IN THE COURT OF COMMON PLEAS
SUMMIT COUNTY, OHIO

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KAREN L. ARMOUR, etc., PLAINTIFF.	:	
VS.	:	CASE NO. CV 2002-07-4063
PATRICK A. RICH, D.O., ET AL., DEFENDANTS.	:	JUDGE COSGROVE

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Deposition of MARK BIBLER, M.D., a witness herein, taken by the defendants, as upon cross-examination, pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement among counsel as to the time and place and stipulations hereinafter set forth, at the offices Mark Bibler, M.D., at 222 Piedmont Avenue, Suite 6000, Cincinnati, Ohio 45219, on Tuesday, November 25, 2003 at 7:00 p.m., before Terence M. Holmes, a notary public within and for the State of Ohio.

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HAWKINS COURT REPORTING
1160 Innercircle Drive
Cincinnati, Ohio 45240
(513) 851-2313

APPEARANCES:

On Behalf of the Defendant, Dean Rich, D.O.:

Patrick J. Murphy, Esq.
Bonezzi, Switzer, Murphy & Polito Company L.P.A.
1400 Leader Building
526 Superior Avenue
Cleveland, Ohio 44114-1491

On Behalf of the Defendant, Dean Rich, D.O.:

Phillip Kuri, Esq.
Reminger & Reminger Co., L.P.A.
200 Courtyard Square
80 South Summit Street
Akron, Ohio 44308

On Behalf of the Plaintiff: Karen Armour, etc:

Howard Mishkind, Esq.
Becker & Mishkind Co., L.P.A.
Skylight Office Tower
1660 West 2nd Street, Suite 660
Cleveland, Ohio 44113

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C O N T E N T S

E X H I B I T S

MARK BIBLER, M.D.

of lawful age, a witness herein, being first duly sworn, as hereinafter certified, was examined and deposed as follows:

MR. MURPHY: Terry, this is Pat Murphy speaking first and I represent Dr. Dean Rich in this litigation.

DIRECT EXAMINATION

BY MR. MURPHY:

Q. Because we're doing it by phone, Dr. Bibler, I think we have to be extra careful to let me finish my question and for you to finish your answer before we would speak over each other, okay.

A. Yes.

Q. All right. For the record, would you state your full name and your business address?

A. It's Mark Richard Bibler, 222 Piedmont Avenue, Suite 6000, Cincinnati, 45219.

Q. Okay. I do have a copy of your CV, but you are an internist?

A. Yes, I am.

Q. Board certified in that field?

A. Yes.

Q. And practicing internal medicine for how long now?

A. I've been in practice since 1986.

Q. Okay. In addition to clinical practice do you have teaching responsibilities?

A. Yes, I'm full-time faculty at the College of Medicine, University of Cincinnati.

Q. And when you say you're a full-time faculty I would take that to mean you don't have a private practice outside of it?

A. No, I do.

Q. You do?

A. I can explain how that all works.

Q. Just briefly.

A. I get two paychecks. I have a private internal medicine practice, all of my partners or 10 of us are all faculty at the College of Medicine and we all do a varying amount of patient care in the private office and a varying amount of teaching and administrative things. I'm employed by Alliance Primary Care for all the patient care activities. I'm typically in the office seeing private patients eight half days a week, that's from 7:30 to 5:00. I staff the Internal Resident Continuity Clinic two half days a week, so that's the resident clinic, but some months the responsibilities are different. Two months of the year I'm a ward attending in the hospital, and if

you're familiar with how all that works, a ward team is me, a couple of senior residents, a couple of interns, a couple of fourth-year students and a couple of third-year students and collectively we are on call every other night and take admissions through the Emergency Room and so forth. So I'm the attending physician of record for a month for that team and that obviously is a mixture both of teaching and patient care because I'm the one who is responsible for all the patients, so that's two months of the year. I do some didactic stuff. There's a conference called Morning Report that I do one month a year for an hour a day. At least two or three months of the year I'll have a third year medical student in my private office with me, so it's a whole variety of things.

