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IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO
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BESSIE M. BROOKS, etc.,
Plaintiffs,
vs Case No. 397309
Judge McCafferty
THE CLEVELAND CLINIC FOUNDATION,
Defendant.

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DEPOSITION OF STANLEY P. BALLOU, M.D.
WEDNESDAY, NOVEMBER 22,2000
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Deposition of STANLEY P. BALLOU, M.D., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, commencing at 8:30 o'clock a.m. on the day and date above set forth.

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APPEARANCES:
On behalf of the Plaintiff
Becker & Mishkind Co., L.P.A.
By: HOWARD D. MISHKIND, ESQ.
Skylight Office Tower
1660 W. 2nd Street Suite 660
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant
Reminger & Reminger
BY: THOMAS B. KILBANE, ESQ.
113 Saint Clair Avenue, N.E.
Cleveland, Ohio 44114-1273
216-687-1311

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(Thereupon, BALLOU Deposition Exhibits 1 thru 4 were marked for purposes of identification.)
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STANLEY P. BALLOU, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF STANLEY P. BALLOU, M.D.
BY MR. MISHKIND:

Q. Doctor, state your name for the record, please.
A. Stanley P. Ballou.
Q. You are a physician employed at MetroHealth Medical Center; true?
A. That's true.
Q. Do you have a CV that would be handy?
A. Yes, I can have my secretary provide one for you.
Q. Is that the young lady seated out at the computer?
A. Right.
Q. Do you think you could ask her to

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print one out?
(Recess had.)
Q. We went off the record and my understanding is that your secretary, or your substitute secretary is going to try to find a copy of your CV?
A. Right. I have an old outdated copy in my office if she can't find one. It's not up to date, but I can give you that.
Q. How long have you been at Metro?
A. Twenty-seven years.
Q. Were you affiliated with a different hospital before you came to Metro?
A. No.
Q. Where did you do your training?
A. Medical school at the University of Pittsburgh.
Q. I have had a chance before the deposition began to look at your file in an effort to try to determine what it is that you have reviewed for purposes of your opinions in this case.
As I understand it, when you prepared your report, you had the medical records for Mr. Brooks and expert reports of Drs. Eisner,

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Dineen and Preston; true?
A. That's correct.
Q. I believe you also had the autopsy?
A. That's correct.
Q. Subsequently, you have been provided with a copy of the deposition of Dr. Preston?
A. That's right.
Q. And a copy of a report from a nursing expert, Mary Jane Smith, most recently; right?
A. That's right.
Q. I want to identify a couple items on the record before we start going into the specifics of the opinions that you hold.
I guess just to sort of set the scope for our discussion, it's my understanding that, it's been represented to me that you intend to provide testimony solely as it relates to the issue of impact that the polymyositis would have had on Mr. Brooks had he survived the hypovolemic shock; true?
A. That'scorrect.
MR. KILBANE: To make sure we are communicating, the polymyositis and his other medical conditions.
Q. You have not been asked to provide

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opinions as to whether the doctors or nurses provided accepted standard of care in the treatment of Mr. Brooks while he was a patient following the PEG tube placement; true?
A. That's true.
Q. So therefore, you are not going to provide any opinions saying that the standard of care was met by any of the doctors and the nurses at Cleveland Clinic; true?
A. That's correct.
Q. So my questions then will intentionally be limited to talking to you about the issue of polymyositis and any co-morbid diseases that Mr. Brooks had and the opinions that you have as to issues of morbidity and mortality. Does that sound fair?
A. That's correct.
Q. That seems to be what you have been asked or retained to do in connection with providing opinions in this case; true?
A. Yes, that's my understanding.
Q. Okay. A couple of housekeeping items.
Plaintiffs Exhibit 1 is a letter written to you by Mr. Kelley dated September

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13th, indicating essentially that you have agreed to review the case of the Estate of Bessie Brooks versus The Cleveland Clinic; true?
A. True.
Q. Enclosed with this letter were the items which you reference in your report?
A. Right.
Q. I take it you didn't have any material from Mr. Kelley prior to September 13th, 2000; is that correct?
A. That's correct.
Q. And he indicates to you that he needs the report by the end of September, according to what he refers to as the Cuyahoga County local rules of practice; true?
A. That's right.
Q. I take it you weren't familiar with that procedure?
A. No.
Q. Now, Exhibit 2 is a copy of the report which you prepared and sent to Mr. Kelley; is that correct?
A. That is correct.
Q. I am going to actually have marked as Exhibit 2-A this document.

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(Thereupon, BALLOU Deposition Exhibit 2-A was marked for purposes of identification.)
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Q. Exhibit 2-A is, in fact, the letter which is 2, only on MetroHealth Medical Center stationery; true?
A. That's right.
Q. And then at the very bottom, just for identification purposes, there is a fax from Reminger & Reminger dated October 26th, 2000, and their fax number 687-1841. Do you see that?
A. Yes.
Q. Now, did you fax the letter to Mr. Kelley on October 26th?
A. I have no idea.
Q. Or might this be the date that Mr. Kelley forwarded it on to, perhaps, Mr. Mishkind, myself?
A. I really have no idea.
Q. Do you have any correspondence that would reflect or any documentation that would reflect the date that you sent this September 29th report to Mr. Kelley?

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A. I don't with me at the moment. My secretary probably would have that information of when she sent this. The September 29th is the date that I would have dictated this report, and after that, I would have briefly reviewed it and given it to my secretary, and she would have faxed it or sent it at some point. She could give you that information.
Q. But as to whether it was sent on the 29th or some date between the 29th and October 26th, as you sit here right now, you can't state; true?
A. That's correct.
Q. Do you recall having a discussion with Mr. Kelley between the time that you reviewed the material on September 13th and prior to preparing the September 29th letter?
A. I don't recall.
Q. By that, I take it, you may have discussed with him your opinions and then proceeded to prepare the report thereafter?
A. I might have. Usually if the letter indicates, please call me with your thoughts, I will do so before preparing a report. I don't see such a request, so I imagine that I did not

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discuss it with him before preparing my report.
Q. As you sit here right now approximately three, two and a half weeks, three and a half weeks from trial, you have not seen any of the testimony of any of the family members; true?
A. That's correct, yes.
Q. Have you been provided with any summaries of any of the testimony of the family members as to Mr. Brooks' premorbid condition prior to the month of May, 1998?
A. No, I haven't.
Q. As I understand it, part of the process that you go through in terms of evaluating the prognosis for a patient with polymyositis is to look at the onset of the disease process in terms of the patient's condition prior to the diagnosis and how long the patient had had symptomatology that was eventually related to the polymyositis; true?
MR. KILBANE: Objection.
A. Yes.
Q. And not that it is an issue of questioning the care by anyone, but sometimes polymyositis is picked up in a relatively quick

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period of time; say, within a month or so of the symptoms being there. Other times the diagnosis may be made months, perhaps even years after the patient's symptoms start; true?
A. That's correct.
Q. And the prognosis is usually better for patients if the diagnosis is made early and the appropriate treatment is started early as opposed to a patient having the disease process for months to years without being treated; true?
A. There are two sides to that.
Q. Tell me about them.
A. The first one is the earlier the patient is treated in the course of the illness from the onset of symptoms, the better the prognosis. That's one side.
Q. Okay.
A. The other side deals with the rapidity of the onset of the disease. Individuals who have a slow insidious -- that means extended -- onset tend to have a better prognosis than people who have an abrupt onset.
Q. We can agree, can we not, that Mr. Brooks, from the time that his symptoms were demonstrated, apparent, to the time that the

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diagnosis was made, that the diagnosis was made in a short period of time; an early diagnosis was made; true?
A. That's correct.
Q. So with regard to that one aspect, that helps with the prognosis factor in terms of the long-term predictability; is that true?
A. That's correct.
Q. Now, the other aspect is how significant the onset of those symptoms are, even if the diagnosis is made early; true?
A. Right.
Q. And just give me sort of your overall assessment. Recognizing that you have not talked with or read any of the deposition testimony of the family, but just from what you gathered in the records, how would you describe from the time that an early diagnosis which is good was made, to the time that he started showing the manifestations of the disease process, how would you describe his course, if you would?
A. His course relative to outcome, it is true that he was diagnosed early in the course, which is a good thing, and treated early in the course, also a good thing. It's not such a good

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thing that the onset was fairly abrupt in terms of the severity over a period of time. So I would say initial recognition was good on his behalf, as well as treatment.
Q. Okay.
A. But the onset was not a good factor.
Q. So in terms of the kind of things that you look at, the beginning of this prediction, if you will, he had two out of three good aspects -- early diagnosis, early treatment -- but the onset was rather abrupt, so that was a strike against him. So he had two out of three good things; correct?
A. That's right.
MR. KILBANE: Objection. Your question sort of assumes they are all equal.
Q. In the final analysis, they are all of significant consideration, are they not?
A. They are all significant considerations.
Q. Now, I sort of got ahead of myself. The document that was just brought in is your CV?
A. That's correct.
Q. And we are going to mark that as Exhibit 5.

