here today, the deposition. I take it you understand that?
A. Yes.
Q. It's important you understand all the questions that I ask and it's important that you give truthful and full answers to the best of your ability. You understand that?
A. Yes.
Q. It's an open book examination, so if you need to look at the records or a file or notes or anything else before answering, please feel free to do that, okay?
A. Yes.
Q. What did you do to prepare for your deposition today?
A. The two of us met together today and I met with Mr. Malone, the two of you together, previously.
MS. DISILVIO: And you need not tell us about our meetings or the substance of our discussions, but you can go ahead and tell him what you reviewed to prepare yourself for today.
A. I reviewed these records provided to me today, which

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are Xeroxs of the progress notes, the orders, and I did not review every page, but the substance in the clinical record. I also reviewed what we have in our computerized patient record, which includes microbiologic data, radiologic data and laboratory data.
Q. The computer data in the records, is that different than the information that's also been printed out in the patient's chart?
A. It is a subset of the patient's chart. It doesn't contain all the progress notes, but it does summarize the cultures in a neat and accessible way chronologically.
Q. So it's duplicative of what would be in the patient's chart, correct?
A. Yes, a portion of what would be in the patient's chart, that's right.
Q. Have you had a chance to talk to anyone, aside from the Cleveland Clinic lawyers, to prepare for your deposition today?
A. No.
Q. Have you talked at any time with Dr. Barnett since the filing of this lawsuit about this case?
A. No, I have not.
Q. Do you have an independent memory of Mary Lou

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Zimmerman as you sit here today?
A. Yes, I do.
Q. Tell us what you can remember about her.
A. Well, it's a pretty general question. Can you be more specific?
Q. Okay. First of all, would you be able to recognize her if you saw her?
A. I don't know.
Q. Do you remember any conversations that you had with her?
A. I remember that at that time she did not have much verbal output. I remember I saw her daily as part of my medical rounding for a period of two weeks, but my substantive conversations were really more with her family. My conversations with her were more like asking her did she have pain, was she nauseated, asking her to raise her hand or things of that nature.
Q. What do you remember about substantive conversations you had with her family?
A. Again, can you be more specific? I mean, I met and spoke with her family because they were always in the room, so I talked with them frequently.
Q. Well, let me ask it this way. For what condition were you treating Mary Lou Zimmerman?

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A. I was continuing antibiotic treatment started by my colleague, Dr. Rehm, for a brain abscess and bloodstream and wound infection due to klebsiella and staph aureus.
Q. And was it your belief that those two organisms were the cause of both the brain abscess, the bloodstream infection, and the wound infection?
A. That was our belief, yes.
Q. And does that remain your belief today?
A. Yes.
Q. What is the basis for that belief?
A. I was not the first one to evaluate her, but my understanding is that on October 4th she developed, or shortly before that, a high fever, had cultures taken from the blood, from the wound, from the urine and spinal fluid. The blood cultures, two sets, grew those same two organisms, the wound grew those two organisms, the urine grew a klebsiella pneumonia, which is a different organism from klebsiella oxytoca, the same family, and shortly thereafter her CT scan evolved to demonstrate an abscess in the right frontal lobe.
Q. And what antibiotic treatment did you continue to treat Mary Lou Zimmerman for for these three infections, or for the infections of these three

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locations?
A. You mean initially or later on? She had a variety of antibiotic changes.
Q. Okay. Let's start initially.
A. Okay. When I first took over she was receiving Oxacillin and Ceftriaxone. This was on 10 -- sorry. Let me just look at the record. I took over on 10-19 and she was on Oxacillin and Ceftriaxone at that time.
Q. And did her brain abscess ultimately respond to that treatment?
A. It responded partially.
Q. Does that further support your opinion that the bugs that were causing that abscess were the same as what were cultured in the blood and on the wound?
A. Yes.
Q. Did anybody in infectious disease here at the Clinic to your knowledge express a different opinion?
A. About -- I'm sorry, can you clarify that, please?
Q. Sure. About the bugs that were causing the brain abscess.
MS. DISILVIO: In other words, were they something other than klebsiella sxytoca and staph aureus?
MR. LINTON: Correct.

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A. I don't recall anyone expressing that opinion.
Q. Can we agree that based on your medical experience that with reasonable medical probability the likely--
- - - -
(Off the record.)
- - - -
A. Sorry to interrupt you.
Q. We can agree that the most likely organisms causing the brain abscess were the klebsiella and the staph that you just identified, correct?
A. Yes.
Q. Can we also agree that those organisms most likely came from the same source?
A. I can't say that for sure.
Q. Would you say it's probably from the same source?
A. I would say it's likely, but I can't say it conclusively.
Q. Why do you believe it was likely that they would come from the same source?
A. Well, it's unusual to have two simultaneous infections at exactly the same moment from different sources, although that can occur.
Q. Far more likely to be from the same source?
A. I would say so. I'd say likely.

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Q. Now, Dr. Barnett told us that there were three possible sources for these bugs, that would be direct inoculation at the time of surgery from a contaminated probe, that would be a post-op wound infection or a bacteremia. Would you agree that those are the three likely causes of the infections you were treating?
A. Yes.
Q. Are you able to say which of those three is the most likely?
A. No.
Q. Dr. Barnett says that her clinical picture is consistent with an infection from a contaminated probe at the time of surgery. Do you agree with that?
MS. DISILVIO I'm going to object to the characterization of Dr. Barnett's testimony. With that objection, you may answer.
A. I don't know.
Q. Well, let me ask it this way. Do you believe that her clinical picture is inconsistent with there being contamination of the probe at the time of the surgery?
MS. DISILVIO Clinical picture at what

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time?
MR. LINTON: At any time during the time she was here at the Cleveland Clinic.
A. I really think it could have been any of the possibilities we mentioned.
Q. So her picture is entirely consistent with it coming from a contaminated probe at the time of the surgery?
A. That and the other possibilities also.
Q. What about her -- strike that.
What would be the basis for your conclusion that it could be caused by a contaminated probe?
A. I haven't concluded -- oh, that it could be caused?
Q. Right.
A. Well, first of all, the general principle is that surgical postoperative infections may relate to events in the operating room, events later on in the postoperative phase regarding the wound, or seeding from a distant site. In this case I don't have a specific opinion about which of those was the cause.
Q. Just so I'm clear, you cannot state with reasonable medical probability which of those three was the cause, correct?
A. Correct.

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Q. How long does it take for a scalp wound, like the kind Mary Lou Zimmerman had for her surgery, to heal in the ordinary course of events?
A. My impression is that it varies with the patient and in addition neurosurgery patients frequently being on steroids may delay wound healing, so it can be quite variable.
Q. What would be the range, in your experience?
MS. DISILVIO For a neurosurgical patient?
MR. LINTON: For patients like Mary Lou Zimmerman, correct.
A. That's hard for me to say, because I really don't get called to see patients that heal without problem.
Q. Well, I assume when you are called and there is a problem you have some expectation as to what the normal healing process would be.
A. True, but I actually deal a great deal with immunocompromised patients, so it doesn't surprise me if a wound hasn't healed after some weeks.
Q. Did the wound in Mary Lou Zimmerman's case heal initially, the scalp wound?
A. I can only speak to the time that I saw her on the 19th of October. At that point it was healed,

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however, I cannot speak to the healing time before that.
Q. And when you say was healed, all four incisions?
A. To the best my recollection. Or if they weren't completely healed, they were close enough that they did not look worrisome to us.
Q. Assuming that the cause of an infection like this is bacteremia, how do the organisms get in the blood; how could that happen?
A. Well, if the organisms are present at some other site where they are infecting, they may enter the bloodstream in a variety of ways, but it is also more common to have a bacteremic infection when somebody is on steroids.
Q. And what's the source of the infection?
A. I'm sorry, of which infection?
Q. When they're on steroids, how do the organisms actually get into the blood?
A. Right. Really, there can be a number of sources. I did not see the patient at the time that she had this infection, so it's difficult for me to comment on what other potential sources she could have had.
Q. Did you form an opinion at any time during your treatment of Mary Lou Zimmerman about which of the three sources of -- strike that.

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Did you form an opinion at any time during your treatment of Mary Lou Zimmerman as to which of the three causes of the infection were the most likely?
A. I don't recall that I did.
Q. Do your notes reflect that you did?
A. I don't believe so.
Q. How did this infection happen?
A. I don't know.
Q. Do you have any thoughts as to how it happened?
MS. DISILVIO Objection.
A. Well, to repeat what I said to you a little earlier, if I may --
Q. Don't necessarily repeat anything you two discussed it private, but just tell me your own thoughts.
A. Sure. This is my own thoughts.
MS. DISILVIO: And I'm going to object. Other than the three things she's already told you, you may answer the question again.
A. Okay. There is no sterile technique in the world that is a hundred percent guaranteed of no germs because we're dealing with things like skin, which is a nonsterile surface to begin with, and I think that no matter what techniques are used bacteria can get into a wound and bacteria can turn up in the

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operating room, albeit at a very low wound infection rate, nonetheless this can occur despite all of our good intentions. My general thoughts about postoperative wound infections is that they happen and that that is not necessarily due in any one case to an error.
Q. We can agree that breach in sterile techniques can cause an infection, correct?
A. That's true, correct.
Q. So for example, if the probe in this case was not properly sterilized, that could have caused this infection, correct?
A. It is possible.
Q. Likewise, if there was a breach in sterile technique and the patient was not properly prepped, that too could cause this infection, correct?
A. It is possible.
Q. Likewise, if there was a breach in sterile technique and the physician or one of the assistants failed to properly scrub, that too could lead to this type of infection?
A. That is possible.
Q. And likewise, if in the postoperative period during a dressing change proper sterile technique was not followed, that too could cause this type of

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infection?
A. That is possible.
Q. And have you ever seen a record that you've reviewed here at the Cleveland Clinic that actually stated that there was a breach in sterile technique? Is that information something that's typically charted?
A. Yes, I actually recall -- it was actually at my previous institution where I trained as an infectious disease fellow.
Q. Up at Harvard?
A. At Massachusetts General Hospital, yes.
Q. How long have you been at the Cleveland Clinic?
A. Since 1993.
Q. How many postoperative wound infections have you treated or assisted in the treatment of?
A. I don't know the number, but certainly there have been numerous ones over the years. We see a huge volume of patients of all varieties, some are postoperative, many are not.
Q. Would it be fair to say you've seen more than a hundred post-op wound infections since 1993?
A. I'd really have to go back and look at our numbers. I can't give you a good estimate.
Q. Would it be more than 50?