Q. When you talked before about your private office clinical practice?

A. Yes.

Q. I understood you to say you're there eight half days a week?

A. Correct.

Q. So you're dividing the week into 10 halfs I guess?

A. Correct.

Q. All right. I was trying to follow that

through for a moment.

A. Sure I should have said four days, it would have been easier.

Q. That's fine. In your private office practice how many of your internal medicine colleagues from the university are part of your private office practice?

A. Well, the Division of General Medicine is about 45 strong, that's apart of the Department of Internal Medicine, so the department includes all the medical and subspecialties like pulmonary and renal and cardiology and so forth. The Division General Internal Medicine there are about 45, I suppose. Probably half of them are primarily in research, the other half are scattered about town in different practices. In my specific practice there are 10 of us.

Q. Ten of you, okay, you may have mentioned 10 before.

A. That's a call group basically and we share responsibilities, we're geographically in the same place.

Q. In that 10-man practice do you from time to time cover for each other if somebody is on vacation or somebody is tied up at the university for

a whole month on academic responsibility?

A. Yes. It's a very collaborative arrangement because we are all full-time faculty. It's frequent where we're called away from the office to do our teaching responsibilities or administrative responsibilities. For example, this month I'm on the ward service, I'm in the hospital from 7:30 to 1:00 every day.

Q. I'm guessing, although I don't know for a fact that you've had your deposition taken prior to this evening?

A. Yes.

Q. And you've reviewed other medical-legal cases in the past?

A. Yes, I have.

Q. Okay. When did you first start reviewing medical-legal cases?

A. Probably the late 1980s.

Q. And from a frequency standpoint can you give me an estimate as to how many cases you might receive a year to take a look at?

A. This past calendar year has, for some reason or another kind of snow balled, I must have done probably 15 this year, I'm guessing. That's far and away more than I've done in any previous year.

Over the whole 15 year time I would say, I don't know, 40 perhaps.

Q. Okay.

A. It's just a guess.

Q. I understand. Have you reviewed cases previously for Mr. Mishkind?

A. Subsequent to receiving this one he did send me, or actually one of his associates did, sent me another case that I was unable to help with, so just these, just those two.

Q. Okay. Prior to this case involving Jean Speicher had Mr. Mishkind's office either, Mike Becker or Gene Tosi or Larry Peskind ever sent you cases to review?

A. No.

Q. Okay. The cases that you get to look at, Dr. Bibler, are they on both sides of the fence?

A. Yes.

Q. Is there a breakdown you can approximate for me?

A. I would say probably in the order of 75 to 80 percent for the defense.

Q. Okay. Do you know whether or not your name is associated with any sort of expert referral group or agency that helps attorneys find physicians

in different specialties to look at cases?

A. I think, I'm not even remembering when, a year ago perhaps I have done, I may have signed up for one on line, I don't remember the name, I've got gotten any cases to my knowledge from them and that's the only possible such service that I'm aware of. Most of them I think come word of mouth.

Q. Do you have a set fee structure for this type of work?

A. I charge $425 an hour for everything that I do, whether it's reviewing cases, giving depositions, testifying at trial, just a flat-fee structure.

Q. Have you actually testified in a courtroom previously?

A. Yes, I have.

Q. On how many occasions?

A. Four prior occasions.

Q. And from a deposition standpoint, how often have you found yourself in a situation you're at tonight where you're giving a deposition on a case you previously reviewed?

A. Well, I mean every deposition I give is on a case I reviewed.

Q. True, okay, but I guess --

A. You're asking total number of depositions?

Q. Yes, sir.

A. Between 10 and 15.

Q. Now I have a copy of a letter that you addressed to Mr. Mishkind and it's dated May 10, 2003.

A. Is that my statement of opinions?

Q. Yes, sir.

A. Yes.

Q. You have that there tonight?

A. I do.

Q. Okay. What I'd like to ask you and you've set it forth a little bit in the letter, but I'd like to be a little bit more definitive. As to the material you had to review preparatory to preparing that letter and sent in to Mr. Mishkind?