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(Thereupon, BALLOU Deposition Exhibit 5 was marked for purposes of identification.)
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Q. It probably comes as no mystery, but on the record, Exhibit 5 is, in fact, your CV; true?
A. That's true.
Q. And it is revised as of May '99, according to the page 11. What do we have to add to this to bring it up to November 2000?
A. Probably not a lot of things, but I would have to look it over.
Q. I would like you to take a look -- if you can summarize it on the record, to just help us along, do so. If you might be able to locate a more current one or if it's going to take too long for you to summarize the additions, I am not going to have you bother doing that. I would accept, perhaps, the more significant changes.
The other question I'm going to have for you, as you look at the CV, I want you to tell me whether there is anything that you have written or presented by way of abstracts,

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bibliographies, papers, that in any way relate to the topic of polymyositis, okay?
A. Okay.
Q. You have sort of two questions there. One to update me and two to tell me if you have written anything that would be relative to polymyositis.
(Pause.)
Q. Off the record, you have had a chance to look at Exhibit 5. The first part of my question was updates.
A. Yes, there is no significant update.
Q. The second part was have you written, co-authored, provided any presentations that would relate to the issue of polymyositis?
A. No.
Q. Is there anything in your presentations, your background, from the standpoint of authoring or lecturing that would be relevant to the issue of polymyositis or any of the diseases that are similar to polymyositis?
A. Well, as it turns out, next week I'm gaing to give the lecture on polymyositis to the second year class at the medical school, which is their lecture on the subject. During the course

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of their medical school training, they get one lecture on the disease, and I have lectured on polymyositis and other connective tissue diseases at various hospitals.
Q. How are you lecturing to the medical students next week on polymyositis?
A. This will be their introductory lecture, so I will be talking to them about epidemiology, concepts of pathogenesis, clinical manifestations, differential diagnosis will be also included.
Q. Will you be providing them with any handouts?
A. Sure.
Q. Have you prepared those handouts already?
A. Yes, I prepared an outline for them. It goes on their electronic syllabus. I am also preparing a handout that I may make available as hard copy, but I haven't gotten to that yet.
Q. What do you have that is prepared now that perhaps we can get a copy of before we leave today?
A. I have a copy of the outline of my talk, which is going to be part of their

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electronic syllabus.
Q. Could you impose upon that nice secretary of yours to get us a copy of that outline so we can continue to move along?
A. It's actually on my own computer.
Q. Which you only have access to?
A. Yes. I am not sure she could find it.
Q. How long will it take you to access that?
A. About two minutes.
Q. Let's go off the record and I will let you get that. I will take a look at your CV and see if there is anything I want to ask you about it, then we will move right along.
(Recess had.)
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(Thereupon, BALLOU Deposition Exhibit 6 was marked for purposes of identification.)
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Q. We will mark this as Plaintiff's Exhibit 6, which is the outline that you are going to be using. We had a discussion off the record.
Do you intend to cover all of what's

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in this outline with the students?
A. No, not all of it.
Q. What parts are you likely not to cover?
A. I'm likely not to spend much time on the treatment issues, which is a level of sophistication a little greater than the students' level.
Q. And I asked you off the record whether or not the outline covers prognosis, and I think you said no?
A. It does not, yes.
Q. Do you intend to talk about prognosis for polymyositis in this lecture?
A. I probably will not.
Q. The students, are they first year medical students?
A. Second year.
Q. Do they have a rheumatology or a neurology text that they use in connection with this course?
A. They do.
Q. Which text do they use?
A. During their musculoskeletal rotation, they utilize the primer on rheumatic diseases,

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which is a nice brief survey of major rheumatic diseases.
Q. Does it have fairly reliable information on polymyositis?
A. Fairly reliable.
Q. Are you the sole professor for that course?
A. No, no. I'm one of the teachers. I'm going to be teaching on connective tissue diseases, of which polymyositis is one.
Q. Are there any other either rheumatology or neuromuscular texts that you consider to be more reliable for a general understanding of the differentiation between inflammatory myopathies and the treatment of inflammatory myopathies and the prognosis of inflammatory myopathies?
A. There are a number of good texts that deal with polymyositis and other diseases. I use them all.
Q. Rather than giving me the whole laundry list, tell me which one do you consider to be the best of the ones that you use, unless you want to give me the whole laundry list; but sometimes people say to me I can't name them all,

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so I will make it easy for you.
A. I like the Kelley text, because it's thorough, well written, and because I contributed a chapter.
Q. In that order? Is it called Kelley?
A. It's called, I think, Textbook of Rheumatology.
Q. By Kelley?
A. Kelley is the senior editor. There are four editors and I can't recall all of them offhand.
There is the Oxford text. I think that's the name. I think Klippel is the main editor of that one. It's a good one, as well.
The original Hollander text is a quite good text, and I think that's just called Rheumatology, as I recall.
Q. Without continuing on, the ones that you named would be --
A. Those three are the major ones I use.
Q. And the ones that you would consider to be the most reliable for reference material on this topic?
MR. KILBANE: Objection.
A. In actuality, I and other physicians,

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we also use papers from the literature I think equally to the text, because the texts are always a year out of date and the papers are more current, and they deal with specific issues when we have specific questions.
Q. But of these texts which are equally reliable, are these the best of the texts in terms of reliability?
A. I think so. I think they are good referral sources.
Q. Ones that you refer to from time to time?
A. Yes.
Q. And ones which you direct future medical -- future doctors to refer to for reliable information?
A. Yes, I do.
Q. Now, this is the outline. Is there any other material that you are planning on giving them for purposes of this class?
A. Yes. I wrote up an illustrative case. Their morning on connective issue diseases will include case discussions and I wrote an illustrative case of a patient with polymyositis to serve as a discussion point.

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Q. Do you have a copy of that?
A. Yes. I can give you a copy of that.
Q. Will you do that?
A. Fine.
(Recess had.)
- - - - -
(Thereupon, BALLOU Deposition Exhibit 7 was marked for purposes of identification.)
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Q. Exhibit 7 is a copy of the illustrative case that you are going to use for purposes of second year medical school class?
A. That's correct.
Q. Is this at all based upon Lee Brooks?
A. No.
Q. Are the facts distinguishable from Mr. Brooks' fact pattern?
A. Well, this is a case of polymyositis, which I made up. It represents, I think, a typical polymyositis. It's different than Mr. Brooks' case in a number of ways, but similar in some ways, too.
Q. Mr. Brooks did not ultimately have interstitial lung disease secondary to the

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polymyositis: true?
A. As far as is known, yes, that's true.
Q. And we unfortunately have the benefit of an autopsy in this case to confirm that he didn't have interstitial lung disease?
A. That's correct.
Q. Had he had interstitial lung disease secondary to polymyositis, that would be one of the poor prognosticators for this gentleman; true?
A. Yes.
Q. He also did not have any type of a lung carcinoma; true?
A. That's correct.
Q. That would also have been a poor predictor in terms of how he would have done in the long term; true?
A. Yes.
Q. He also did not have colon carcinoma; true?
A. That's true.
Q. In fact, there was no evidence of any malignancies that Mr. Brooks had that would worsen his prognosis from his polymyositis; true?
A. That's true.