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A. I'd have to look at the numbers.
Q. Aside from the one incident you just pointed out at Harvard, are you aware of any time that's been charted in the Cleveland Clinic record that there was a breach in sterile technique in any of the cases in which you were called to treat or assist in the treatment of a post-op wound infection?
A. Not that I can recall.
Q. Would you agree that klebsiella oxytoca is an unusual organism to have in a post-op wound infection? Strike that.
Would you agree that klebsiella oxytoca is an unusual organism to have in a post-op infection, neurosurgery case?
A. Neurosurgery, I'd say it is, it's unusual, but it's not unheard of.
Q. Have there been any other neurosurgical cases that you've been involved with here at the Cleveland Clinic that have had that organism in a post-op infection?
A. Let me think back. In preparing for this I didn't go back over all the other cases I've treated over the years, so I don't recall other bacteriology.
Q. Have you been involved in any infection control committees here at the Cleveland Clinic that have

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addressed klebsiella infections here at the hospital?
A. No, I personally have not.
Q. Have you reported at all to those committees?
A. I consult with them periodically, but I don't recall speaking with them about klebsiella specifically.
Q. How about Dr. Barnett's procedures?
A. No.
Q. How about stereotactic procedures?
A. No.
Q. Have you been involved in treating any other post-op neurosurgery infections involving psychosurgery by --
MS. DISILVIO: Wound infection?
Q. Post-op infections, either wound or abscess, relating to psychosurgery, cingulotomies or capsulotomies?
A. I don't recall any others of that nature.
Q. Is the klebsiella oxytoca an organism typically found on the scalp?
A. It's most commonly found in the colonic and intestinal flora. Klebsiella is a normal inhabitant of the gut bacterial flora, however, for people who are debilitated, elderly, diabetic or immunocompromised, they may be more likely to have

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gram negative bacteria on widespread areas of their skin.
Q. And why is that?
A. Well, partly maybe from issues of hygiene and self inoculation, and in addition they may just be less resistant to colonization by those organisms elsewhere.
Q. Well, let's talk specifically about Mary Lou Zimmerman. Did you know she had obsessive-compulsive disorder?
A. Yes, I did.
Q. And what was your understanding as to the nature of her disorder?
A. I really don't have all the details regarding that.
Q. Do you know she had an obsession with cleanliness?
A. I did not know that.
Q. Were you aware of any hygiene problems that she had when she presented here for surgery?
A. I didn't see her when she presented.
Q. Do you have firsthand knowledge of any, based on your review of the record?
A. All I can mention is that it's mentioned in one of the notes that she did have some fecal incontinence at some time during the admission.
Q. Was that pre-op or post-op?

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A. That was post-op.
Q. Anything to suggest she had any problems with hygiene pre-op?
A. I really can't say I reviewed the record as to that.
Q. So you don't know of any as you sit here?
A. I don't know.
Q. Any problems that you know of Mary Lou Zimmerman having relating to self inoculation before surgery?
A. I don't know.
Q. Anything about her medically that would make her less resistant than the normal population with respect to a gram negative bacteria?
MS. DISILVIO: Pre-op or post-op?
MR. LINTON: Pre-op.
A. I really don't know enough about her pre-op status to say that.
Q. You don't know of any as you sit here?
A. I don't know enough about her post-op status.
MS. DISILVIO Pre-op.
A. I'm sorry, pre-op.
Q. But you don't know of any as we sit here, correct?
A. Correct.
Q. Is there any reference anywhere in the records that you're aware of that Mary Lou Zimmerman may herself

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have been contaminating her wound site after the surgery?
A. In terms of a direct description of this, no.
Q. How about any reference at all in the record to her contaminating her own wound site?
A. Not that I'm aware of.
Q. Were you aware during the two-week continual basis you saw her of her in any way contaminating her own wound site?
A. No, I was not.
Q. Was she compliant with the medical treatment, to your knowledge?
A. Well, speaking of the period from October 19th to November 1st, which was well after the events that occurred, I don't recall truthfully whether she was compliant with anything or not or whether she may have refused medications at times. I don't recall.
Q. Do you have any chart in your records during that two-week period of her being noncompliant?
A. I haven't reviewed the records with that in mind.
Q. Before your deposition I assume you reviewed all your entries for that two-week period, didn't you?
A. I looked at my notes, yes, but I didn't read every other note.
Q. In terms of your notes, did you note her being

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noncompliant during that time period?
A. No, I did not.
Q. Is that a significant finding that you ordinarily note, if in fact she had been noncompliant with your treatment during that time?
A. I would not necessarily have known or commented on that.
Q. That's not something that you typically put down?
A. Not necessarily.
Q. Do you have an independent memory as you sit here of her being noncompliant during that time?
A. I really can't recall.
Q. Would you agree that if Mary Lou Zimmerman's surface wound had healed before October 4th of 1998 it was unlikely to be the source of her Infection?
A. No, I would not agree with that.
Q. And why is that?
A. Because we sometimes see wounds that look innocent actually turn out to be sources of infection.
Q. Have you ever been present during this type of surgery?
A. No.
Q. Have you ever been present during neurosurgery?
A. Yes.
Q. When was the last time you were physically present

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during neurosurgery?
A. It must have been a long time ago. We are occasionally called to the operating room to assist with delivering culture specimens, but it would have been a while ago.
Q. When you say a while ago, how long a time are we talking about?
A. Probably at least four or five years.
Q. Do you know what techniques are used by the neurosurgeons to follow proper sterile technique before doing this type of surgery?
A. No, I really don't.
Q. Do you know what techniques are used at Cleveland Clinic to see that the probe and other surgical equipment are properly sterilized before the surgery?
A. No, I don't.
Q. And do you know how the skin is prepped for this patient before this type of surgery is performed?
A. No.
Q. Why was it that you were originally called in to consult on this case on October 19th?
A. We have a routine switch in our infectious disease consult service every two weeks, and I was scheduled to take over for Dr. Rehm at that time.

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Q. And is that likewise why Dr. McHenry took over for you?
A. Correct.
Q. Before taking over Mary Lou Zimmerman's case, did you have a discussion with Dr. Rehm about her condition?
A. I'm sure I did because we always sit down and have a sign-out session, but I don't recall what she said.
Q. Likewise, before Dr. McHenry took over, did you have a session with him to discuss the status of her condition?
A. I'm sure I did, but I don't recall the contents of that either.
Q. Can you give me some idea in a normal week in the Clinic back in 1998 how many patients you would have consulted for?
A. At anyone time we might be following between 15 and 25 patients, occasionally more.
Q. Do you recall any discussions you had with the family about the cause of the infection?
A. Yes.
Q. What can you tell us about that?
A. I recall that they wanted to know what the source of the infection was, and I told them similarly to what I just said, that there were three major general

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possibilities for a source but that often in practice we don't have a good way of determining which of those it could have been.
Q. Who was present during that discussion?
A. I don't remember.
Q. Was Mr. Zimmerman there, Sherman Zimmerman?
A. It's very possible, because I remember speaking with him, but I don't know if it was that exact conversation. I remember speaking with a number of different family members over time, but I don't recall exactly which conversation went with which family member.
Q. Are you able to pinpoint a date of this conversation based on the notes in your chart?
A. I recall that they asked me fairly soon after I took over, so it might have been on the second or third day, but I can't be sure exactly.
Q. Did you have more than one discussion with the family about the source of infection?
A. Yes. I recall they repeatedly asked me this question, and I gave them really what was the best answer I could.
Q. Did they ever tell you that people at the Cleveland Clinic had told them otherwise?
A. Otherwise than --

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Q. Than what you said in terms of the source of the infection.
A. No, I don't recall their ever saying that.
Q. Were you present at any time when any of the neurosurgeons discussed the source of the infection?
A. Yes. There was a family meeting which occurred shortly after Dr. McHenry took over, in fact I think it was the first day he took over, and present was Dr. Barnett, Lori Bell, the social worker, myself, the psychiatrist, and some family members, I don't remember exactly which ones, and Dr. Barnett reviewed the whole course, discussed it with them.
Q. And what did he say?
A. I really don't recall exactly what he said.
Q. Do you recall what he said in terms of the source of the contamination, the source --excuse me, the source of the infection?
A. I don't recall that he felt there was a definite source at that time.
Q. Did he at any time?
A. Not that I'm aware of.
Q. Did anybody on neurosurgery, to your knowledge?
A. Speak to me about a source, no.
Q. Did anybody in your presence speak to the family

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about a source?
A. Not that --
MS. DISILVIO: Other than what we've already talked about?
A. Other than what we've already talked about, not that I recall.
Q. Did you make any requests or assist in any requests to have the Cleveland Clinic waive any medical expenses of Mary Lou Zimmerman's?
A. I don't recall being asked about that. Could I please refer to my notes of that family meeting? I think I did leave a note. Let me see if there's anything else I can add.
Q. Oh, sure.
A. Maybe I didn't leave a note. Sorry, I don't find a note from myself that day.
Q. Do you know if Mary Lou Zimmerman was given prophylactics before surgery, prophylactic antibiotics?
A. I know she received Ancef, which is Cefazolin, for 48 hours after surgery, which was in her postoperative orders, but I did not look to see what her preoperative prophylaxis was, if any.
Q. Assuming that the most likely cause of her infection was direct inoculation with a contaminated probe at

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the time of surgery, what effect would the post-op antibiotics have on her infection?
MS. DISILVIO: Objection to the hypothetical. You may answer.
A. Well, I don't really think I'm competent to answer that question.
Q. Why is that?
A. I don't know of any data where direct inoculation of that nature was followed by 48 hours of antibiotics, so I can't really say whether or not that would have prevented an infection.
Q. Can we agree that it would delay the onset of symptoms from that infection?
MS. DISILVIO: Objection. You may answer.
A. I would say it's possible, but I really can't say that. I don't have expertise enough to say one way or the other. I'm sure there is -- I'm sure there must be research of that nature, I just don't know it.
Q. Did you review any medical literature to prepare for your deposition here today?
A. No.
Q. Did you review any medical literature at any time in connection with your care of Mary Lou Zimmerman?

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A. I don't recall. I mean, I read all the time, but I don't remember specifically reading something regarding her.
Q. I assume that in your capacity here at the Clinic you teach fellows and residents in infectious disease?
A. Yes.
Q. If one of your fellows or residents wanted to learn more about post-op wound infection, what medical textbooks would you refer them to?
A. Well, I think rather than textbooks these days we would do a search and update our literature. A lot of the literature I trained with now is old, so we try to get the latest when we can.
Q. And what medical literature would you refer your students to?
A. Well, I'm trying to think what I've looked up recently that's helpful regarding something like that. I mean, our basic textbook we refer to most often is Mandell, Douglas, Barnett, but I wouldn't say that it is definitive in every word because things are changing rapidly.
Q. What about in terms of medical literature, what journals would you refer your students to?
A. Journals in general or particular articles?

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Q. Let's talk particular articles.
A. Okay. Well, the particular articles that I give my students and fellows most often, I have a set of articles on catheter related infections, I have a set of articles on endocarditis, I have all these in the office, if you're interested, sternal wound infections.
Q. Did you say external?
A. Sternal.
Q. Sternal.
A. We do a lot of cardiac surgery here, as you know, and my particular specialty is transplant infectious disease. So I can cite you to any literature pretty much in that field, but I don't recall pulling any articles recently on neurosurgical wound infections.
Q. What journals would you go to if you were researching that?
A. Well, again the surgeon could turn up articles in many different journals, but the ID journals we read most often include Clinical Infectious Disease, Journal of Infectious Disease, New England Journal, Annals of Internal Medicine, JAMA, et cetera.
Q. I want to just go over a few things. I think we've covered them, but you cannot tell us how Mary Lou Zimmerman got infected, can you?