A. Yes. It's pretty much what I said in the first paragraph or second paragraph, first paragraph I guess. I had office notes of Dr. Rich from 1986 onward. I had the what I believe to be full hospital records for the Barberton Citizens Hospital Admission and the Akron General Medical Center Admission including the death certificate, and I had the deposition transcripts of both Drs. Patrick and Dean Rich.

Q. And in your report there you indicated you reviewed their depositions but didn't rely on their depositions for your opinions?

A. Correct. I basically based my opinions on what was in the medical record itself.

Q. Okay. Subsequent to your writing this report have you received additional material to review, for example, reports from any other consultants or experts that have looked at the case?

A. Yes. I'd be happy to list all of that for you.

Q. Could you, please?

A. Sure. First I have the similar brief statements of opinion from Dr. Conomy, C-o-n-o-m-y, Dr. Bacik, B-a-c-i-k, Dr. Ammerman, A-m-m-e-r-m-a-n, Dr. Herwig, H-e-r-w-i-g and Dr. Martin. I also have several deposition transcripts. I've already mentioned the transcripts of both Dr. Dean and Dr. Patrick Rich. Karen Armour, Linda Speicher, John Conomy, Ronald Bacik. I don't seem to have it here, but I also reviewed that of the granddaughter.

Q. Okay.

A. And that's all.

Q. Very good. Did you prepare any notes as you reviewed the material we just talked about?

A. Yes, I did, I have them with me.

Q. Do you have those with you?

A. I do.

Q. Are they handwritten?

A. They are.

Q. Are they legible?

A. To me.

Q. Okay. That --

A. I will tell you that they are really statements of fact and contain no opinions, but.

Q. Okay. Could you give the notes to the court reporter and have him mark them as Exhibit 1 for this deposition?

A. Yes.

Q. Thank you.

(Doctor's Statements of Fact Eight pages, marked for identification, marked as Bibler Deposition Exhibit 1.)

COURT REPORTER: So marked.

A. Let me count the pages for you.

Q. Okay.

A. One, two, three, four, five, six, seven -- Eight pages handwritten on a yellow legal pad.

Q. And they've been marked as Exhibit 1?

A. Correct.

Q. Okay. At the conclusion of the

deposition, I don't know if your Xerox machine is there in the office or not, if you could copy that and give a copy to the court reporter.

A. Can I give the original to the court reporter and have them --

Q. Send it back.

A. -- send them back to me.

Q. Absolutely, we can do it that way, too, if that's easier.

A. Okay. I don't think I can get a Xerox machine tonight.

Q. Okay. Out of curiosity, the answer is probably, no, but do you know any of the other doctors that reviewed this case, the other parties in the case?

A. No, I do not.

Q. With respect to your letter of May 10, 2003, and it was, what, three and a half page letter, was that prepared shortly after you reviewed the material contained in the first paragraph of that letter?

A. I got the medical records and, the medical records of the office notes and the two hospital admissions, reviewed them on March 17th and called, actually Mary Ellen Sandsbury to give her a

preliminary opinion, and then it was two months later when I got or when I reviewed actually the two depositions transcripts and prepared my written report, and to do that I re-reviewed the original clinical records, as well.

Q. Okay. Are you making reference now to some type of an invoice or billing that gives you the time frames?

A. Yes.

Q. Okay. Could we mark that as Exhibit 2?

A. We can, it's the inside leaf of a Manila folder, so, I guess I can do that.

Q. Okay.

A. It's basically just a listing of what I did when, number of hours essentially.

MR. MISHKIND: Pat, if you want to, rather than the court reporter having to take the doctor's entire file, why don't he just, court reporter, mark it as an exhibit and then the doctor can photocopy that and fax me a copy and I'll get it to you and to Phil.

MR. MURPHY: That's fine, that sounds like it would be a little bit easier.

A. I can even read it to you if you

prefer.