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Q. So we have the facts that he didn't have any underlying malignancy or any underlying interstitial lung disease. Those are good things?
A. Good things.
MR. KILBANE: I want to make sure I'm clear. From the autopsy, does it show he does not have interstitial disease or just not show one way or the other? I am making sure that it's clear.
MR. MISHKIND: It sounds like you are asking him a question.
Q. And you have answered that there is no evidence to support an argument that he had interstitial lung disease at autopsy; correct?
A. There is no evidence to confirm that.
Q. So you can't take the stand and say more likely than not this man had interstitial lung disease; true?
A. I cannot say that.
Q. And again, going back to my original question, not only do we have the records from Cleveland Clinic, but then we ultimately have the autopsy where tests are done to determine whether or not a patient had any underlying pathology.

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And had there been evidence of interstitial lung disease that would cause you to say that that would have been a poor marker from the standpoint of the man's likely long-term survival and the morbidity associated with the disease; true?
A. It is true that that has a severe implication for prognosis, the presence of interstitial lung disease.
Q. And there is no evidence to a probability that this man had evidence of interstitial lung disease in this case; true?
A. Certainly there is not sufficient evidence to document that he definitely had that condition at this point.
Q. Well, you are not going to be able to state to a reasonable degree of probability that he did have it; correct?
A. That's right.
Q. Any such a statement would be pure speculation?
A. That's correct.
Q. Fair enough.
Before I lose track of my train of thought, let me just finish identifying the items on here.

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Exhibit 3, the original of which we will leave with you, are notes that you made at the time that you reviewed the case?
A. That's correct.
Q. And this is the extent of -- Exhibit 3 is the extent of the notes that you made prior to preparing your September 29th, 2000 letter; true?
A. That's correct.
Q. Did you read the report from the nurse?
A. Yes. I think maybe yesterday.
Q. And does that have any bearing at all on the opinions that you intend to provide at the trial?
A. No.
Q. So it was interesting to read, but it really has no relevance to your involvement; true?
A. Correct.
Q. Exhibit 4, I think, are notes that you wrote after reading Dr. Preston's deposition?
A. That's correct.
Q. You have a note, page 105 -- is that one or six?
A. I don't know what it is.

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Q. I can't help you because you wrote it. I think you did, didn't you?
A. I wrote it. When I write a page, it just means something that may have had some significance to me at the time, so it's something to look back on. But apparently it wasn't sufficiently significant that I made any remarks.
Q. And then the other is page 110. Is that morbidity?
A. Mortality.
Q. Mortality. And then what does it say after that?
A. Also treatment related.
Q. Those are the only notes that you made when you read Dr. Preston's deposition?
A. That's correct.
Q. And I think page 105, line 1 is where Mr. Kelley was asking about Dr. Preston's strong feelings when he read your report. Is that probably why you marked that page down? If you turn to page 105.
A. Oh, I think I marked page 105 because that's the beginning of where Dr. Preston addresses prognosis and my own report. So I think that was the significance there. Prior to

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that it doesn't seem like he specifically addressed my report. So that's what the significance of that is.
Q. As you read through the deposition prior to getting to 105, were there any areas of Dr. Preston's testimony that you took issue with?
MR. KILBANE: Objection.
A. I frankly didn't pay a lot of attention to it. I didn't feel that that was within the area that I was inclined to look at with regard to this case.
Q. And that's still your position as you sit here right now?
A. That's correct.
Q. And no one has asked you to comment at all or to provide any reaction to what's contained prior to page 105; true?
MR. KILBANE: Objection.
A. That's correct. Prior to page 105, the information relative to his treatment was not significant to me.
Q. Now, we are going to talk a little bit about the differences that the two of you have and the specifics of Dr. Preston's disagreement,

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and then I am going to want you to provide me with some reaction to that, okay?
A. Okay.
Q. We are not going to do that right now. I'm just sort of letting you know that we will be talking about that.
A. Okay.
Q. Page 110. On page 110, Dr. Preston makes statements that, number one, polymyositis is an autoimmune disease. That's true; correct?
A. Correct.
Q. Sometimes occurring as part of other autoimmune diseases; correct?
A. That's correct.
Q. And those diseases may carry a higher morbidity and mortality; correct?
A. Sometimes.
Q. Did he have other autoimmune diseases aside from his polymyositis?
A. No, not that I can tell.
Q. The increased mortality of polymyositis primarily has to do with the association of a number of things, including malignancy; true?
A. Yes.

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Q. He continues on, the association with an interstitial lung disease, that also increases mortality; true?
A. True.
Q. The association with other connective tissue disorders: true?
A. That's true.
Q. Taken as a whole, that first paragraph is an accurate statement?
MR. KILBANE: Objection. Howard, you walked him through bit by bit all of them but left off the last sentence, where he says those are the primary conditions. To be fair, if you are asking him the whole paragraph, we need to include that also.
MR. MISHKIND: I meant the whole sentence. Your statement is well taken then.
MR. KILBANE: Fair enough.
A. Those sentences as stated are true.
Q. Now, continuing on, Dr. Preston says, those are the primary conditions which increase the mortality of polymyositis. Do you agree with that statement?
A. That's not completely accurate.
Q. Is it partially accurate?

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A. It's partially accurate.
Q. In your opinion, what needed to be added to that to make that completely accurate?
A. As you can see on the remarks which I wrote when I reviewed this initially, it's also clear from my experience from the world literature that there is a tremendous morbidity and mortality associated with treatment of this disease, and, in fact, probably in most series, the second or third most likely cause of death is infection, often related to treatment.
Q. Treatment being the immunosuppressant therapy?
A. And steroids.
Q. Is the immunotherapy Methotrexate?
A. It can be.
Q. Imuran?
A. It could be.
Q. Are those the two immunosuppressants of choice?
A. Yes, at present, they are.
Q. In conjunction with Prednisone?
A. Yes.
Q. The length of time that one is on those medications varies depending upon the

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response that a patient has to treatment; true?
A. That's true.
Q. The goal is to treat a patient for a period of weeks to months and to see how the patient does in response to the immunosuppressant therapy and the steroid therapy; true?
A. Yes.
Q. And to watch the patient?
A. Yes.
Q. And obviously to look for signs of infection that may develop as the patient is being treated?
A. Correct.
Q. If the patient responds well to the immunosuppressant therapy, whether Methotrexate or Imuran, in conjunction with Prednisone, over time the dosage is tapered; true?
A. Often, yes.
Q. And then there is a maintenance dose that the patient is kept on?
A. Most often, yes.
Q. And if a patient is fortunate enough to have a favorable response to the immunosuppressant therapy and is tapered, then one starts looking in a favorable light toward

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the long-term prognosis for that patient; true?
A. Yes.
Q. In Mr. Brooks' case, we don't have the benefit of him surviving the intraabdominal hemorrhage and the multi-system organ failure to see precisely how he would have responded to the immunosuppressanttherapy and the Prednisone; true?
A. He didn't receive immunosuppressant therapy during the course of his life. I assume that he would have. But we certainly didn't have adequate time to observe his response to the steroids.
Q. And again, that's not to criticize anyone at The Cleveland Clinic in terms of the treatment of the polymyositis, because the first line of attack is to start them on Prednisone?
A. That's correct.
Q. And then in conjunction with Prednisone and therapy, then in a patient that doesn't develop complications like he did, then you start them on the immunosuppressant therapies; true?
A. Often that is a good choice, yes.
Q. Would that likely have been what would

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have happened with Mr. Brooks?
A. That is likely what would have happened.
Q. In fact, I think the record talked about him being --
(discussion off the record.)
Q. The records even would reflect that he was going to be transferred the following day to a subacute facility for rehab?
A. Yes.
Q. And that would have been an appropriate thing to do?
A. That would have been appropriate to do.
Q. And then he would have been treated with the steroids and the immunosuppressant therapy for a period of four to six weeks with tapering thereafter; true?
A. Probably something of that nature, yes.
Q. In fact, that's what the plan was before he experienced this tragic outcome; true?
A. True.
Q. And you would agree with the doctors at The Cleveland Clinic when they talked about

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his rehab potential as being good; correct?
MR. KILBANE: Objection.
A. I don't recall seeing that right offhand.
Q. Well, I will represent to you that the day before his PEG tube was done, the rehab potential in the records indicate, the M.D. prognosis notes and the occupational therapy notes indicate his rehab potential was good; that they recommended subacute treatment with occupational therapy to increase independence with activities of daily living and functional mobility.
If, in fact, the rehab potential, as they viewed it, was good with that plan, you wouldn't take issue with The Cleveland Clinic on that, would you?
MR. KILBANE: Objection. Let's either go to the records or do it as a hypothetical.
Q. I will give you that as a hypothetical, and if I am wrong with what I stated, I will fall flat on my face, but I will represent to you that that's what the record says.
A. If the record indicates that he has