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MS. DISILVIO: Objection. Asked and answered. You may answer again.
A. Correct.
Q. You cannot say when she received the infection?
MS. DISILVIO Objection. Asked and answered. You may answer again.
A. You mean when the infection originally started, when was the onset? The term received the infection was --
Q. That was vague. You can't tell us when she -- you can't tell us the source of the infection, correct?
A. Correct.
Q. And if the source -- strike that.
You can't tell us whether the brain infected the surface wound or the surface wound infected the brain, correct?
A. Correct.
Q. And likewise, you can't tell us whether the brain infected the surface wound --strike that.
You can't tell us whether the brain infected the blood or the blood infected the brain?
A. Correct.
Q. Assuming the brain was the cause of the -- strike that.
Assuming that it was a contaminated probe that

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caused the Infection in the brain and that then caused the infection on the wound and the brain likewise caused the infection in the blood, assuming that scenario, what would you expect the spinal fluid to show?
MS. DISILVIO: Objection.
A. Well, the spinal fluid at this point is going to be dependent on the presence of a brain abscess regardless of which caused which. I believe the spinal fluid was consistent with what we call a parameningeal focus, meaning not directed to the spinal fluid itself, but contiguous enough to cause an infection in an inflammatory pattern, however that doesn't speak to what caused what regarding the brain abscess.
Q. So the brain abscess, in effect, spreads to the spinal fluid?
A. No, it doesn't spread in terms of direct bacterial spread, but the contiguity inflames the meninges, which are the linings in which the spinal fluid resides, and that usually causes a moderate elevation in the spinal fluid white count, but not nearly as high as if you actually had bacferia within that fluid itself.
Q. There's no evidence here that her white blood count

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was high enough to show an actual contamination of the CSF itself?
A. Correct, although I prefer the term infection rather than contamination there, yes.
Q. And likewise, the presence or absence of the infection in the CSF does not say anything about the source of the infection?
A. Correct.
Q. Tell me, with the bacteremia how does the organism get into the back -- excuse me. How does the organism get into the blood to begin with?
A. Well, many different possible ways, depending on the source, but usually there's some apparent or inapparent breach in some lining somewhere or inflammation in some normal lining.
For example, when a gallbladder is inflamed, bacteria present within the gallbladder can take the opportunity to traverse the lining and enter the bloodstream, or when someone has inflammation or ulcers in the colon, then bacteria from the colon that normally stay there can proceed through that lining and enter the bloodstream. But depending on the source and the site, there are many different ways that that could occur.
Q. Based on your treatment of the patient and your

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review of the records, did you notice any abnormal condition or process going on in her gut that would make her more susceptible to a blood infection?
A. Not that I recall.
Q. What would be the potential sources of the blood infection or bacteremia for Mary Lou Zimmerman?
A. Well, I can't say that there's any one source that I can implicate.
Q. What are the potential sources?
A. Of bacteremias in general?
Q. In general that would apply to her case.
A. Right, right. Well, I don't really know how to apply it to her case since I didn't see her during this time when she was developing the infection, but possible sources for bacteremias include lungs, urine, GI tract, skin, catheter sites or sites of any other indwelling foreign bodies like chest tubes or things of that nature, which she didn't have, but not having seen her again during the initial evaluation I can't really pinpoint any particular source that might have been there.
Q. Can you rule out any sources?
A. No.
Q. Did she have, to your knowledge, any abnormalities in her lungs?

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A. No.
MS. DISILVIO: Are you talking about initially postoperative?
MR. LINTON Yes.
A. I don't know.
Q. How about in her urine?
A. She had a urine culture at the same time as the bacteremia that grew klebsiella pneumonia, so she did have a urinary tract infection.
Q. You said she did?
A. Yes.
Q. So doesn't that most likely rule it out as the source of the bacteremia in terms of probabilities?
A. I actually looked into this because I wondered if that could, in fact, be the same organism misidentified by the microbiology lab, and I asked our head of microbiology, Dr. Procop, P-R-O-C-O-P, and he said that usually they can distinguish those pretty readily, but they are similar organisms.
Q. So there is the possibility that they can be mistakenly identified, in this case they probably were properly identified?
A. I think that's probably a good way to put it.
Q. And assuming it's a different organism, isn't it unlikely to be the cause of the infection in the

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blood, which is of a different organism?
A. Well, I'm still not sure. I still think it's an awfully funny coincidence that we should have two klebsiellas at the same time turning up on exactly the same day. So despite what our micro director says, I still wonder, but I certainly have no definitive way to state that that's the source.
Q. Assuming that the kleb. in the urine was different than what's in the blood, can we agree that the urine was likely not the source of the infection in the blood --
MS. DISILVIO: Objection.
Q. -- just in terms of probability?
MS. DISILVIO. Asked and answered.
Q. We're not talking about absolute certainties, but in terms of probabilities.
A. Well, I would say that if we knew for sure they were two different, but that makes it less likely, however --
Q. Assuming--
MS. DISILVIO. Bob, please let her finish her answer.
Q. But based on the assumption they are two separate bugs, then it is likely not the cause of that infection, correct?

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MS. DISILVIO. Doctor, please continue to answer the question.
A. I'm sorry, let me catch my train of thought.
Q. I'm going to interrupt.
MS. DISILVIO Can you let her finish her answer? Laura, could you go back and read me her answer and where we got cut off at the however.
A. That's okay. I think I remember it.
Q. Goahead.
A. Assuming that we knew for sure these were two different bugs, that would make it less likely, however I have seen cases where one bug in the urine overgrows and masks the presence of others. I admit that's unusual, but I can't be a hundred percent sure.
Q. Do you have any evidence in this case that her skin was the likely source of the infection in the blood?
A. No.
Q. Do you have any evidence in this case that her catheter was a likely source of the infection in the blood?
A. You mean the intravenous --
Q. Yes.

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A. No, I don't.
Q. What about her chest tube; she had no chest tube?
A. She did not have a chest tube. That was just in general.
Q. So that obviously was not the case here, correct?
A. Correct.
Q. And do you have any evidence that her GI tract was a likely source of her blood infection here?
A. No, but with the mention of fecal incontinence that raises some questions, however I have no direct evidence.
Q. What would be required for fecal incontinence to lead to a blood infection?
A. Well, any kind of inflammation in the colon and diarrhea of all sorts. I assume with fecal incontinence, they may be talking about diarrhea. Diarrhea can damage or injure the lining of the intestinal mucosa, and that could potentially allow a bacteria to enter the bloodstream.
Q. What if she had fecal incontinence without diarrhea?
A. Well, again, even from hemorrhoids or small fissures near the anus, if she were having difficulty passing stool and was straining for example, then stool bacteria could potentially enter from the anal

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area.
Q. Do you have any evidence in fact that she had hemorrhoids or fissures?
A. No.
Q. If we could go through your progress notes. Having just reviewed the laundry list of possible causes of bacteremia, do you agree you have no evidence that the blood infection was, in fact, the likely cause of the brain abscess or the wound infection in this case?
MS. DISILVIO Well, I'm going to object because she's already told you she didn't see the patient immediately postoperative, but with that objection if you can answer it, go ahead.
MR. LINTON: I understand.
A. Correct.
Q. If we can go through the progress notes, I'd like you to review for us the notes that you would have written or signed.
A. Uh-huh. Do you want me to read them to you?
Q. If you would. First of all, the first entry is on 10-19?
A. 10-19, correct.
Q. Okay. If you don't mind, I'm going to look over

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your shoulder so I can see what you're looking at.
A. Do you want me to come over to that side?
Q. There's probably more room on your side.
A. Okay. 10-19-98, taking over ID consult service from Dr. Rehm today. Continues on Oxacillin, Ceftriaxone for MSSA/klebsiella, that's a slash, MSSA, slash, klebsiella.
Q. Take your time.
A. Brain abscess and bacteremia. White blood count 4.46 bears watching. Creatinine 0.6. Plans for repeat CT noted, agree with check C diff. So she must have had diarrhea because we were ordering a C difficile to see if that was the cause of her diarrhea. Do you want me to go to the next one?
Q. Yes.
A. Okay. 10-20-98, afebrile and stable. Awake, staring, not following commands to my exam but reportedly more verbal at times. Chest clear, COR, no murmur, abdomen soft, plus bowel sounds, nontender, Hickman in place, extremities negative, skin negative.
That would have meant no rash because that's what we were looking for with the antibiotics. Labs, urine 10-19 negative, C diff. 10-18 negative, CSF 10-16 culture negative, creatinine 0.6, white

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count 4.7, CT, will review. No change per neurosurgery. impression--
Q. Go ahead.
A. Impression, one, we're at approximately eight weeks. Oxacillin, slash, Ceftriaxone for MSSA/klebsiella, brain abscess, bacteremia, plans for LP noted. Two, relative leukopenia following decrease over time, on high dose beta lactam. If neurosurg. feels no drainage procedure will be necessary, we can set up IV antibiotics at any time at rehab facility, if desired by team, with lab work faxed to us.
Q. Let me ask you, was there an issue at this point as to whether the abscess should be drained?
A. I recall that question coming up. I do recall Dr. Barnett addressed this during the family meeting because the family asked would that have accelerated her improvement, and as I recall his answer was that that had a chance of making her significantly worse neurologically.
Q. Is that a treatment issue that you defer to neurosurgery, or do you make that recommendation independent of whether surgery is a necessary form of treatment for a brain abscess?
A. We generally defer to neurosurgery.