Q. Not necessary.

A. Okay. So he's gonna mark and then -- I'm gonna photocopy it and mail it.

MR. MISHKIND: You can just fax it me, Doctor.

A. I don't think I can fax it, it's a Manila --

MR. MISHKIND: I mean after you photocopy it.

A. Okay. Oh, I see, all right. That's fine.

MR. MISHKIND: Okay.

(Inside of Manila Folder, marked as Bibler Deposition Exhibit 2.)

Q. We're presuming that Manila folder is what you have that contain your file so we?

A. Well, it's the letters back and forth, it's the handwritten notes that we talked about, that's all that's in it.

Q. Okay. Did you have a chance to review your report again either tonight or shortly before this evening preparatory for tonight's deposition?

A. I looked it over last night.

Q. Does that report set forth all of the opinions you hold regarding the standard of care

exercised in this case?

A. Yes.

Q. In reviewing it did you see anything that you wanted to change or add or delete?

A. I guess I would comment on Paragraph 4 referring to Dr. Dean Rich's interaction with Mrs. Speicher.

Q. And which page are we on?

A. Oh, gosh, my pages aren't numbered, it's Page 3.

Q. Okay.

A. The number Paragraph 4.

Q. Gotcha.

A. I said there that the presenting complaint when Mrs. Speicher came to see Dr. Dean Rich appeared to be in dispute; that the chief complaint recorded by the medical assistant was short of breath while Dr. Rich noted that the shortness of breath had resolved and she now complained of cough, whereas subsequently the emergency room physician who saw her four days later recorded a history of persistent shortness of breath that had progressed over the entire last week unresolved, and actually I think his notes said that she denied cough. That has been now buttressed by the deposition testimony I read from the

family members who confirmed that in fact Mrs. Speicher remained progressively short of breath from the time she was discharged from Barberton to the time she was admitted to Akron General Hospital, and in fact that was the reason they brought her to see Dr. Rich in follow-up was because her shortness of breath was progressing. So that again makes me think that Dr. Rich missed the reason for the visit and the diagnosis.

Q. Okay.

A. So that's not really a new opinion I don't believe, it just reinforces my preliminary feeling about the visit.

Q. When you look at the whole case historically when is it that you believe Mrs. Speicher started to throw some pulmonary emboli?

A. At the time she started the complaint of shortness of breath, I believe it was a day or two before she came to see Dr. Patrick Rich.

Q. And you're referring to that visit of January 25?

A. Yes.

Q. Okay. Have you had occasion to see people, see patients either in your office or in the hospital who have in deed been having a problem with

some pulmonary emboli for a week or so prior to their seeing you?

A. Yes.

Q. Is there anything that stands out clinically in those people when you see them?

A. I guess I'm not entirely sure what you're asking. Are you talking about complaints or physical exam findings or laboratory findings or are they different than somebody who comes in the same day their symptoms start or?

Q. Okay, no, I'm glad you asked me that, in fact the opposite, I should have, I kind of jumped into the deposition and I typically tell witnesses if you don't understand a question don't be bashful about saying so or it's confusing like that one was, let me know that and we'll break it down. Let me break it down a little bit. Let's take a patient in your own experience that you may have seen who you either know or you learn of the fact after you work 'em up that they had had some pulmonary emboli within the last week, from a respiratory standpoint what is their clinical presentation normally like?

A. Well, the most common complaint that a patient with, presenting with pulmonary embolus has is shortness of breath, and that's really born out in,

you know, many, many studies, that that's the single most common chief complaint a patient has is shortness of breath. Very often they will also have chest pain, and then the rest of it depends on the magnitude of the embolus.

Q. Okay.

A. So you mentioned have I seen people that have come in who have been doing this for a week, sure. If you shower a small pulmonary emboli over the course of a week each individual one doesn't make them sit up and take notice so much, but, you know, eventually because they're persistently having episodes of chest pain or shortness of breath they seek attention.