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good rehab potential, I think that that's appropriate for them to so state. Can I leave it at that?
Q. Well, do you or do you not disagree with The Cleveland Clinic in terms of the statement that they made, before there is any litigation and while they are looking at this patient, that he had good rehab potential?
MR. KILBANE: Objection. Asked and answered. Go ahead.
A. My point here is that everybody with this disease has rehab potential. And everybody deserves rehabilitation.
I am not clear about "good" here. I have seen a number of patients with this disease. I personally am not certain that I would have said good rehabilitation. Certainly rehabilitation potential and certainly he needed this treatment, but they may -- I didn't see him and they saw him. Maybe they somehow had a better feel for it than I got from reading the case.
Q. Reading the case as an expert witness that's coming in to provide opinions in this case as an expert retained by The Cleveland Clinic,

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what would you have indicated as his rehab potential?
A. Fair.
Q. Several days before his PEG tube was placed, there is a notation in the records -- I ask you to assume hypothetically, just to save some time --that Mr. Brooks was told that he would be going to a subacute facility first for physical therapy before he could then be discharged back to his home.
Number one, assuming that's the information that they gave to him, would that likely be an accurate statement of anticipated treatment for him?
MR. KILBANE: Objection.
A. That would be an accurate statement of an anticipated treatment, yes.
Q. Assuming that the patient survived the intraabdominal hemorrhage and this catastrophic death that he experienced and went to rehab, can we agree that he would have been a candidate for rehabilitation at the subacute facility with subsequent discharge to his home?
MR. KILBANE: Objection. Go ahead.
A. I presume that would be the plan, yes.

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Q. And to a probability, with treatment, can we agree that he likely would have gone to rehab for a period of time and then likely have been discharged to his home?
A. I feel certain that he would have gone to rehabilitation for a certain period of time. I'm not so certain that he would have been discharged home. I think that clearly would have depended upon his response to therapy and his condition when he had reached optimal rehabilitation.
For example, I see patients who failed to have adequate success with rehabilitation in whom, for whatever reason, it is felt that an extended care facility is more appropriate.
Q. But you can't state to a probability that Mr. Brooks would not have responded to immunosuppressant therapy and have been able to be discharged?
A. There clearly was not enough time to tell this.
Q. So when you take the stand and testify, you are not going to be able to state that it's my opinion to a reasonable degree of probability that he would have been in a rehab

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facility and then a long-term facility for the rest of his life; true?
MR. KILBANE: Objection.
A. I cannot conclude that.
Q. We can all agree that he needed treatment for the polymyositis and rehab. What you are agreeing with me about is that the future, as to where he would live and what type of independence he would have, you are not going to be able to give an opinion one way or the other on that; true?
MR. KILBANE: Objection.
A. One can only frame this in terms of probabilities.
Q. And can you state to a probability what type of independence he likely would have had?
MR. KILBANE: Feel free to refer to your report or any of the records.
A. My estimate is that he would not have reached full functional recovery perhaps ever. My estimate is that he would probably have, with good rehabilitation, immunosuppressant therapy, that he probably would have had about a 50-50 chance of independent mobility. That means

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ambulation with perhaps assistance, but independently, say with a walker or cane or something like that.
Q. Those are your opinions to a probability?
A. That's my opinion.
Q. Thankyou.
I am going to redirect your focus now away from polymyositis. Parenthetically though, I am going to come back to polymyositis before we conclude.
A. That's fine.
Q. I am going to talk to you about your medical/legal experience.
A. Okay.
Q. Have you ever served as an expert witness in a medical negligence case before?
A. Once or twice.
Q. How long ago would that be?
A. The most recent was within the past two months.
Q. Now, in this case, you are not providing opinions on standard of care; i.e., that The Cleveland Clinic met accepted standards of care. You are testifying on the issue of

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proximate cause, the issue of disability had he not succumb to this situation.
In the other case two months ago, was your role different?
A. Yes. It was relative to standard of care.
Q. Was this in a rheumatological condition?
A. Yes.
Q. What was the nature of that condition?
A. Rheumatoid arthritis.
Q. As to whether rheumatoid arthritis was treated properly?
A. That was part of the issue, yes.
Q. Was there some other diagnosis arrived at?
A. Yes. The person had tuberculosis.
Q. Probably had night sweats?
A. Yes.
Q. Is that case still pending?
A. I don't believe so. I think it was concluded.
Q. Was your deposition taken?
A. Yes.
Q. Were you appearing as the expert for

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the patient, the plaintiff, or an expert for the doctor or hospital that was implicated?
A. I was appearing on behalf of the defense.
Q. And who was the doctor or the hospital, or both?
A. The hospital was University Hospital, and the doctor was Dr. Van Warren.
Q. And who was the lawyer that you were working with?
A. The firm was Reminger.
Q. That would be Reminger & Reminger?
A. Reminger & Reminger.
Q. I have heard of them.
And who would the lawyer be that you were working with in that case?
A. The lawyer I was working with?
Q. From the Reminger firm.
A. From Reminger? I just saw his name. Conway.
Q. Tom Conway?
A. That's it.
Q. A red head, tall, thin?
A. I don't remember what he looked like.
Q. Better looking than Kilbane?

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A. I don't remember what he looked like.
(Discussion off the record.)
Q. Your deposition was taken by the plaintiff's attorney in that case?
A. Yes.
Q. And who was the plaintiff's attorney; do you recall that?
A. I forget.
Q. The depo was taken two months ago. And to your knowledge, the case has gone away?
A. I think the case was settled, I think.
Q. Was the lawyer, by chance, Bill Carlin?
A. That sounds like it could be it.
Q. Sort of a heavy set fellow?
A. Yeah, I believe it was.
Q. Aside from that situation, any other cases that --
A. Not in recent memory. Maybe one or two in the past.
Q. Had you ever testified in a deposition in a med/mal case before this one a couple months ago?
A. Once I testified in a deposition in a medical malpractice case where the patient was my

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patient and I wasn't on either side. I was asked to testify about my patient's condition.
Q. You were the treating physician?
A. I was the treating physician. So I guess they just wanted information from me about my patient.
Q. So the time that this lawyer took your deposition in the University Hospital case, would that have been the first time where you were retained specifically to provide expert opinions in a standard of care context?
A. Where I actually was deposed, yes. I have been in other cases where I wasn't deposed.
Q. And that would be one or two other occasions?
A. One or two.
Q. And that would be where you wrote reports perhaps to the attorney but never got to the deposition or trial stage?
A. Exactly.
Q. I take it you have never marched into the courtroom and testified, taken the stand and testified in a medical malpractice case?
A. That's correct.
Q. The other one or two cases, roughly

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speaking, that you reviewed and wrote reports on, would those have been at the request of attorneys representing the physician or hospital or the attorney representing the patient?
A. Both.
Q. One of each?
A. Yes, one of each, I think.
Q. Fair enough.
Have you ever had the misfortune of being named as a defendant in a medical negligence case?
MR. KILBANE: Objection. You can answer.
A. I think so.
Q. Why do you say it in that manner? That's something normally known if you are,
A. About 20 years ago, I was named as a defendant in a suit, because I had given a lecture. And so I had to do a deposition and then I was dismissed.
Q. Other than that situation, you fortunately have not been named?
A. That's correct.
Q. Fair enough.
Are you currently reviewing any other

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matters for the Reminger & Reminger firm?
A. No.
Q. And when Mr. Kelley contacted you, I take it, it was because of having received your name from Mr. Conway?
MR. KILBANE: Objection.
A. I really have no idea.
Q. Have you ever provided your name to any of the services that make expert witnesses available in medical negligence cases?
A. I don't believe so.
Q. Has the department of rheumatology here at Metro published any literature dealing with the issue of morbidity and mortality associated with polymyositis?
A. Not that I'm aware.
Q. Are you aware of any studies or literature from the Mayo Clinic that have to do with the issue of morbidity and mortality associated with polymyositis?
A. Oh, years ago there was a very good paper published by a bunch from the Mayo Clinic on the treatment of polymyositis using Imuran. I don't recall whether they addressed the issues of morbidity -- well, they did address the issues of