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Q. Let me just stop for a moment here.
A. Yeah, we might be missing something here.
Q. On pages like this, the 10-22-98, it says ID with Dr. Avery. Is that written by your resident?
A. Yes, this is either a medical student or resident on our team.
Q. We'll come back to those entries, but let's just look for your entries right now.
A. Right, right. And I can't find mine from 10-22 for some reason. Here's 10-23. Afebrile, above CSF culture noted, it is GPC, that means gram positive cocci, in pairs and chains, suspect viridans strep, likely contaminant since covered by the regimen she has been on already. Also only six percent – only six white cells with one percent polys, doubt new bacterial infection, however, will check isolate identification later today with micro lab. Urine negative, C diff. negative, creatinine 0.6, white count 3.98, CSF 10-21, glucose 51, protein 73, red cells 14, while cells six, one percent polys. 10-16, glucose 58, protein 46. This is also a CSF, I'm sorry. RBC 35, while cells six. On exam, comfortable, afebrile, nonverbal. Impression, status post cingulotomy for OCD, MSSA, slash, klebsiella, bacteremic brain abscess, on Oxacillin

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and Ceftriaxone, planning six to eight weeks Rx from 10-4 culture at least until 17-15-98.
Two, new GPC, pairs and chains, 10-21 CSF, suspect viridans strep contaminant, no fever, CSF six, white blood cells stable, one percent polys, await final identification with micro but suspect can discontinue Vanco. soon. We started Vancomycin in response to that culture.
Three, leukopenia, white blood count acceptable currently, but if falls much lower might need to add GCSF to keep white blood cell up and keep her on antibiotics. I am hesitant to decrease doses of antibiotics --
Q. Just take your time.
A. Doses of antibiotics in this situation. Addendum, spoke with patient's husband at length concerning ID issues, gave him my office number if further questions.
Q. Do you remember --
A. That must have been one of those talks. I don't recall the exact substance of that. 10-23-98, addendum, see my note earlier today, CSF, GPC in quotes, has been identified as coag. negative staph plus enterococcus, likely laboratory contaminant and not new infection, given clinical stability, no

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change in CSF, white blood cells and double isolate. Agree with repeat LP.
Q. What does that mean, likely to be lab contaminant?
A. Oh, that it's not actually from the patient, but it's introduced in the processing because the culture systems are so sensitive they pick up tiny amounts of bacteria. In this case she didn't look like she had a new infection, plus when you get two bugs that are coag. negative staph it's a frequent contaminant. Well, not always. That suggests that it was not from that fluid.
Q. That was a false positive?
A. False positive, right. That's what we thought. 10-24-98. Afebrile, drowsy this p.m., pupils react appropriately, not following my commands. Chest clear, COR, no murmur, abdomen soft, nontender. CSF 10-24, ten white blood cells, one poly, 92 lymphs, five monos, protein 89, glucose 60. By the way, that one poly, 92 lymphs, five monos refers to the composition of those ten white cells. It doesn't mean there were 92 white cells. White blood count 3.77, micro, 10-24 CSF, diagram stain, few polys, no organisms. 10-21, CSF MRSE, slash, ENTC. 10-21, urine negative, parentheses, 10-8 CSF was MSSE, closed parentheses. Impression, one, klebsiella,

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slash, MSSA, bacteremia plus brain abscess, continue Oxacillin, stash, Ceftriaxone, six to eight weeks Rx at least until 11-15. Two, CSF 10-21 with MRSE and enterococcus, suspect lab contaminant. Not same coag. negative staph as 10-8 CSF which was MSSE. CSF 10-24 also does not suggest new bacterial infection.
Three, leukopenia, would consider discontinuing Vanco., which like Oxacillin and Ceftriaxone can contribute. And I put on the side would re-check LFTs on Oxacillin.
Q. Okay.
A. 10-25-98, afebrile, will review CT, repeat CSF, culture negative to date. Suspect staph coag. negative, slash, enterococcus is contaminant and could D/C Vanco. where neurosurg. is comfortable. I think I meant if it's already with them. Repeat white blood cell pending, but with 3.77 may increase when Vanco. discontinued, await liver profile.
10-26-98, thirty-seven six, lethargic, chest clear, COR, no murmur, abdomen soft plus bowel sounds, nontender, extremity, PAS on. That's PAS stockings. Labs, white blood count up 4.08. LFTs, ALT 52, AST 39, bilirubin 0.3, alkaline phosphatase 88. Micro urine screen positive, UA positive for

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yeast, and this is cut off a bit. I think I was saying, one, continue Ox., Ceftriaxone until at least 11-15, two, Fluconazole 200 QD times three days, and I said something about check with ID pharmacist, won't change Neurontin level, and something about Tegretol level. That's because we were starting Fluconazole, the drug interactions.

10-27-98, temp up to 40 today, no cough, sputum, had nondiarheal stool. Exam, no distress, eyes open, won't open mouth, chest clear. COR, no murmur, Hickman site clean, nontender, abdomen soft, plus bowel sounds, nontender. Extremities, PAS on, skin, no rash.

Labs, 10-27, blood cultures, urine culture pending, 10-25 urine, yeast, 10-24 CSF negative, creatinine 0.6, 10-26 white blood count 4.08. Chest x-ray pending, will review.

Impression, one, new fever, source not obvious to exam. Doubt being off Vanco. briefly had anything to do with it since Vanco. is long acting. Also, she was not febrile prior to Vanco. Will review chest x-ray. No respiratory symptoms. Urine, yeast treated since 10-26, doubt cause of fever unless positive blood cultures. That means I doubted the yeast would be the cause unless it

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showed up in the blood. Hickman site looks fine but still could be source, even without rash. Drug fever can occur and could be due to any of her antibiotics. Less likely with Fluconazole, though it was started most recently. Would continue Vanco., Ox., Ceftriaxone, Fluconazole pending cultures. If looks more septic, would add empiric Cipro 400 q 12, or gram negative cultures, MSSA, slash, klebsiella, bacteremia and brain abscess.

10-28-98, T max 40.2 yesterday then afebrile, now 38.4, no cough, slash, sputum, no diarrhea per nursing staff, looks unchanged, chest clear, COR, no murmur, abdomen soft, plus bowel sounds and nontender, Hickman site nontender, extremities negative, skin negative. Labs, white blood count down to 2.94, micro, 10-27 urine plus yeast, 10-27 blood cultures negative to date, 10-24 CSF culture negative, 10-21 CSF coag. negative staph enterococcus. Chest x-ray, left pleural effusion. Head CT, reported no change, will review.

Impression, one, new fevers times two days, on exam source not evident. Only positive culture recently, urine yeast, despite Fluconazole. Blood cultures are negative to date, but it can take three to four days ior yeast to grow, however suspect drug

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fever. Sometimes Vanco. can cause in absence of rash since we believe that 10-21 CSF was most likely contaminant. I'd be comfortable with discontinuing Vanco. and reculturing. Note that Vanco. is long acting and fevers can persist for two to three days after discontinuation.

Two, persistent fungal UTI, not responsive to Fluconazole, would consider low dose Ampho. B, 0.2 milligrams per kilogram IV, or Ampho. B bladder irrigation. Discussed with neurosurg., okayed, discontinuing Vanco.

10-29-98, temps down, 138.4 yesterday, afebrile so far today. Off Vanco., on low dose Ampho. Family concerned about right arm shaking, increase today. Blood cultures are negative to date. White blood count pending. 10-27, urine yeast.

Impression, one, bacteremic klebsiella, MSSA, right frontal brain abscess, continue Oxacillin and Ceftriaxone for protracted course. Two, leukopenia. Await today's count, last 2.94. May improve off Vancomycin, but if continues to fall, less than 2.0, may need GCSF to maintain. Three, recent fever resolving off Vanco., suspect Vancomycin fever. Also, now on low dose Ampho. for yeast cystitis, doubt cause of fever though. Hope

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will clear with short course, few days. At low dose, Ampho. should not be nephrotoxic. Four, family issues. Discussed ID issues extensively with husband and daughter, gave my card and number. Discussed also with Dr. McHenry who will take over ID consult service on 11-2-98.

10-29-98, addendum, understand from Lori Bell, social worker, that family meeting has been set up for Monday, 11-2, at 11:30. I will try to be there, and Dr. McHenry, who will take over the ID consult service that day, will definitely be there. I have outpatient clinic that a.m., my own and ID fellow's patient, but barring emergencies will try to be there at 11:30.

10-30-98, afebrile, says hi, right arm shaking, chest clear, COR, no murmur, abdomen soft, plus bowel sounds, nontender. Extremities, PAS on, skin no rash. Labs, white count up to 4.68, micro recent blood cultures negative to date. 10-27 urine yeast.

Impression, one, bacteremic klebsiella MSSA, right frontal brain abscess, close to four weeks Rx so far, four to six months planned as per Dr. Barnett. In other words, he intended a much longer course. And then I put appreciated chance to

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discuss ID issues in detail with Dr. Barnett today. Size of abscess is diminishing as per measurements on computerized screen. Her leukopenia is improved. Off Vanco. Fever is improved off Vanco. Two, check UA CNS to assess clearance of yeast. Note, husband not in room tonight when I rounded.

Q. Do you recall what conversation you had with Dr. Barnett as referenced in that note?

A. I recall that he felt that she would need longer therapy than six to eight weeks, that he thought that it might need to be continued longer than that, and as usual we would measure resolution by how things improved on scan, and he stated that he had looked at it on the computerized screen and that the measurements were improving.

10-31-98, seen and discussed issues extensively with husband. Right arm tremor continues, no fever but plus sweats. Frequent bowel movements reported but not diarrhea, apparently. Micro C difficile and urine are pending, blood cultures times two, 10-27 negative to date. White blood count 4.68 up. 10-30, creatinine 0.8.

Impression, one, MSSA, slash, klebsiella, brain abscess, continues on long course of Oxacillin and Ceftriaxone. White blood count now up, off Vanco.

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Two, fevers were likely Vanco., repeat blood cultures negative. Three, yeast UTI, repeat pending. Four, frequent bowel movements but not diarrhea, agree check C difficile. Five, right arm shaking, uncertain of cause but would be unusual side effect for these antibiotics. And I put re-check liver function tests.

11-1-98, afebrile, yeast in urine cleared. Exam, chest clear, COR, no murmur, two branch erythematous lesions right neck and upper chest, did not look cellulolytic. Abdomen soft, plus bowel sounds, nontender. Extremities, no edema, PAS on. Labs, creatinine 0.8, AST 26, ALT 45, alkaline phosphatase 75, bilirubin 0.4, white blood count 7.44. Micro, no new positive cultures. 11-1-98 urine negative.

Impression, one, bacteremic brain abscess, klebsiella, MSSA. On long-term Oxacillin plus Ceftriaxone. Family very focused this p.m. as to whether or not she had, quote, unquote, meningitis as part of her original presentation. Explained she had elevated white cells in the 10-5 CSF at that time but CSF culture did not grow. Emphasized that the longer term issue is the brain abscess and she's been on appropriate therapy for CNS infection all

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along. Two, elevated white blood count last two days, off Vanco., now normal. I mean, increased WBC, not elevated. Three, fungal UTI cleared, D/C Ampho. I think this is after one to two days.

Q. The left-hand margin?

A. Dr. McHenry takes over ID consult service in a.m., both of us will try to attend family meeting tomorrow, family at bedside, daughter is lying in bed with mother.

Q. Having reviewed all your records now, do you have any additional independent memories that were refreshed that you haven't covered already?

MS. DISILVIO Other than what she told you about the diarrhea?

MR. LINTON: Correct.

A. Yeah, well, that last just reminded me that there really appeared to be some rather unusual interactions between her and her family, but that's probably about all I can add.

Q. In what way were the interactions unusual?

A. Well, finding the daughter in bed with the mother in the hospital bed I would say is a little unusual.

Q. What was the mother's physical condition at that time?

A. Well, pretty much what we've described. I don't

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know that I can add that much to it. I think that detailed neuro exams I wasn't doing since I wasn't focused on those issues, nor was I really focused on her functional capabilities.