There are in fact patients who have silent pulmonary emboli who come in with fixed pulmonary hypertension that's probably developed over a number of years, and when you do a pulmonary angiogram you see that they've probably been having pulmonary emboli for years and they, you know, never had a discrete episode of shortness of breath or chest pain, so that's one very end of the spectrum, and then of course the opposite end is somebody who has collapsed in the field and is brought in by life squad with a massive pulmonary embolus, it's everywhere in

between. The problem with pulmonary embolus is you have to have a very high suspicion for it because the findings in many patients are subtle.

Q. When a patient would present with maybe a week-long history of having thrown some pulmonary embolism, obviously not a massive one that's made them unstable because they're able to present to your office, does that impact on their respiratory rate?

A. Sure it can. Patients don't come in with a history of pulmonary embolism.

Q. Understood.

A. They come in with a change in how they feel.

Q. Okay.

A. And, for example, in this case the notes are pretty clear from Dr. Patrick Rich that something was suddenly different. She had a sudden onset of progressive shortness of breath where she couldn't, you know, walk to take the trash out and then she woke up in bed 'cause she couldn't breath and that's clearly different than anything that had gone before, and that's the kind of reason patients come in is because they've had a change in their breathing. You can have a patient who's got chronic shortness of breath for whatever reason and they come in because

they're more shortness of breath. So it's a change in the patient's perception of his or her symptoms that brings them to see the doctor regardless of, you know, whatever disorder you're talking about.

Q. A moment ago, Dr. Bibler, you called to my attention primarily Karen Armour's deposition testimony or at least her deposition testimony about her mom's shortness of breath subsequent to the Barberton admission?

A. Yes.

Q. We discussed that briefly or you pointed that out to me briefly. I guess the question I have to you is whether or not in your opinion do you believe that Mrs. Speicher was short of breath when she presented to Dean Rich on February 1 or not?

A. Well, I know the respiratory rate was 18.

Q. Okay.

A. Normal would be 12 to 14 and that's similar to what her respiratory rate in the hospital was, it was 18 to 20 in Barberton Hospital, so that's really no different. It wasn't actually counted on her visit on the 25th to see Patrick Rich. Second, we have the medical assistant's record of the patient's chief complaint which is short of breath. So those

two things are at least in the office note, and then we have Karen Armour's testimony that in fact her mother was progressively more short of breath from the time she left Barberton Hospital or at least wasn't getting any better and that's the reason they made the appointment to see Dr. Dean Rich, and then there's the testimony of the other daughter stating that her mother really was too short of breath to talk to her on the phone and that was a real change 'cause they used to have daily-long conversations and her mother just wasn't up to it. So I think all four of those lines suggest to me that in fact, yes, she was short of breath and then when she presented to the Emergency Room at Akron General Hospital the history to the Emergency Room Physician was that she never really got better; that she had been short of breath progressively more so and that's what lead her to come to the Emergency Room at Akron General.

Q. Okay. From the standpoint of your opinion regarding Dean Rich does it make a difference in your judgement as to whether when Jean Speicher was actually in his office being examined by him, whether she was or was not short of breath as far as what he should have done or shouldn't have done?

A. Well, of course every doctor gets a

history and relies on the history that he or she gets to guide further evaluation and treatment, so the simple answer to that of course is, yes. My question would be did he miss it? Patients don't walk in with a history on a platter. There's an adage in internal medicine at least that 90 percent of the diagnosis is in the history, and physical exam in labs really are only to confirm a clinical suspicion, and I find that to be generally true, that most of the time I can make a diagnosis without examining the patient or ordering any laboratory studies, not to say that those aren't important, so it's critical how you elicit the history.

I have residents tell me all the time that this patient is a poor historian, and what that means is that the resident or the student wasn't able to elicit the history. The patient is not the poor historian, the person may be a poor gatherer of the history. So the way I would read this is the history is what it was; that Dean Rich did not get the correct history from the patient.