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morbidity, absolutely they did. I don't know about mortality.
It was a nice study focusing on the benefits of Imuran to the current therapy, which at that time was mostly Prednisone.
Q. How long ago was that article written?
A. That was probably in about 1980 to '82, somewhere around that range.
Q. Have things changed with regard to the treatment and the issue of morbidity and mortality in polymyositis over the last 20 years?
A. Yes. More people are using certainly immunosuppressants along with steroids. There are recent trends to use Methotrexate rather than Imuran. And even recent studies from Pittsburgh and other areas have suggested that certain other agents such as Cyclosporine A could also be used for refractory cases.
Q. And certainly you are not going to be able to state to a probability that Mr. Brooks had a refractory case of polymyositis; true?
A. That's true.
Q. The Mayo Clinic study then in terms of the treatment modalities wouldn't really be up to speed with regard to the current thought process

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as it relates to treatment modalities for the year 2000; correct?
A. There is more recent data that we use, yes.
Q. And even more recent than 1998?
A. Yes.
Q. I am talking about current. This was a 1998 situation. So the analysis and the treatment modalities would not have been guided by the study from 1980 at the Mayo Clinic; true?
A. That's right.
Q. What about any studies or literature from Johns Hopkins that you are aware of dealing with the issue of morbidity and mortality associated with polymyositis?
A. Mark Hochburg has published a nice study of morbidity and mortality in 1986. It was a nice study that addressed this issue.
Q. What was the name of that doctor?
A. Mark Hochburg.
Q. How does he spell his last name?
A. H-O-C-H-B-U-R-G.
Q. Have you reviewed his article at all in connection with the preparation of the opinion letter that you have prepared?

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A. No, not recently. I am familiar with the article, but I haven't reviewed it recently.
Q. Do you consider it to be authoritative?
MR. KILBANE: Objection.
A. Well, there is really quite a few articles I think in this fashion. I use a vast number of articles. I mean, I still like the Mayo Clinic article, I like Hochburg, the famous Peter and Bolan article. I like more recent articles from Targoff in Oklahoma and Kagan at HSS. So there is really quite a few papers that I read about this. I read about this, as do most rheumatologists quite often.
Q. In arriving at the opinions that you expressed in this report -- I am trying to shortcut it because I realize you have patients -- did you look to any of the medical literature in citing any of the statistics that you have relied on for purposes of this letter?
A. The statistics that I cited, I'm aware of, I was already aware of from the literature. I didn't cite that many statistics. I think I only cited a couple of them. But those are things known to me from just my review of the

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literature previously.
Let's see, 80 percent, five year survival represents -- there is a range certainly and there are other survival figures reported -- but this is one that I happen to remember.
Q. Let's deal with one at a time on that. I don't mean to interrupt you. I am going to let you continue to answer that, but I think maybe to help us move things along, on that point, you state the 80 percent survival without associated malignancy; correct?
A. That's right.
Q. And that would be where Mr. Brooks would fall; correct?
MR. KILBANE: Objection.
A. Not necessarily. This is an 80 percent, five year survival in all adult patients, including patients age 55. That would not apply to an individual age 65.
Q. Well, this doesn't talk about --
A. This is an 80 percent, five year survival of all adult patients, which the mean age is probably mid 40s.
Q. Okay.
A. So this statistic would not apply to a

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65-year-old, Mr. Brooks or any 65-year-old.
Q. Let me ask you this. Can you cite me any literature that would address the issue of the morbidity -- I'm sorry, the survival with reasonable and prudent treatment for polymyositis for a gentleman that is 65 years of age, that has Mr. Brooks' co-morbid conditions that does not have any associated malignancy?
A. To my knowledge, that data does not exist in the literature.
Q. As far as the survival of 80 percent at five years in adult patients, would you agree that those studies deal with patients of all adult ages?
A. Yes.
Q. And in fact, if I'm referring to the same studies that you are -- maybe I'm not -- but those studies include patients older than 65, as well as younger than 65?
A. All adult patients.
Q. And the conclusion was 80 percent, five year survival in those studies, but it doesn't break it down to a 30 percent for people at 65, a 90 percent for people at 55; correct?
A. That's my recollection, yes.

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Q. So the best scientific evidence that's available right now is what you have stated in terms of 80 percent, five year survival in adult patients without associated malignancy; correct?
A. Yeah, that would be a reasonable projection, yes.
Q. Are you aware of any studies that have projected out beyond five years in terms of the degree of survival on patients that have polymyositis with an onset at the age of 65?
A. There is a study recently that addressed prognosis in older individuals. There have been several such studies. I don't know if they actually looked at Kapman Myer statistics, which is survival rates as you see here in older individuals. But studies that have looked at age, always associate age as a poor prognostic factor; that is, with increasing age, survival and, in fact, morbidity are reduced.
Q. Can you tell me in this case if Mr. Brooks had not encountered this disease of polymyositis with his underlying coronary artery disease what his life expectancy would have been?
A. I can hazard a guess.
Q. If it's a guess, I don't want it. If

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you can provide me with an opinion to a reasonable degree of probability what his life expectancy would be, then I do want that.
A. No, I think you could find such information from tables, from national tables of individuals with coronary artery disease, black males age 65, I think you can find expected survival rates and I won't quote you one.
Q. Well, you are aware of the United States life tables, are you not?
A. Yes.
Q. And the United States life table address a 65-year-old black male; correct?
A. Correct.
Q. And that deals with all comers?
A. Yes.
Q. So that takes an average of certain people that will live beyond those figures and certain people that are going to die earlier?
A. That's correct.
Q. If I told you the life expectancy for a 65-year-old man, according to the United States life tables, is 15 years, all comers, some going to live longer, some live less, and I represent that to you to be what the United States life

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tables provide, would you have any basis to dispute that?
A. No, not at all.
Q. Would you expect that with polymyositis -- again, not knowing how his response was going to be because he hadn't had the immunosuppressant therapy, but assuming he had a good course to the Methotrexate and/or the Imuran and that he was able to be ambulatory -- we know that he had the PEG tube, so he was no longer at risk for aspiration pneumonias; correct?
A. Uh-huh.
Q. That's a yes?
A. That's theoretically correct, yes.
Q. So if he had had a good response to the immunosuppressant therapy and/or the Imuran and became ambulatory, can you state to what extent his life expectancy would have been reduced from the United States life table expectations?
MR. KILBANE: Objection to a hypothetical. Go ahead and answer.
A. Yes. Ignoring other co-morbid diseases, such as atherosclerosis and just

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focusing on polymyositis, if he had a very good response to therapy and became ambulatory, his survival would still have been reduced, just on the basis of having polymyositis alone. And my estimate is that it would be reduced, oh, if you said 15 years survival, say, for example, 10 to 12 years, 10 to 12 years total.
Q. So his life expectancy would be 10 to 12 as opposed to that theoretical 15?
A. Right.
Q. So roughly a ten to 20 percent reduction in life expectancy?
A. Right.
Q. The overall prognosis being worse in African-Americans than Caucasians, do you have any studies that support that proposition?
A. It has been mentioned in the literature.
Q. What literature?
A. The literature focused on the polymyositis in a number of papers and a number of reports have suggested that.
Q. Can you cite me to any specific?
A. Not without going back and looking at my files.

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Q. Do you have files that deal with --
A. Polymyositis?
Q. Specifically that would address the issue of Caucasian versus African-American survival?
A. I have a large file of papers on polymyositis and some of them do address this issue.
Q. I would like to see those if they are the ones that you are relying on for that proposition.
MR. KILBANE: Objection.
Q. Will you look for those and make those available?
A. If you would like me to, I can show you such statements in the literature.
Q. Are you aware of whether or not that is more of a component of the quality of medical care that historically has been provided to African-Americans versus Caucasians?
A. The answer to that is not clear. If we look at a related condition called lupus where there is clearly a reduced survival in African-Americans with this disease, it is thought that socioeconomic factors and access to

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care could be part of the explanation, but probably not the entire explanation, and there are a reasonable number of individuals, including myself, who think that there are potentially genetic factors that also play a role.
Q. But you certainly wouldn't rule out that our socioeconomic setup is such that at least a factor in why African-Americans do worse than Caucasians has been access to medical care?
A. I think that's one factor, yes.
Q. It may not necessarily be an overwhelming factor?
A. It's one factor.
Q. When one talks about African-Americans having a poorer prognosis than Caucasians with polymyositis, you certainly have to admit that a factor that has to be taken into account by people listening to that is access to medical care hasn't always been the same for black Americans as it has been for white Americans?
A. I'm sure that's true.
Q. Older age is known to be associated with worse prognosis and you have greater than 55.
A. Yes.