Q. Do you know what time of day you did that consult?

A. When I came by that day?

Q. Yeah.

A. I have no idea.

Q. Many of the references that you read talk about bacteremia, brain abscess or brain abscess, bacteremia. You're not suggesting with the order of those words that one caused the other, both were separate conditions; is that correct?

A. I'm not suggesting one caused the other, that's correct, and oftentimes we're writing these notes in a relative hurry. I will have a shorthand for the condition we're treating. I like to repeat in each note the condition we're treating in case someone is coming to the chart fresh, but it doesn't mean that reflects my thoughts on the genesis.

Q. So again, your opinion is you're unsure as to which caused which?

A. Correct.

Q. Can you now identify, without reading the note, the notes that were done by – whether they were done by

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a student or a resident, are you able to tell us that based on who signed off from the note?
MS. DISILVIO: The ID notes from the very beginning of time?
Q. Just from --
A. I can tell which ones.
Q. Can you tell us who they were?
A. Oh, you mean who the people were who wrote them?
Q. Right, whether it was a medical student or a medical resident.
MS. DISILVIO So the record is clear, from October 19th until she went off the service?
MR. LINTON: Correct.
A. Sure, I can do that. I'll start from the beginning of 10-19. This Stephanie is the last name, I think his first name was Brian, and I believe he was a med student at that time, Brian Stephanie. 10-20, this is Brian Stephanie again. 10-21, Brian Stephanie. 10-22 is Brian Stephanie. That's not mine. 10-25 is a new person on the team, I believe, and I think, yeah, this is Dr. Seshadri, S-E-S-H-A-D-R-I, and he is -- he was a medical resident, and I don't recall his first name. 10-26 is Dr. Seshadri. There must have been a change of

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service for the residents at that time. 10-27 is Dr. Seshadri. 10-28, Dr. Seshadri. 10-29, Dr. Seshadri. 10-30, Dr. Seshadri. 11-1, Dr. Seshadri. And that ended my tour of duty. Dr. McHenry came on on 11-2.
Q. We'll attach this as Exhibit 1 to your deposition, your CV. I take it that's your most recent one?
A. Correct.
Q. Are there any articles that you have authored or assisted in authoring that relate to the issues in this case?
A. No.
MR. LINTON: Give us just a minute, if you would.
- - -
(Thereupon, Plaintiffs' Avery Exhibit 1 was mark'd for purposes of identification.)
- - -
(Thereupon, a discussion was had off the record.)
- - -
Q. I want to make sure that you have now covered all discussions that you can remember that you had with this family.
A. Let me think one more time.

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Q. Sure. Take as much time as you need.
A. I do recall conversations on one other topic, which was they asked me repeatedly what I thought the extent of her neurologic recovery would be and what would be the time course of that recovery. Unfortunately, I really couldn't answer that very well, because it's highly variable from one person to another. Other than that, I think that was about it.
Q. What deficits did she have as a result of the infection?
A. Well, I did not do detailed neurologic testing on her, as you know. As I recall, she had very little verbal output, she did not always follow commands, and she moved her right side more than her left side, but beyond that I could not be more specific.
Q. Have we now covered all the conversations you can recall having with the family?
A. Yes.
Q. In your entire time here at the Cleveland Clinic, can you recall any other postoperative infection that cultured a klebsiella oxytoca?
A. Oh, I am sure I have seen it. It's not totally uncommon, but I can't recall the specific circumstances.

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Q. Have you ever seen it in any other neurosurgical case?
A. You know, I really couldn't be sure. As I said, I'd have to go back and look at my records.
Q. How about a combination staph and klebsiella oxytoca?
A. We do occasionally see polymicrobial infections, meaning more than one bug, and that particular combination I know I've seen before.
Q. Following surgery?
A. I can't recall the details, but I know that combination has occurred before in patients that I've seen.
Q. As you sit here can you recall a single other operation that led to an infection with both those organisms?
A. I can't recall any details, but that's not an unheard of combination.
Q. The abscess was on the right side of the brain?
A. The right frontal lobe, correct.
Q. And the cultured positive wound was actually on the left side, correct?
A. Correct.
Q. Assuming that it was the brain abscess that then led to the wound site infection, why is it that it goes

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to the left side as opposed to the right side?
MS. DISILVIO: Objection. You may answer.
A. That's okay. It's an interesting question and actually in reviewing the records today I noted from Dr. Rehm's notes and the notes at the time that initially the left side drained and then they mentioned the left side relatively dried up and then the right side began to drain and for some days the right side was far more purulent.
Now, my understanding of the stereotactics, again, I don't know that much about it, but I believe that they are going in and meeting at a similar point, so for one reason or another, the left side was the first to be involved, the right side was wound manifested later. Whether that had to do with the brain abscess being primary and draining first out one side or the other, or whether it started on the left wound side then became a brain abscess which subsequently drained out the right side, or whether it started at some other source, again, I cannot say.
Q. So the fact that it may have started on the right side in the brain would not rule out it going to the left side and then the right side of the brain?

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A. Correct, because if the brain abscess were primary, pus drains, it likes to drain, it takes the path of least resistance. So if the left sided tracts were easier for it to pass through, I suppose it could cross sides, but again, I can't express any strong opinion on that.
Q. You'd be speculating either way?
A. Highly speculating, yes.
Q. Let me ask you this, we got into a discussion earlier about the --starting to ask about the source of the infection and then you said about the onset of the infection. Based on your review of the chart, what was the first noted onset of an infection or symptoms related to an infection?
A. Again, I did not see her at that time.
Q. I assume --
A. But the major event seems to have been on or around the 4th or shortly before that when she spiked a 39 and the purulent drainage from the wound was noted.
Q. This likely would be the last time I get to talk to you before this case goes to trial and I just want to make sure I cover with you any opinions that you have in this case. Are there any opinions that you hold with a reasonable medical probability that you've not expressed to this point in this case?

63

MS. DISILVIO: About --
Q. About anything related to Mary Lou Zimmerman.
A. Not that I can recall.
MR. LINTON: Okay. Thank you very much.
MS. DISILVIO We'll read it. If you could send one copy to the doctor here, one copy to me, and I'll have her tell you her mailing address. And, Doctor, if it's ordered, and I suspect your transcript will be ordered, it will come in a little booklet form. I know Laura has taken down everything perfectly, but you have the opportunity to read it and to make any corrections that need to be made to maybe spellings or as we went through the progress notes we went through it rather quickly, so you'll have the opportunity to read it and make any corrections that are needed, and that's what we'll do.

ROBIN K. AVERY, M.D.

64

CERTIFICATE

The State of Ohio) SS:
County of Cuyahdga.)

I Laura L. Ware a Notary Public within and for thk State of Ohio, do hereby certify that the within named witness ROBINK. AVERY M.D., was by me first dulysworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 27th day of September, 2000.

Laura L. Ware

Laura L. Ware, Ware Reporting Service
21860 Crossbeam Lane, Rocky River, Ohio 44116
My commission expires May 17, 2003.

MS. DISILVIO: About --

Q. About anything related to Mary Lou Zimmerman.

A. Not that I can recall.

MR. LINTON: Okay. Thank you very much.

MS. DISILVIO: We'll read it. If you could send one copy to the doctor here, one copy to me, and I'll have her tell you her mailing address. And, Doctor if it's ordered, and I suspect your transcript will be ordered, it will come in a little book et form. I know Laura has taken down everything perfectly, but you have the opportunity to read it and to make any corrections that need to be made to maybe spellings or as we went through the progress notes we went through it rather quickly, so you'll have the opportunity to read it and make any corrections that are needed, and that's what we'll do.

ROBIN K. AVERY, M.D.

Case Title: MARY LOU ZIMMERMAN VS. CLEVELAND CLINIC

Case Number: 399411 Deposition Date: 9/11/00

I, ROBIN K. AVERY MD, wish to make the following changes:

PAGE	LINE	
44	4	CHANGE: "we're at approximately" should be "we plan approximately"
47	22	CHANGE: "dragram stain" should be "Gram stain"
50	8	CHANGE: "or gram negative cultures" should be "For Gram-negative coverage"
51	12	CHANGE: "138.4" should be "38.4"
54	9	CHANGE: "branch" should be "blanching"
54	11	CHANGE: "cellulolytz" should be "cellulitz"
57	16,18,19,20	CHANGE: "Stephanie" should be "Stephany"
		CHANGE:
		CHANGE:
		CHANGE:
		CHANGE:

I have read my deposition, and having made the corrections that I wish to make hereby affix my signature.

Signature: Robin K. Avery MD Date: 10/17/00

Ware Reporting Service

Full Service Court Reporting
21860 Crossbeam Lane
Rocky River, Ohio 44116
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LauraWare@cs.com

October 18, 2000

Robert F. Linton, Jr., Esq.
Linton & Hirshman
Hoyt Block Building - Suite 300
700 West St. Clair Avenue
Cleveland, Ohio 44113

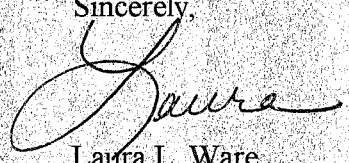
Re: **Mary Lou Zimmerman, et al. vs. The Cleveland Clinic Foundation**
Cuyahoga Common Pleas, Case No., 399411
Deposition: Robin K. Avery, M.D., taken 9-11-00

Dear Bob:

Enclosed please find the errata sheet(s) and signature page signed by Dr. Avery regarding the above-captioned case.

If you have any questions, please do not hesitate to call.

Sincerely,



Laura L. Ware

LLW/nh

Enclosures

cc: Marilena DiSilvio, Esq.

M

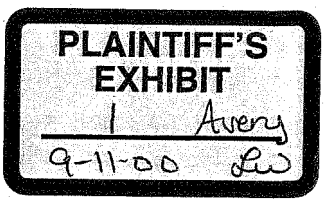
N

O

P

Q

R



CURRICULUM VITAE
ROBIN K. AVERY, M.D.

Robin Kimiko Avery, M.D.
26055 Hurlingham Rd.
Beachwood, Ohio 44122

Cleveland Clinic Foundation
Department Infectious Disease/S32
9500 Euclid Avenue
Cleveland, Ohio 44195

Telephone Number: (216) 444-8977
Fax Number: (216) 445-9446
E mail Address: averyr@cesmtp.ccf.org

EDUCATION

B.A. 1980 Harvard-Radcliffe College, summa cum laude (Philosophy)
M.D. 1985 Harvard Medical School, cum laude

POSTDOCTORAL TRAINING

1985-88 Medical Internship, Junior and Senior Residency in Internal Medicine, Massachusetts General Hospital (Senior Residency in the Primary Care Program)

1989-1993 Infectious Disease Fellowship, Massachusetts General Hospital

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Transplant Executive Committee, Cleveland Clinic Foundation
Bone Marrow/Infectious Disease Study Group, Cleveland Clinic Foundation

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1992,93	Lab instructor, HMS-II Pathophysiology of Infectious Disease Course, Harvard Medical School (Received highest evaluation of instructors in that course, 1992)
1993 on	Teaching of fellows, residents, and medical students at Cleveland Clinic

GRANTS AND SUPPORT

1990-93	American Cancer Society Postdoctoral Fellowship #PF-3488 for the project, "Cytolytic Hybridomas and Resistance to Lysis." (Mentor: Dr. Mark Pasternack, Infectious Disease Unit, Massachusetts General Hospital.)