Q. When you look at Dr. Dean Rich's note with Mrs. Speicher advising him of her recent hospitalization of the fact that she was diagnosed with hyperthyroidism and so forth, going through the

whole note it doesn't appear to me and I'll ask you it doesn't appear to me that Jean Speicher was a poor historian, it looked like she was able to relay to the doctor cogently what was going on, would you agree or disagree with that?

A. Well, of course I've never met Mrs. Speicher.

Q. Right.

A. I think she was, seemed to be as far as I can gather a reasonably intelligent and healthy woman. Part of the history really depends on what questions you ask, and of course this is not a recording of questions asked and answered, it's a question of the -- What we have here in the record is the patient's history as interpreted by Dean Rich written down probably in an abridged form. I don't know what the patient may have volunteered. Some patients are more passive, some are more active, some are more insistent, some are more intimidated, so on and so forth, there's the huge number of variables that enter into it. Depends in part on the doctor's manner and, you know, if the doctor conveys that he's in a hurry asks short questions and cuts the patients off, you know, that can be very intimidating, patients may not volunteer much. I have no idea, this of

course is all speculation.

Q. Understood, okay.

A. I wasn't there for the interaction and I don't know either of the parties that were involved. Best I can say is that this is Dean Rich's interpretation of the history as he was able to gather it.

Q. Okay.

A. And again my comment would be as I think he did not gather an appropriate history based on what came before and after.

Q. Okay. Would it seem logical to you, Dr. Bibler, that with a medical assistant writing down a chief complaint of shortness of breath prior to Dr. Dean Bibler (sic) seeing the patient that logically that would be a subject of discussion between the physician and patient?

A. Certainly should have been.

Q. And it's possible, would you can see that it's possible that he inquired of her about the shortness of breath and was told by her that, yes, I was in the hospital recently for that, but it's resolved?

MR. MISHKIND: Objection. This is Howard Mishkind. Go ahead, Doctor.

A. I think it is possible and I think he alluded to that in his deposition, as well.

Q. Okay. And in his office note, too, I mean that's --

A. Yes --

Q. -- basically what he said?

A. -- he said shortness of breath resolved.

Q. Now when we talk about the respiratory rate of 18, although perfectly normal as you said is maybe 12 to 14, 18 is not considered markedly elevated, would you agree with that?

A. It's not markedly so, I mean it's not 40, I agree.

Q. Do you know from your review of the records what Jean Speicher's baseline respiratory rate was?

A. I don't recall seeing a baseline, that's not a vital sign that's ordinarily recorded in most, at least routine instances. I know it was not reported that I could find on the note to Patrick Rich on the 25th. I can look back through, but you can probably save us both time.

Q. Yeah, we can all look, too.

A. I don't think the previous respiratory

rates were recorded.

Q. Okay. And when you say it's not something that's typically recorded are you referring to an office setting where the typical vital signs recorded would be blood pressure and pulse normally?

A. Correct.

Q. And respiratory rate would be recorded if there were some component of a respiratory issue upon presentation?

A. Yeah, and ordinarily even then, at least in my office, I don't think the medical assistant would record it, in fact in this patient it was Dr. Dean Rich who recorded it. Respiratory rates are funny. If you ask anybody to estimate a patient's respiratory rate they're almost always wrong and they almost always underestimate it just by, you know, they're gestalt observation of the patient. It often fools you when you actually sit down and count it, it's very often higher than you suspect.

Q. Okay. If on February 1, 2001 when Dean Rich was covering for his dad while his dad was on vacation and in the office that day, if when Jean Speicher presented to him he inquired of her about the shortness of breath the medical assistant had written down and she talked to him about that and told him

that that problem had been resolved, she wasn't having that problem anymore and was in fact having a recent problem with coughing and he worked her for the cough and came up with an impression of bronchitis and treated her for the bronchitis with, I think it was his Apacs he prescribed?

A. Correct.

Q. If that were the scenario that developed that day would you have a problem with his management of her for that acute cough problem?

MR. MISHKIND: Objection. This is Howard Mishkind, but go ahead, Doctor.