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Q. Can you cite me to any literature as it relates to polymyositis that would support a 55 age cutoff, if you will, where patients above 55, Mr. Brooks, being ten years older than that, but a patient above 55 has a poorer prognosis from polymyositis than a patient under 55?
A. Yes, I have seen that in the literature.
Q. Have you also seen articles that indicate patients 65 have the same kind of prognosis as patients the age of 55?
A. See, the literature doesn't make -- different studies make different age cutoffs. I have seen it said that individuals 65 and older do worse. I have seen it reported that individuals 55 and older do worse. So we deal with a whole body of literature of which there are multiple age cutoffs.
Suffice it to say, that virtually all studies indicate age as being a substantial risk factor as you get older throughout life, probably. I don't know that we could definitely say there is one cutoff age where people are clearly going to do worse.
Q. So for purposes of understanding the

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opinions on morbidity and mortality, there are a number of different studies, none of which predominate such that you can say that Mr. Brooks had a lower survival rate simply because he was over age 55; true?
MR. KILBANE: Objection.
A. I am not sure I understand that question.
Q. Fair enough. You indicate that older patients are known to have a worse prognosis of -- let me put it to you this way. Can you tell me how worse off he would have been in terms of his prognosis in this case, simply because he was 65 years of age?
A. Can I quantify how much worse?
Q. Yes.
A. I think that that is probably not possible to do.
Q. Fairenough.
The pharyngeal dysfunction which occurs in ten to 15 percent of the cases, that's associated with substantially worse prognosis; true?
A. That's correct.
Q. Fortunately, he had an early diagnosis

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of his polymyositis; true?
A. True.
Q. And he had an attempt to avoid further esophageal dysfunction by putting the PEG tube in; correct?
MR. KILBANE: Objection.
A. To avoid complications of the esophageal dysfunction.
Q. And had the PEG tube been successful and he didn't develop an intraabdominal hemorrhage and then die following that, the issues of esophageal or pharyngeal dysfunction would not have been a factor in Mr. Brooks' case; true?
MR. KILBANE: Objection.
A. Not entirely. The pharyngeal dysfunction as a sign of poor prognosis is related to two factors: One is the complications of that dysfunction, aspiration, et cetera, which clearly would be corrected by placement of the PEG tube.
The other aspect is the significance of pharyngeal dysfunction in terms of the disease severity. And this is clearly noted in the literature, and it's my experience, as well,

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individuals who have disease severe enough to cause pharyngeal dysfunction almost always have the most severe muscle involvement, generally. So it portends a poor prognosis just from it's an indicator of the disease severity, which is substantial.

The ten to 15 percent of individuals with pharyngeal dysfunction are also those who have the most severe disease. This is not just the literature, this is my experience, as well.

Q. But, doctor, wouldn't you agree with me that in the literature that the patients that have the pharyngeal dysfunction which have a much more substantial worse prognosis are more often than not the patients that have had a long course of symptoms before they are treated and diagnosed with polymyositis?

A. Not necessarily. Some are. But I have seen and it is well described, some individuals, unfortunately with a poor prognosis, do present rapidly and dramatically with profound weakness within weeks, including pharyngeal dysfunction. And the literature suggests, and I agree with that, that these individuals have the severest disease and the worst prognosis.

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Q. But again, you wouldn't disagree with me when I say that there are studies that show that patients with pharyngeal dysfunction that have worse prognosis are also frequently those who have had a long course of symptoms before they are diagnosed and treated for the polymyositis?

MR. KILBANE: Objection.

A. I'm not sure of the use of the term frequently. Some have.

Q. And the poor prognosis associated with the pharyngeal dysfunction in a lot or in a large majority of those patients that have a poor prognosis, they have already experienced aspiration and complications from the pharyngeal dysfunction; correct?

MR. KILBANE: Objection.

A. I'm not certain that's correct. Most individuals in my experience with substantial pharyngeal dysfunction seek medical care quite quickly. It's a tremendously dysfunctional complication, manifestation.

These patients can't control their own secretions. It's rare in my experience for individuals to have significant pharyngeal

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dysfunction for long periods of time without seeking medical care. It's an awful situation if you see it clinically.

Q. But he is in the hospital at The Cleveland Clinic when these symptoms develop that started portending the existing pharyngeal dysfunction; true?

MR. KILBANE: Objection.

A. Right.

Q. He is treated early for the pharyngeal dysfunction at the Cleveland Clinic; true?

A. That's correct.

Q. That would be a good prognostic indicator as it would relate to the association?

A. It's a good prognostic indicator relative to preventing complications such as aspiration, yes.

Q. Severe muscle weakness at presentation is a very poor prognostic factor?

A. That's right.

Q. However, you also recognize that patients have a variable course in terms of the response to Methotrexate and to Imuran and even patients with severe muscle weakness frequently become ambulatory and independent; true?

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A. I am not sure about frequently. There is certain a gradation of muscle weakness. I see many patients who present and are diagnosed and are ambulatory at the time they are diagnosed with mild dysfunction. It is in my experience uncommon to see someone with muscle weakness so profound that they have truncal weakness, unable to support themselves in bed. That's profound weakness. Such cases are quite uncommon.

I think in patients with this severity of weakness -- I have seen maybe two -- and really the severity of this weakness is substantial. It does not preclude improvement, but I have to temper my statements with I think it would require prolonged treatment, a tremendous Tour de Force of rehabilitation and I doubt that the outcome would be entirely satisfactory. This is profound weakness.

Q. And you have said to me, taking everything into account, that he had at best a 50-50 chance of becoming ambulatory?

A. Correct.

Q. Taking all factors into account?

A. Taking solely the extent of his weakness and the rapidity of his onset.

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Q. Because we didn't have the benefit of, the opportunity to see how he responded to the immunosuppressant therapy?
A. We did not, but my guess is he would not have any better than a 50-50 chance of being ambulatory.
Q. Obviously you would be optimistic and be encouraging the patient and the family that he would be able to be independent in the future; true?
A. I would hope so.
Q. And you want to be optimistic and encouraging the family because you know that with treatment and with tender loving care from the family that that 50-50 shot of becoming ambulatory could become better; correct?
MR. KILBANE: Objection.
A. Partially. It is good to be optimistic. It is also good to tell the family the truth. I think it's important that the family and the patient realize the challenges ahead.
I have no problem with telling a patient or their family that this is a serious, serious problem, and without tremendous effort on

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everybody's part, the outcome could be worse. I want people to know up front exactly what I think is going on. I want them to accept this as challenging, because most of the rehabilitation occurs on the part of the afflicted individual and it's hard.
Q. So then you think that The Cleveland Clinic, when they say that the rehab potential was good, you, Dr. Ballou, think that maybe they are painting the glass half full rather than half empty?
A. That particular comment. That single comment you mentioned, whoever made it, yes, I think.
Q. Now, when you find out that a patient has polymyositis as opposed to something like Lou Gehrig's disease, you are happy, are you not?
A. I don't treat Lou Gehrig's disease, but certainly if I had to have one or the other, I would rather have polymyositis.
Q. Because polymyositis, while it's not curable, it is treatable?
A. It's treatable.
Q. Would you agree that Mr. Brooks was initially treated with Solu-Medrol?