ONGOING PROTOCOLS

1. RPC #4742 -"A Pilot Trial to Evaluate the Pharmacokinetics. Safety and Efficacy of a Liquid and Virally Inactivated Formulation of Cytomegalovirus Immune Globulin (CMVIG) combined with Ganciclovir in Liver Transplant Recipients at risk for Primary Infection:
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ABSTRACTS

1. Avery R, McCarthy P, Mossad S. Goormastic M, Bott-Silverman C, Hobbs R, James K, Rincon G, Pelegrin D, Waldmann T, Stewart R. Cytomegalovirus prophylaxis with ganciclovir after heart transplantation. Poster presentation, American Society of Transplant Physicians, 15th Annual Meeting, May 1996.

2. Braun W, Avery R, et al : Infections in patients with long-term functioning renal allografts, Oral presentation, International Transplant Meeting, Barcelona, 8/96.

3. Husni R. Gordon S, Quereshi M, Arroliga A, Haug M, Kirby T, Avery R, Longworth D. Risk factors for invasive aspergillosis in lung transplant recipients. Abstract IDSA 34th Annual Meeting 1996.

4. Kathawalla SA, Stillwell PC, Gordon S, Haug M, Perl M, Arroliga AC, Mehta AC, Avery R, Kirby T. Cytomegalovirus infection in seromismatched lung transplant recipients with and without prophylaxis with CMV immunoglobulin, Presented, Lung Transplant meeting, 1995. Transplantation Proceedings 28:(suppl 2); 16, 1996

5. LaRosa S, Gordon S, Kalmadi S, Truesdell L. Avery R, Arroliga A, Longworth D. Should prophylaxis for Pneumocystis carinii pneumonia in solid organ transplant recipients ever be discontinued? Presented, IDSA 34th Annual Meeting.

6. Nasser R, Hajjar I, Sandhaus S, Hall G, Washington J, Bolwell R, Avery R, Longworth D, Adal K. Routine cultures of bone marrow and peripheral stem cell harvests: clinical impact and cost analysis. Presented, IDSA 34th Annual Meeting.

7. Snydman D, Avery R, Perlino C, Freeman R, Rohrer R, Fairchild R, Crowley M. Falagas M, O'Rourke E, and CMVIG Study Group. Combination cytomegalovirus immune globulin (CMVIG) plus ganciclovir (GCV) prophylaxis for CMV seronegative liver transplant recipients (R-) of a CMV seropositive donor organ (D+): preliminary analysis of an open-label study. Abstract, submitted for International Transplant meeting, 8/96.

8. Avery RK: The disproportionate burden of CMV in lung transplant recipients. Oral presentation, Abstract #285, 16th Annual Meeting, American Society of Transplant Physicians, 1997.

9. Avery R, Longworth D, Pohlman B, et al: Prophylaxis of invasive aspergillosis with itraconazole in allogeneic bone marrow transplant recpients; Preliminary results. Poster presentation, ASTP, 1997, Abstract #531.

10. Avery RK, et al : The yield of blood cultures in febrile autologous peripheral blood progenitor cell transplant recipients. Poster presentation, ASTP 1997, Abstract #532.

11. Avery R, Pohlman B, Longworth D et al:A randomized prospective trial of single daily dose vancomycin and tobrmycin plus oral ciprofloxacin versus standard triple antibiotics in febrile neutropenic recipients of autologous progenitor cell transplants. Poster presentation, ASTP, 1997, Abstract #530.

12. Avery R, Pohlman B, Adal K. et al: High prevalence of diarrhea but infrequency of documented C. difficile in autologous peripheral blood progenitor cell transplant recpients. Poster presentation, ASTP, 1997, Abstract #533.

13. Avery R, Mossad S, Pelegrin D et al:Prophylaxis of primary cytomegalovirus infection and disease after heart transplantation: does adding cytomegalovirus immune globulin to ganciclovir help? Oral presentation, ASTP 1997, Abstract #282.

14. Avery R, Brakeman J, Adal K. Henderson JM Bolwell B, Longworth D et al: infectious outcomes in transplantation in international patients. Poster presentation, IDSA 35th Annual Meeting, 1997.

BLIOGRAPHY

1. Raba JM, Joseph H, Avery RK et al. (1990) Homelessness and AIDS. In Under the Safety Net: The Health and Social Welfare of the Homeless in the United States, eds. P.W. Brickner et al, W.W. Norton, New York/London.

   (The above book received the World Hunger Year's World Hunger Media Award for Best Book for 1990)

2. Avery RK (1991). AIDS and HIV Infection. In The Manual of Common Communicable Diseases in Shelters, eds. James J. O'Connell and Janet Groth, Boston Health Care for the Homeless Program.

3. Avery RK, O'Connell JJ (1992). Human Immunodeficiency Virus and Homeless Persons. In Deliverina Health Care to Homeless Persons, eds. David Wood. Springer Publishing Company.

4. Avery RK, Bleier KJ, Pasternack MS (1992). Differences between ATP-mediated cytotoxicity and cell-mediated cytotoxicity. J Immunol, August, 1992.

5. Avery RK, Baker AS. Chlamydial infection. In Principles and Practice of Ophthalmology, eds. Daniel M. Albert and Frederick A. Jakobiec, W.B. Saunders, 1994.

6. Avery RK, Madoff S, Zartman G, Baker AS: Mycoplasma hominis wound infection. Infect Dis Clin Pract, 1994;3(1):32-34.

7. Avery RK : infections and immunizations in organ transplant recipients: a preventive approach. Cleveland Clinic J Med 1994;61(5):386-392.

8. Avery RK, Salrnan S, Baker AS: Rhinoscleroma treated with ciprofloxacin: a case report. The Laryngoscope, 105:1-3, July 1995.

9. Avery RK, Longworth DL:Viral pulmonary infections in thoracic and cardiovascular surgery. Semin Thorac Cardiovasc Surg 1995;7:88-94.

10. Wagner L, Avery RK, Bensinger L, Kusinitz F, Hibberd PL, Pasternack MS: Inhibition of cytotoxic T lymphocyte-triggered apoptosis by target cell surface-coupled aprotinin. Mol Immunol 1995, 32(12):853-864.

11. Avery RK, Pasternack MS: Approach to the adult patient with recurrent infections. Cleveland Clinic J Med 1997, 64(5):249-257.

12. Mayes JT, O'Connor BJ, Avery R et al: Transmission of Toxoplasma aondii infection by liver transplantation. Clin Infect Dis 21:511-5, 1995.

13. Dodds EM, Lowder CY, Foster RE, Avery RK, Prayson RA. Serous retinal detachments in a patient with clinically resistant cytomegalovirus retinitis. Archives of Opthalmology. 1996 July; 114(7):896-897.

14. Avery RK, McCarthy P, Mossad S et al: CMV Prophylaxis in heart transplant recipients. In preparation.

15. Charles R, Brzezinski A, Avery RK, et at: Case report. Disseminated cytomegalovirus infection presenting as Crohn's disease with pyoderma gangrenosum In preparation.

16. Levin L. Avery RK, Shore J. Woog, J, Baker AS. The spectrum of orbital aspergillosis. Survev of Ophthalmology, 1996, 41:142-54.

17. Avery RK, Eavey RD, Torre TD, Ramos D, Pasternack MS. Bilateral otitis media and mastoiditis caused by a highly resistant strain of Mycobacterium chelonae. Pediatric Infectious Disease Journal 1996 Nov;15(11):1037-1040.

18. Kathawalla SA, Stillwell PC, Gordon S, Haug M, Perl M, Arroliga AC, Metha AC, Avery R, Kirby T. Cytomegalovirus infection in seromismatched lung transplant recipients with and without prophylaxis with CMV immunoglobulin. Transplant Proc 1996 Dec;28(6 Suppl 2):16.

19. Avery RK, Brakeman J, Adal K, Bolwell B, Henderson JM, Novick A, Longworth DL. infections in international transplant recipients. To be submitted to Transplantation

20. Avery RK, Barnes D, Teran J et al: Listeria monocytoaenes tricuspid valve endocarditis with septic pulmonary emboli in a liver transplant recipient. Transplant Infectious Disease 1999 Dec; 1(4):284-287.

21. Mossad S. Avery RK, Goormastic M, Hobbs RE, Stewart R, Significance of positive cultures from donor left atrium and post-preservation fluid in heart transplantation. Submitted to Transplantation.

22. Braun WE, Avery RK, Gifford RW Jr, Straffon RA. Life after 20 years with a kidney transplant: redefined disease profiles and an emergining nondiabetic vasculopathy. Transplant Proc 1997;29:247-249.

23. Muruve NA, Novick AC, Goldfarb DA, Flechner S, Dennis V, Avery R, Hodge EE. Risk factors, management, and outcome in renal transplant recipients experiencing CMV infections. (Submitted to Transplantation).

24. Avery RK. Transplant infectious disease:messages for the generalist. (submitted to CCJM)

25. Husni R, Northington D, Goldman M, Camisa C, Avery RK. Severe cutaneous reactions to vancomycin: report of three cases and review of the literature. (To be submitted).

26. Nasser RM, Hajjar I, Sandhaus L, Bolwell BM, Avery RK, Longworth DL, Hall GS, Adal KA. Routine cultures of Bone Marrow and Peripheral Stem All Harvests: Clinical impact, cost analysis, and review of the literature. Submitted for publication.

27. Khan A, Lytle B, Taylor P, Longworth DL, Dorosti K, Walsh M, Avery RK. The spectrum of highly symptomatic cytomegalovirus infection after non-transplant cardiac surgery. (To be submitted).

28. Avery RK, Baker AS. Chlamydial Disease. Chapter 250 (revision for 1997 edition): Princioles and Practice of Oohthalmoloav, Second Edition, WB Saunders.

29. Helm TN, Avery RK, Tomecki KJ. Respiratory dimorphic fungal infections. In Tooics in Clinical Dermatoioay, et. Boni E. Elewski, 1997.

30. LaRosa S, Gordon S, et al. Should prophylaxis for Pneumocystis carinii pneumonia in solid organ transplant recipients ever be discontinued? Submitted for publication.

31. Husni R, Gordon SM, Longworth DI, Arroliga A, Stillwell P, Avery RK, Maurer JR, Mehta A, Kirby T. Cytomegalovirus infection is a risk factor for invasive aspergillosis in lung transplant recipients. Submitted for publication.

32. Avery, RK, Prevention and treatment of cytomegalovirus infection and disease in heart transplant recipients. Current Opinion in Cardiology, 1988 Vol. 13:122-129.