A. Well, that is the scenario as presented in the progress note and as defended in his deposition, and if in fact that's what was going on I think that was appropriate, but when -- What bothers me is that history is incongruent with the previous history of her course up to that visit, her subsequent history after that visit and the history is recorded by other observers including his father, the family and the subsequent Emergency Room Physician.

Q. Okay. Let's see here. Towards the end of your letter, I guess it's Paragraph Number 5.

A. Yes.

Q. Towards the end of Paragraph Number 5

you set forth a statement there anticipating had she not had the massive PE which we know she had looking back at retrospectively, if she hadn't had that you believe she would have had a normal life expectancy with good functional status for about 10 more years?

A. Well, at least 10 more years, I think -- That's life table data.

Q. Okay.

A. If you get to be 77 your average survival is 10 more years, that's all it covers. In a woman like her who really had no significant underlying disease it could well have been longer than that.

Q. Okay. Do you know from looking at the Akron General records that she did have an ischemic stroke there?

A. Yes.

Q. A rather significant one?

A. A large one.

Q. Okay. Did the records reflect or do you have an opinion that Jean Speicher had cerebral vascular atherosclerotic disease that contributed to the stroke?

A. Well, we know that her extracerebral vessels were normal, she had had a corroded Doppler

exam done at Barberton, so she didn't have any extracranial corroded disease. I believe the pathogenesis of her stoke is hypotension; in other words, inadequate perfusion to that hemisphere of her brain in the setting of sustained low blood pressure. I did read Dr. Conomy's deposition and I believe he did postulate some narrowing in the cerebral artery on that side accounting for why it was a larger insult to that hemisphere than to the rest of the brain. I would have to defer to his expertise on that.

Q. As an neurologist?

A. As an neurologist.

Q. Okay. If we assume she did have some atherosclerotic cerebral vascular disease which contributed to the stroke, in your opinion would that disease process itself impact her going forward, again, if she hadn't had this pulmonary embolus, the large one, would this atherosclerotic disease impact either her life expectancy or her future morbidity issues in your judgment?

A. That would depend obviously on the degree, and I was unfamiliar with statistics that Dr. Conomy quoted because that's out of my field, but I believe he quoted a 3 percent risk per year cumulatively in a 77 year old woman. So over a 10

year period his estimate was, cumulatively would be a 30 percent risk of having that same stroke. I believe that's dependent on the degree of stenosis and or atherosclerotic involvement of that artery, and of course we have no way of knowing what that was.

MR. MURPHY: Okay. I think that's all I have, Dr. Bibler, appreciate your time.

DR. BIBLER: Okay.

DIRECT EXAMINATION

BY MR. KURI:

Q. Doctor, this is Phil Kuri, I represent Dr. Patrick Rich.

A. Yes, sir.

Q. Again, if you don't understand any of my questions or you need me to repeat them especially because we're over the phone, please let me know and I'll be happy to do so, okay.

A. Yes, sir.

Q. All right. Let me just pick up from where Pat was discussing the life expectancy of Mrs. Speicher. When you responded to his original question regarding life expectancy you stated that the average survival rate for a 77 year old with no ongoing disease process would have been about 10 years, correct?

MR. MISHKIND: Objection. I think you've misstated his testimony, but go ahead.

A. Yes. To get to be 77 in the first place implies reasonably good health simply because those who aren't as healthy have already died, so you're already eliminating a lot of people with heart disease and other complications of diabetes and so on and so forth, so surviving to age 77 in and of itself is predictive of many more years of good survival. In her particular case she didn't have any known underlying cardiac problems, pulmonary problems, diabetes, any of the, no known cancer, any of the things that, you know, on the face of it would directly decrease her survival.

Q. Okay. Doctor, when you wrote your report you probably weren't aware that she had some type of sclerotic cerebral vascular disease, correct?

A. Correct.

Q. So let's apply that to her life expectancy now that you know that, what would her life expectancy be now knowing that she had sclerotic cerebral or vascular disease, at least relayed by Dr. Conomy?