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A. Yes.
Q. That's the steroid?
A. Right.
Q. And he then would have required --we have talked about this --the immunosuppressant therapy over months?
A. This is an individual that would have required that, yes.
Q. Could you tell me with successful treatment how long he would have needed the immunosuppressant therapy before being tapered off completely?
A. I think it's unlikely that he would have been tapered off any immunosuppressant completely.
Q. He would have been tapered; true?
A. He would have been tapered from the steroids. I doubt that he would have been taken off of the immunosuppressant.
Q. Why?
A. Because many patients have recurrences, at least a third. Most of my patients with polymyositis are on immunosuppressants for a long time. I currently have six patients with polymyositis, all but one

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still on immunosuppressants, and this is years following diagnosis.
Q. What is the longest term patient that you have had that has polymyositis?
A. Well, that I am currently following, I am following a fellow who has had it for 15 years and he is still on Methotrexate.
Q. How old is that fellow?
A. Now, he is probably about 45.
Q. What is the oldest patient that you have that has polymyositis?
A. I have a woman who is in her probably early 70s with polymyositis.
Q. Did you treat her from the onset?
A. Yes.
Q. Is she ambulatory?
A. Yes.
Q. Was she ambulatory at the time of onset?
A. She was always ambulatory.
Q. What were her symptoms?
A. Weakness in her arms and legs; some difficulty getting out of a chair; some difficulty getting in and out of the car; feeling of weakness when she was doing her hair.

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Q. What about any pharyngeal dysfunction?
A. None.
Q. Do you have any patients that had pharyngeal dysfunction?
A. Yes. I have over the years, yes.
Q. You have, okay. How long did you treat those -- do you still have any patients that have pharyngeal dysfunction?
A. The one man who I have treated with Methotrexate now for 15 years, he had pharyngeal dysfunction that has now resolved.
Q. Did they PEG him?
A. He did not need a PEG.
Q. A patient that has pharyngeal dysfunction that has a PEG tube that is treated with immunosuppressant therapy, are they lifetime committed to the PEG tube?
A. I don't know for sure. I have only had one patient who was treated with a PEG tube for pharyngeal dysfunction. I don't know if it's lifetime.
Q. A patient that you had that was treated with the PEG tube, does the patient still have the PEG tube or was it reversed?
A. He died.

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Q. What did he die of?
A. He had a cardiac death related to his myositis.
Q. Was there an autopsy done?
A. I don't recall. This was probably 12, 15 years ago.
Q. How old was that patient?
A. He was about 48.
Q. A young man. Do you know anything about Mr. Brooks' preJune '98 activity level and abilities in terms of his functioning?
A. I do not.
Q. I am doing the best I can, doctor. I know you are pressed for time.
(Discussion off the record.)
Q. Going through your report, at page two, where it says it is possible that Mr. Brooks may have had pulmonary involvement from polymyositis, we have talked about that. You can't state to a probability that he had such pulmonary involvement; true?
A. I cannot state that.
Q. As far as his cardiac condition, can we agree that the cardiac condition that was described both at autopsy and in the records,

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while he did have ischemic cardiovascular disease and had high cholesterol, his cardiac status was stable?
A. I'm not certain that we can actually state that.
Q. Are you able to state that he had significant ongoing cardiac abnormalities that would cause him to be unstable from a cardiac standpoint?
A. Well, the autopsy reflected that he had cardiomegaly and hypertrophy. I'm not a cardiologist. But those are not good things to have. I think they reflect the presence of significant cardiac disease, per se. How significant, you would have to ask a cardiologist.
Q. You are certainly not going to be in a position to testify that a cardiac condition in and of itself was likely to cause this gentleman's death in the foreseeable future, are you?
A. What I can say is the fact that he had significant cardiovascular disease would have adversely influenced his mortality as compared with a 65-year-old African-American male who did

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not have ventricular hypertrophy or cardiomegaly.
Q. Can you state to what extent from a quantification standpoint?
A. I cannot.
Q. Fair enough. Mr. Brooks did not have the presence of Jo-1 or SRP antibodies, did he?
A. Not that I saw in the record.
Q. And certainly Jo-1 and SRP antibodies are also poor prognostic features; correct?
A. Yes, they are thought to be, yes.
Q. Just for my edification, Jo-1 antibody is what?
A. Jo-1, I believe, is, it's an anti-tRNA synthetases. I think it's Histadyl tRNA synthetases, but I am not sure which one. There are several. Jo-1 is a major one and there are other ones.
Q. In your report, you state that Mr. Brooks would have had an extremely low probability of functional recovery to his premorbid status and considerably diminished survival compared with that expected in a 65-year-old man with his premorbid health status.
Without repeating everything that you

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have already told me, can you elaborate on that beyond what you have already said or do you feel that you have explained the basis or bases for that statement adequately?
A. Most individuals with this disease -- and I would say more than 80 percent -- do not recover premorbid functional muscle strength. Premorbid muscle strength; that is the muscle strength they had prior to acquiring the disease. More than 80 percent do not recover full muscle strength.
Q. So that would be the muscle strength that he would have had before May of 1998?
A. Exactly. So it's a very low likelihood of full recovery, in anybody, in everybody, in my patients. In the patients I am treating now, most of them are on continuing treatment for that reason. They still have weakness.
Q. Okay.
A. I don't know if you want me to expound on that further?
Q. I guess I want to understand beyond what you have already shared with me as we have talked about.

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A. There are certainly grades of improvement. While I do not believe that, I think very few people recover full functional status, a substantial number can recover acceptable or functional muscle status, so they can carry out activities, they can be ambulatory and do their hair, do their housework, et cetera.
But then there are, of course, the minority who do not recover even that kind of functional recovery, and unfortunately, based on Mr. Brooks' presentation, I believe he is likely to be among the minority who does not have that degree of functional recovery.
Q. And again, you have stated that at best, he would have had a 50-50 likelihood of being ambulatory?
A. Yes.
Q. And if he didn't respond to the immunosuppressant therapy and fell below that 50-50, he would be probably needing a wheelchair to get around?
A. That's correct.
Q. But would have been able to live independent at home as opposed to in a long-term

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facility; true?
A. Depending on the home situation.
Q. If he has a caring wife?
A. If the family was very supportive, he could be managed at home. That would be optimal.
Q. Do you have any evidence from what you have reviewed that he didn't have that kind of family support that he would be able to be cared for at home?
A. I didn't review those issues.
MR. MISHKIND: Give me a minute or two to review my notes.
(Recess had.)
Q. You have referenced a number of articles or authors, as well as you talked about some studies. Are you aware of any studies that have been generated from Case Western Reserve University that specifically deal with the issue of morbidity and mortality associated with polymyositis?
A. Yes. There was a rheumatologist who is now retired, whose name -- oh, Paul Vignos V-I-G-N-0-S. He was a rheumatologist at University Hospital for many years. He has been retired, oh, probably for five or ten years now.

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Certainly five years.
He did a lot of work in polymyositis. This would have been back in the '70s and '80s. And he was, I think, a highly regarded investigator in this area. I don't recall any of his papers specifically. They are from the '70s and '80s and I don't use that literature that old anymore, but he was a well regarded investigator.
Q. Well, there has been some suggestion that there is some current literature that's emanating or been published from Case Western Reserve University dealing with the issue of polymyositis, morbidity and mortality issues.
Are you aware of any such literature?
A. No, I'm not. Not recently.
Q. What you are familiar with goes back to the '70s and '80s, and we talked about the advances that have taken place both with regard to treatment and with regard to the issue of morbidity and mortality; true?
A. Yes.
Q. Do you have any type of a working relationship with The Cleveland Clinic?
A. Personally, me?
Q. Yes.

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A. I know the rheumatologist there. I don't interact with him in terms of patient care or research.
Q. You don't see patients from The Cleveland Clinic?
A. Only if there is an insurance change and they no longer can be seen there and they see me.
Q. Do you know any of the physicians that are involved in this case?
A. No. Well, during the last part of his hospitalization, he was seen by a rheumatologist, whom I know. This was on the last few days of his life.
Q. Who is that?
A. I believe Dr. Scheetz saw him on a couple occasions.
Q. Other than Dr. Scheetz, do you know any of the other caregivers in this case?
A. No.
Q. Do you know Dr. Preston?
A. No.
Q. He apparently has a specialty in neuromuscular disorders. Did you gather that from his deposition testimony?