33. Dumot JA, Barnes DS, Younossi Z, Gordon SM, Avery RK, Domen RE, Henderon M, Carey WD: Immunogenicity of hepatitis A vaccine in decompensated liver disease. American J of Gastroenterology, 1999 Vol 94:1601-1604.

34. Mossad, SB, Tomford, JW, Avery, RK, Hussein, MA, Vaughn, KW: Isolated Primary Hepatic Lymphoma in a Patient with Acquired Immunodeficiency Syndrome. International Journal of Infectious Diseases, 1999 Vol 4 Number 1: 57-58.

35. Avery RK, Pohlman B, Adal K, Bolwell B, Goldman M, Kalaycio M, Hall G, Andresen S, Mossad S, Schmitt S, Mason P, Longworth D. High prevalence of diarrhea but infrequency of documented ***Clostridium difficile*** in autologous peripheral blood progenitor cell transplant receipients. Bone Marrow Transplantation, 2000 Vol. 25: 67-69.

OTHER PROJECTS IN PROGRESS

1. Retrospective review of infections in allograft BMT recipients. Cleveland Clinic Foundation 1992-95. 1. CMV prophylaxis. 2. Utility of BAL and open lung

biopsy. 3. Infections in sulfa-intolerant patients.

2. Infectious complications in long term (15-20 year) recipients of renal transplants (with W. Braun, M.D.)

3. Hypogammoglobulinemia in lung transplant recipients. With Dr. N. Goldfarb and Dr. J. Maurer.

GRAND ROUNDS PRESENTATIONS

10-14-93 Medical Grand Rounds, Cleveland Clinic Foundation (with Dr. Steven Gordon) "New and Emerging Infectious Disease Pathogens in the 1990's.

OTHER TALKS

October 20-21, 1993 "Infections and Immunization in the Renal Transplant Patient." Nephrology Update. Cleveland Clinic Foundation.

November 15, 1993 "Infections and Immunization in the Renal Transplant Patient." American Society of Nephrology Boston, Massachusetts

December 22, 1993 infectious Disease Grand Rounds, Cleveland Clinic Foundation. "Infectious Diseases and the Skin".

January 18, 1994 "Infectious in the Immunocompromised Host", Cleveland Clinic Foundation.

February 9, 1994 "What's New in Transplant ID". Infectious Disease Grand Rounds, Cleveland Clinic Foundation

1994-1995 "Liver Disease After Transplantation". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.

"Role of Superantigens in Disease Causation." Infectious Disease Grand Rounds. Cleveland Clinic Foundation

September, 1995 "Reconstitution of the Immune System after Bone Marrow Transplant". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.

January 24, 1996 "Unusual Causes of Lymphadenopathy". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.

March 1996 Workshop: Medical Management of Renal Transplant Patients,

	With Drs. W. Braun, D. Goldfarb and B. Brouhard, Nephrology Update 1996.
May 1996	American Society of Transplant Physicians. Luncheon Workshop, Post-Transplant Infections, with Dr. Robert Rubin.
June 1996	"Infections in the Immunocompromised Host", Cleveland Clinic Eighth Annual Intensive Review of Internal Medicine.
August 1996	Martin C. McHenry Symposium;"Transplant infectious Disease for the Generalist."
Nov. 1996	Medical House Staff Conference "Infections in the Immunocompromised patient."
March 5, 1997	Infectious Disease Grand Rounds: infections in Autologous Bone Marrow Transplant Reciepients: Research Update. Cleveland Clinic Foundation.
March 12, 1997	"Infectious complications in recipients of Autologous Peripheral Stem Cell Transplants, Medical College of Ohio.
March 19, 1997	Nephrology Update 1997 Workshop: Medical Management of the Renal Transplant Patient
May 22, 1997	Tick-Borne Diseases. In "2nd Annual May Day Therapy: Dermatology", Cleveland Clinic Foundation.
June 3, 1997	Lung Transplantation: Infections and You. Second Wind Lung Transplant Support Group.
October 27, 1997	Talk to Skin Care Team; "skin Infections"
November 4, 1997	Medical House Staff. Noon conference. "Infections in the Immunocompromised Host."
November 3, 1998	I.D. Subspeciality Conference at Fairview Hospital: "Infections In Renal Transplant Patients
November 2, 1999	I.D. Conference at Fairview Hospital: "Granulocytopenia, immuno Comp Host and Infections."

INTRA-DEPART~ENTALTEACHING

Monthly Transplant ID Lunch conference (case presentations, discussions, with Dr. Sherif Mossad).

Extensive teacing of fellows, residents, and students on ID inpatient consult service (12 weeks/year), primary service (4 weeks/year), Bone Marrow service and Outpatient Modules (rest of year.)

OUTSIDE MEDICAL ACTIVITIES

Cleveland Health Care for the Homeless: Wednesday afternoon clinics at Payne Avenue Clinic and Monday evening clinics at City Mission (volunteer service). Providing direct care (general internal medicine) to homeless patients with a wide variety of conditions; supervising and teaching nurses in the Homeless Program and rotating CCF primary care residents.

PROFESSIONAL SOCIETIES AND COMMITTEES

American Society of Transplant Physicians, Member 1997 (ASTP)

Post Transplant Infections Committee

Visiting Faculty Program, "Progress in Prevention of CMV Disease in Solid Organ Transplantation," Sponsored by Tufts University (1997)

Viral Hepatitis Clinical Guidelines Committee, Cleveland Clinic Foundation (1997)

Ware Reporting Service
Full Service Court Reporting
21860 Crossbeam Lane
Rocky River, Ohio 44116
(216) 533-7606 ˙ Fax (440) 333-0745
LauraWare@cs.com

September 28, 2000

Robin K. Avery, M.D.
The Cleveland Clinic Foundation
9500 Euclid Avenue, Desk S32
Cleveland, Ohio 44195

Re: **Mary Lou Zimmerman, et al. vs. The Cleveland Clinic Foundation**
Cuyahoga Common Pleas, Case No. 399411

Dear Dr. Avery:

Enclosed please find your deposition which was taken on September 11, 2000. **Once you have read and signed the last page of your deposition and made any corrections on the errata sheet(s) provided, please mail the entire transcript along with the errata sheet(s) in the self-addressed envelope enclosed.**

According to the Ohio Rules of Civil Procedure you have 7 days within which to sign the transcript, unless otherwise agreed to by Counsel, or your signature will be deemed waived.

If you have any questions, please feel free to call.

Sincerely,

Laura L. Ware

Enclosures

c: Robert F. Linton, Esq./Mark W. Ruf, Esq.
Marilena DiSilvio, Esq.

CURRICULUM VITAE
ROBIN K. AVERY, M.D.

Robin Kimiko Avery, M.D.
26055 Hurlingham Rd.
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ABSTRACTS

1. Avery R, McCarthy P, Mossad S. Goormastic M, Bott-Silverman C, Hobbs R, James K, Rincon G, Pelegrin D, Waldmann T, Stewart R. Cytomegalovirus prophylaxis with ganciclovir after heart transplantation. Poster presentation, American Society of Transplant Physicians, 15th Annual Meeting, May 1996.

2. Braun W, Avery R, et al : Infections in patients with long-term functioning renal allografts, Oral presentation, International Transplant Meeting, Barcelona, 8/96.

3. Husni R. Gordon S, Quereshi M, Arroliga A, Haug M, Kirby T, Avery R, Longworth D. Risk factors for invasive aspergillosis in lung transplant recipients. Abstract IDSA 34th Annual Meeting 1996.

4. Kathawalla SA, Stillwell PC, Gordon S, Haug M, Perl M, Arroliga AC, Mehta AC, Avery R, Kirby T. Cytomegalovirus infection in seromismatched lung transplant recipients with and without prophylaxis with CMV immunoglobulin, Presented, Lung Transplant meeting, 1995. Transplantation Proceedings 28:(suppl 2); 16, 1996

5. LaRosa S, Gordon **S,** Kalmadi S, Truesdell L. Avery R, Arroliga A, Longworth D. Should prophylaxis for Pneumocystis carinii pneumonia in solid organ transplant recipients ever be discontinued? Presented, IDSA 34th Annual Meeting.

6. Nasser R, Hajjar **I,** Sandhaus S, Hall G, Washington J, Bolwell R, Avery R, Longworth D, Adal **K.** Routine cultures of bone marrow and peripheral stem cell harvests: clinical impact and cost analysis. Presented, IDSA 34th Annual Meeting.

7. Snydman D, Avery **R,** Perlino C, Freeman R, Rohrer R, Fairchild **R,** Crowley M. Falagas M, O'Rourke **E,** and CMVIG Study Group. Combination cytomegalovirus immune globulin (CMVIG) plus ganciclovir (GCV) prophylaxis for CMV seronegative liver transplant recipients (R-) of a CMV seropositive donor organ (D+): preliminary analysis of an open-label study. Abstract, submitted for International Transplant meeting, 8/96.

8. Avery RK: The disproportionate burden of CMV in lung transplant recipients. Oral presentation, Abstract #285, 16th Annual Meeting, American Society of Transplant Physicians, 1997.

9. Avery R, Longworth D, Pohlman **B,** et al: Prophylaxis of invasive aspergillosis with itraconazole in allogeneic bone marrow transplant recpients; Preliminary results. Poster presentation, ASTP, 1997, Abstract #531.

10. Avery RK, et al : The yield of blood cultures in febrile autologous peripheral blood progenitor cell transplant recipients. Poster presentation, ASTP 1997, Abstract #532.

11. Avery R, Pohlman **B,** Longworth D et al:A randomized prospective trial of single daily dose vancomycin and tobrmycin plus oral ciprofloxacin versus standard triple antibiotics in febrile neutropenic recipients of autologous progenitor cell transplants. Poster presentation, ASTP, 1997, Abstract #530.

12. Avery R, Pohlman B, Adal **K.** et al: High prevalence of diarrhea but infrequency of documented C. difficile in autologous peripheral blood progenitor cell transplant recpients. Poster presentation, ASTP, 1997, Abstract #533.

13. Avery R, Mossad S, Pelegrin D et al:Prophylaxis of primary cytomegalovirus infection and disease after heart transplantation: does adding cytomegalovirus immune globulin to ganciclovir help? Oral presentation, ASTP 1997, Abstract #282.

14. Avery R, Brakeman J, Adal **K.** Henderson JM Bolwell **B,** Longworth D et al: Infectious outcomes in transplantation in international patients. Poster presentation, IDSA 35th Annual Meeting, 1997.

BIBLIOGRAPHY

1. Raba JM, Joseph H, Avery RK et al. (1990) Homelessness and AIDS. In Under the Safety Net: The Health and Social Welfare of the Homeless in the United States, eds. P.W. Brickner et al, W.W. Norton, New York/London.

   (The above book received the World Hunger Year's World Hunger Media Award for Best Book for 1990)

2. Avery RK (1991). AIDS and HIV Infection. In The Manual of Common Communicable Diseases in Shelters, eds. James J. O'Connell and Janet Groth, Boston Health Care for the Homeless Program.