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A. I didn't specifically notice that. I saw that he was a neurologist.
Q. Would you agree that polymyositis is treated both by rheumatologists as well as by neurologists?
A. I am sure that it is.
Q. And certainly, neurologists that have a special interest in neuromuscular disorders would be more likely to see patients as a subset of neurologists than a general neurologist; correct?
MR. KILBANE: Objection.
A. I suppose that would be true.
Q. So that while you and Dr. Preston may have a difference of opinion in terms of the likelihood of Mr. Brooks' long-term survival and morbidity, you don't have any reason to believe that Dr. Preston is not qualified to provide opinions as it relates to the issues of morbidity and mortality, are you?
MR. KILBANE: Objection.
A. I don't have any reason to believe that.
Q. You told me you have about six patients that you treat now that have

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polymyositis?
A. Six that I can recall. There may be others that I see less frequently who are managed by other physicians.
Q. Have you ever treated a patient similar to Mr. Brooks?
A. Yes.
Q. How long ago or is that one of the six?
A. No, this was the man some 10 or 15 years ago who died, and he had a feeding tube.
Q. Was this the 48-year-old man?
A. Yes.
Q. How long did he live from the time of diagnosis until the time he died?
A. I don't recall exactly. I think it was probably in the neighborhood of four years, four or five years.
Q. I take it your license has never been suspended or revoked?
A. That's correct.
Q. You have never had privileges denied at any hospital, have you?
A. No.
Q. Beside this gentleman that died, have

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you ever had any other of your patients with polymyositis that had PEG tubes?
A. I can't recall.
Q. Did this gentleman that had the PEG tube develop any type of an intraabdominal hemorrhage following the PEG tube placement?
A. No.
Q. Do you have an opinion in this case as to the etiology of his polymyositis?
A. No.
Q. More often than not, it's idiopathic, is it not?
A. Yes.
Q. There are certain circumstances where you can trace a probable explanation or am I inaccurate?
A. In those cases, it's not called polymyositis. There are certain drugs that will induce a myopathy which looks like polymyositis and certain viruses can induce a myopathy that looks like polymyositis. Those are called viral induced or drug induced, but this is idiopathic, meaning by definition, unknown cause.
Q. He had a diagnosis of rhabdomyolysis when he was admitted to the hospital?

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A. That's correct.
Q. Is that a component of polymyositis?
A. It can be. In patients with severe muscle injury, the muscle can become necrotic and then you get rhabdomyolysis.
Q. Is that most likely what had caused some of the liver enzyme changes?
A. Actually, in this case, the liver enzyme changes were probably muscle enzyme changes.
Q. Secondary to the --
A. Muscle necrosis.
Q. From the polymyositis?
A. Yes.
Q. Is there any association between alcoholism and polymyositis?
A. Not that I'm aware of.
Q. There has been some talk about Mr. Brooks having had a history years ago of drinking.
Is that in any way a factor, as you see it, in terms of his onset of polymyositis or the likely course with regard to his polymyositis?
A. No. that doesn't seem to be a factor.

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Q. So it would be irrelevant; true?
MR. KILBANE: Objection.
A. Yes.
Q. How long would Mr. Brooks likely have been on steroids?
A. Years.
Q. Tapered again?
A. Tapered.
Q. There are studies, are there not, doctor, that patients that have a severe onset with an early diagnosis are tapered off of steroids?
A. There are some patients who seem to go into remission and can go off steroids, yes.
Q. And again, because we did not have the benefit of time in terms of testing Mr. Brooks' response, are you able to rule out his ability to have come off of steroids as he went through his rehabilitation?
A. His probability for doing so would be extremely small.
Q. Why?
A. I have seen a few such individuals with an abrupt presentation who have gone into remission and gone off steroids. They are

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usually younger individuals. In fact, all the ones I have seen have been younger individuals. They usually have a very rapid response in terms of all kinds of features, their strength, their weakness, their muscle enzymes to steroids.
They usually have not had dysphasia, have usually not had truncal weakness. He does not fit any of these characteristics of this small group who has a dramatic rapid improvement. I would say his likelihood of being in this category would be less than one percent, and maybe less than .5 percent.
Q. Can you state to a probability what complications, if any, Mr. Brooks would have experienced, even with a favorable response to rehab, becoming ambulatory, by being maintained on the steroids?
A. The major complications of steroids include infections, which are always a risk. And a number of other complications, avascular necrosis of bone, diabetes, cataracts, osteoporosis, hypertension, aggravation of atherosclerotic disease, those are some of the factors.
Q. When would he have developed those

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complications?
A. Infections are a risk at any time.
Q. But can you tell me, number one, that he would have developed an infection?
A. I cannot say that for certain. I would say that the likelihood is considerable.
Q. At what stage?
A. At some point. One can't define when that would be.
Q. Okay.
A. Most individuals on long-term steroids do eventually get infections of some type, urinary tract infection, respiratory infections, in which steroids are thought to be a contributing factor.
Q. And that would need to be treated accordingly?
A. It would need to be treated.
Q. You can't tell me when he would experience such an infection, if at all?
A. That's true.
Q. Or what would be the nature of the infection?
A. That's correct, as well.
Q. A vascular necrosis, can you tell me

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when he would've developed a vascular necrosis?
A. No.
Q. Or whether he would have developed it at all?
A. No, I can't say that.
Q. And the impact on his underlying coronary artery disease, can you tell me what impact, if at all, that would have had on his underlying coronary artery disease?
A. It would have aggravated it.
Q. Can you tell me how it would have manifested itself?
A. It might have manifested itself in terms of angina, myocardial infarction, congestive heart failure.
Q. When would those things have likely occurred?
A. Usually those occur after several years of therapy.
Q. Are you saying that Mr. Brooks would have after several years of therapy experienced these problems or is it impossible for you to say that he would have experienced those problems?
A. He could have.
Q. That's the best that you can do?

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A. Right.
Q. Fairenough.
Are there any articles that have been published from Metro or from UH that are of recent vintage besides the one we talked about with Dr. Vignos that deal with pharyngeal dysfunction and prognostic factors?
A. Not that I'm aware of.
Q. Will you be able to provide me in the literature or perhaps give me a name of an author that you believe has provided this opinion that correlates severe weakness at the onset of polymyositis with a poor prognosis?
A. I'm sure I can find such references in the literature.
Q. As you sit here now, do you know of any studies that specifically correlate severity in weakness at onset with a poor prognosis?
A. I can't think of one right off the bat, no.
Q. Most patients that are on immunosuppressant therapy and steroids respond well to the therapy; true?
MR. KILBANE: Objection. Go ahead.
A. The question is -- I have a question

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in terms of the use of the word well. Most patients do have a response. It's almost always a partial response. It's almost never a complete response. But it can be anywhere from a good response to a poor response, anywhere within that range.
Q. Are you intending to testify that Mr. Brooks would have had a poor response to the immunosuppressant therapy?
A. No.
Q. If a patient is treated successfully, recognizing, again, that it's a disease that can be treated but can't be cured, is the greatest morbidity the side effects or the potential side effects of the steroids?
A. I think that's probably the case, the side effects of the steroids, the side effects of immunosuppressants, as well, but both of those in combination provide, contribute substantially to the morbidity.
Q. You watched the labs on patients that are on immunosuppressant therapies; true?
A. Right.
Q. You look for anemias?
A. Right.

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Q. You look for any evidence of leukemia?
A. Right.
Q. Not all patients on immunosuppressants develop the malignancies; true?
A. That's correct.
Q. In fact, a very small percentage do?
A. That's correct.
Q. No reason to believe that he would have developed any type of malignancy associated with the immunosuppressant therapy; true?
A. Not associated with the immunosuppressant therapy. It's still approximately a ten percent chance that he could have developed a malignancy related to having the polymyositis over the next two years.
Q. Ninety percent likelihood that he wouldn't?
A. Approximately, yes.
Q. We have talked about your report. I believe we have gone through it in terms of the factors which you have relied upon in terms of indicating the long-term disability and the impact on his life expectancy.
As you look at your report and as you think about what we have talked about, do you

believe that there are any other opinions that you hold in this case that we have not talked about, doctor? I want to give you, in fairness, an opportunity to express those before we conclude.

MR. KILBANE: Objection.

A. I think that my report pretty well sums up exactly the way I think, the way I feel about this case in terms of his prognosis.

Q. And have we pretty much exhausted the specifics of your report as we have been chatting here for the last couple hours?

MR. KILBANE: Objection.

A. Well, as far as I'm aware at the moment, yes.

Q. Have you been asked to look at any additional information or do any additional research between now and trial in two and a half or three weeks?

A. No.

MR. MISHKIND: Thank you for your time.

(Deposition concluded at 10:45 a.m.)

CERTIFICATE

State of Ohio,



SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named STANLEY P. BALLOU, M.D. Was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.

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

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.



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EXAMINATION OF STANLEY P. BALLOU, M.D.