3. Avery RK, O'Connell JJ (1992). Human Immunodeficiency Virus and Homeless Persons. In Deliverina Health Care to Homeless Persons, eds. David Wood. Springer Publishing Company.

4. Avery RK, Bleier KJ, Pasternack MS (1992). Differences between ATP-mediated cytotoxicity and cell-mediated cytotoxicity. J Immunol, August, 1992.

5. Avery RK, Baker AS. Chlamydial infection. In Principles and Practice of Ophthalmology, eds. Daniel M. Albert and Frederick A. Jakobiec, W.B. Saunders, 1994.

6. Avery RK, Madoff S, Zartman G, Baker AS: Mycoplasma hominis wound infection. Infect Dis Clin Pract, 1994;3(1):32-34.

7. Avery RK: Infections and immunizations in organ transplant recipients: a preventive approach. Cleveland Clinic J Med 1994;61(5):386-392.

8. Avery RK, Salman S, Baker AS: Rhinoscleroma treated with ciprofloxacin: a case report. The Laryngoscope, 105:1-3, July 1995.

9. Avery RK, Longworth DL: Viral pulmonary infections in thoracic and cardiovascular surgery. Semin Thorac Cardiovasc Surg 1995;7:88-94.

10. Wagner L, Avery RK, Bensinger L, Kusinitz F, Hibberd PL, Pasternack MS: Inhibition of cytotoxic T lymphocyte-triggered apoptosis by target cell surface-coupled aprotinin. Mol Immunol 1995, 32(12):853-864.

11. Avery RK, Pasternack MS: Approach to the adult patient with recurrent infections. Cleveland Clinic J Med 1997, 64(5):249-257.

12. Mayes JT, O'Connor BJ, Avery R et al: Transmission of Toxoplasma aondii infection by liver transplantation. Clin Infect Dis 21:511-5, 1995.

13. Dodds EM, Lowder CY, Foster RE, Avery RK, Prayson RA. Serous retinal detachments in a patient with clinically resistant cytomegalovirus retinitis. Archives of Opthalmology. 1996 July;114(7):896-897.

14. Avery RK, McCarthy P, Mossad S et al: CMV Prophylaxis in heart transplant recipients. In preparation.

15. Charles R, Brzezinski A, Avery RK, et al: Case report. Disseminated cytomegalovirus infection presenting as Crohn's disease with pyoderma gangrenosum In preparation.

16. Levin L. Avery RK, Shore J. Woog, J, Baker AS. The spectrum of orbital aspergillosis. Survev of Ophthalmology, 1996, 41:142-54.

17. Avery RK, Eavey RD, Torre TD, Ramos D, Pasternack MS. Bilateral otitis media and mastoiditis caused by a highly resistant strain of Mycobacterium chelonae. Pediatric Infectious Disease Journal 1996 Nov;15(11):1037-1040.

18. Kathawalla SA, Stillwell PC, Gordon S, Haug M, Perl M, Arroliga AC, Metha AC, Avery R, Kirby T. Cytomegalovirus infection in seromismatched lung transplant recipients with and without prophylaxis with CMV immunoglobulin. Transoiant Proc 1996 Dec;28(6 Suppl 2):16.

19. Avery RK, Brakeman J, Adal K, Bolwell B, Henderson JM, Novick A, Longworth DL. Infections in international transplant recipients. To be submitted to Transplantation

20. Avery RK, Barnes D, Teran J et al: Listeria monocytoaenes tricuspid valve endocarditis with septic pulmonary emboli in a liver transplant recipient. Transplant Infectious Disease 1999 Dec;1(4):284-287.

21. Mossad S. Avery RK, Goormastic M, Hobbs RE, Stewart R, Significance of positive cultures from donor left atrium and post-preservation fluid in heart transplantation. Submitted to Transplantation.

22. Braun WE, Avery RK, Gifford RW Jr, Straffon RA. Life after 20 years with a kidney transplant: redefined disease profiles and an emergining nondiabetic vasculopathy. Transplant Proc 1997;29:247-249.

23. Muruve NA, Novick AC, Goldfarb DA, Flechner S, Dennis V, Avery R, Hodge EE. Risk factors, management, and outcome in renal transplant recipients experiencing CMV infections. (Submitted to Transplantation).

24. Avery RK. Transplant infectious disease:messages for the generalist. (submitted to CCJM)

25. Husni R, Northington D, Goldman M, Camisa C, Avery RK. Severe cutaneous reactions to vancomycin: report of three cases and review of the literature. (To be submitted).

26. Nasser RM, Hajjar I, Sandhaus L, Bolwell BM, Avery RK, Longworth DL, Hall GS, Adal KA. Routine cultures of Bone Marrow and Peripheral Stem All Harvests: Clinical Impact, cost analysis, and review of the literature. Submitted for publication.

27. Khan A, Lytle B, Taylor P, Longworth DL, Dorosti K, Walsh M, Avery RK. The spectrum of highly symptomatic cytomegalovirus infection after non-transplant cardiac surgery. (To be submitted).

28. Avery RK, Baker AS. Chlamydial Disease. Chapter 250 (revision for 1997 edition): Princioles and Practice of Ophthalmology, Second Edition, WB Saunders.

29, Helm TN, Avery RK, Tomecki KJ. Respiratory dimorphic fungal infections. In Tooics in Clinical Dermatoloav, et. Boni E. Elewski, 1997.

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32. Avery, RK, Prevention and treatment of cytomegalovirus infection and disease in heart transplant recipients. Current Opinion in Cardiology, 1988 Vol. 13:122-129.

33. Dumot JA, Barnes DS, Younossi Z, Gordon SM, Avery RK, Domen RE, Henderon M, Carey WD: Immunogenicity of hepatitis A vaccine in decompensated liver disease. American J of Gastroenteroloav, 1999 Vol 94:1601-1604.

34. Mossad, SB, Tomford, JW, Avery, RK, Hussein, MA, Vaughn, KW: Isolated Primary Hepatic Lymphoma in a Patient with Acquired Immunodeficiency Syndrome. International Journal of Infectious Diseases, 1999 Vol 4 Number 1: 57-58.

35. Avery RK, Pohlman B, Adal K, Bolwell B, Goldman M, Kalaycio M, Hall G, Andresen S, Mossad S, Schmitt S, Mason P, Longworth D. High prevalence of diarrhea but infrequency of documented *Clostridium difficle* in autologous peripheral blood progenitor cell transplant receipients. Bone Marrow Transplantation, 2000 Vol. 25: 67-69.

OTHER PROJECTS IN PROGRESS

1. Retrospective review of infections in allograft BMT recipients. Cleveland Clinic Foundation 1992-95. 1. CMV prophylaxis. 2. Utility of BAL and open lung

biopsy. 3. Infections in sulfa-intolerant patients.

2. Infectious complications in long term (15-20 year) recipients of renal transplants (with W. Braun , M.D.)

3. Hypogammoglobulinemia in lung transplant recipients. With Dr. N. Goldfarb and Dr. J. Maurer.

GRAND ROUNDS PRESENTATIONS

10-14-93 Medical Grand Rounds, Cleveland Clinic Foundation (with Dr. Steven Gordon) "New and Emerging Infectious Disease Pathogens in the 1990's.

OTHER TALKS

October 20-21, 1993	"Infections and Immunization in the Renal Transplant Patient." Nephrology Update. Cleveland Clinic Foundation.
November 15, 1993	"Infections and Immunization in the Renal Transplant Patient." American Society of Nephrology Boston, Massachusetts
December 22, 1993	infectious Disease Grand Rounds, Cleveland Clinic Foundation. "Infectious Diseases and the Skin".
January **18,** 1994	"infectious in the Immunocompromised Host", Cleveland Clinic Foundation.
February 9, 1994	"What's New in Transplant ID". Infectious Disease Grand Rounds, Cleveland Clinic Foundation
1994-1995	"Liver Disease After Transplantation". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.
	"Role of Superantigens in Disease Causation." Infectious Disease Grand Rounds. Cleveland Clinic Foundation
September, 1995	"Reconstitution of the Immune System after Bone Marrow Transplant". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.
January **24,** 1996	"Unusual Causes of Lymphadenopathy". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.
March 1996	Workshop: Medical Management of Renal Transplant Patients,

	With Drs. W. Braun, D. Goldfarb and B. Brouhard, Nephrology Update 1996.
May 1996	American Society of Transplant Physicians. Luncheon Workshop, Post-Transplant Infections, with Dr. Robert Rubin.
June 1996	"Infections in the Immunocompromised Host", Cleveland Clinic Eighth Annual Intensive Review of Internal Medicine.
August 1996	Martin C. McHenry Symposium; "Transplant Infectious Disease for the Generalist."
Nov. 1996	Medical House Staff Conference "Infections in the Immunocompromised patient."
March 5, 1997	Infectious Disease Grand Rounds: Infections in Autologous Bone Marrow Transplant Reciepients: Research Update. Cleveland Clinic Foundation.
March 12, 1997	"Infectious complications in recipients of Autologous Peripheral Stem Cell Transplants, Medical College of Ohio.
March 19, 1997	Nephrology Update 1997 Workshop: Medical Management of the Renal Transplant Patient
May 22, 1997	Tick-Borne Diseases. In "2nd Annual May Day Therapy: Dermatology", Cleveland Clinic Foundation.
June 3, 1997	Lung Transplantation: Infections and You. Second Wind Lung Transplant Support Group.
October 27, 1997	Talk to Skin Care Team; "skin Infections"
November 4, 1997	Medical House Staff. Noon conference. "Infections in the Immunocompromised Host."
November 3, 1998	I.D. Subspeciality Conference at Fairview Hospital: "Infections In Renal Transplant Patients
November 2, 1999	I.D. Conference at Fairview Hospital: "Granulocytopenia, Immuno Comp Host and Infections."

INTRA-DEPART~ENTALTEACHING

Monthly Transplant ID Lunch conference (case presentations, discussions, with Dr. Sherif Mossad).

Extensive teacing of fellows, residents, and students on ID inpatient consult service (12 weeks/year), primary service (4 weeks/year), Bone Marrow service and Outpatient Modules (rest of year.)

OUTSIDE MEDICAL ACTIVITIES

Cleveland Health Care for the Homeless: Wednesday afternoon clinics at Payne Avenue Clinic and Monday evening clinics at City Mission (volunteer service). Providing direct care (general internal medicine) to homeless patients with a wide variety of conditions; supervising and teaching nurses in the Homeless Program and rotating CCF primary care residents.

PROFESSIONAL SOCIETIES AND COMMITTEES

American Society of Transplant Physicians, Member 1997 (ASTP)

Post Transplant Infections Committee

Visiting Faculty Program, "Progress in Prevention of CMV Disease in **Solid** Organ Transplantation," Sponsored by Tufts University (1997)

Viral Hepatitis Clinical Guidelines Committee, Cleveland Clinic Foundation (1997)