A. Well, again, this is beyond my field of

expertise, so I'm not sure I can give you a number, but taking Dr. Conomy's figures she would have had a 30 percent chance of having a stroke in 10 years, so she would have had a 70 percent chance of not having a strike in 10 years.

Q. All right.

A. Now how you apply that to what her life expectancy would have been, I'm not quite sure how to do that statistically.

Q. Well you said -- You gave it 10 years in your report, correct?

A. At least 10 years is what I said.

Q. And what I'm asking you to do is, and if you can't do it, fine, I mean now I'm asking you to throw in the stenotic cerebral vascular disease, did that change your opinion that it still at least 10 years of life expectancy?

A. Well, I think what I could say I guess based on Dr. Conomy's opinion and again it's beyond my field of expertise, I would say that she has a 70 percent chance of living 10 years.

Q. All right. I'm going to jump around a little bit.

A. Okay.

Q. I'm the second person here, so. Do you

follow patients as a matter of course in your practice?

A. Oh, yes.

Q. So you would actually see the same patient every time they come into your practice?

A. Most of the time, yes, I have a traditional private practice.

Q. Okay. I was just trying to understand. It seems like, kind of you, the way your set up is everybody has so many different things going on that maybe there's just whoever is there that day sees the patient that comes in, but that's apparently not how that works?

A. No, we all follow our own patients. If a patient were to call the same day with an urgent problem and one of us is not there then another one of us would see the patient in an urgent care situation, but other than that we all follow our own patients.

Q. Do you treat or follow people who have suffered a stroke?

A. If a patient is admitted to the hospital with a stroke, most of the time, in fact I would say virtually all the time a neurologist is going to be involved in the care.

Q. All right.

A. If a patient comes to the emergency room and gets admitted to the hospital they're probably more likely to be admitted under the neurologist. If I admit the patient from my office it's more likely that I would probably admit the patient to medicine and have a neurologist consult, but probably in all cases a neurologist would be involved in the care.

Q. What would be a fair statement that you don't treat, follow or follow patients with a stroke at all unless you see them originally when they come in?

A. I would confine that to a pretty narrow time period. Certainly once, you know, for the week the patient is in the hospital I'm certainly following them and helping manage medical issues, but once a patient is discharged from the hospital certainly I continue to follow them and probably see them more frequently than the neurologist does.

Q. Well, I guess my question was poorly worded then. You certainly bring in a neurologist for the expertise regarding the stroke and the care and treatment in relation to the stroke is usually run by a neurologist or a neurosurgeon, correct?

A. Absolutely.

Q. Okay. Having that being said how do you feel that you are qualified to render opinions regarding how a stroke occurred?

A. Well, this is a scenario that we see not infrequently. A patient has some medical illness that drops the blood pressure and as a consequence of that there's a decrease perfusion to multiple different organs as was in this particular case, so for example she had ischemic hepatitis and she had acute tubular necrosis and she had gastrointestinal bleeding, all of which I think are probably from low tissue perfusion to those specific organs, and the same thing happens to the brain. So whether a patient comes into the hospital with a drop in blood pressure from sepses or a myocardial infarction or a pulmonary embolus or a gastrointestinal bleeding or whatever the case we frequently see patients who suffer a stroke in the context of systemic hypotension from some medical problem.

Q. Doctor, in those cases don't the patients usually suffer a global type of insult to the brain?

A. Some time, yes, some times it vocal, I've seen both.

Q. In this case what is your opinion is it

global or vocal from your review of the records?

A. Well, I believe she had both. She certainly had a massive hemispheric stroke and that's vocal. There was some evidence that she had some more global insult termed anoxic encephalopathy originally. It's difficult to evaluate that very well because patients need to be cooperative for an exam, and this lady was on the ventilator and had also had all these other medical problems and had had the hemispheric stroke, as well. So the hemispheric stroke is easy because you can see it on the scan and you can appreciate that the patient is not moving one side of the body, so that's pretty easy, but the more defuse anoxic encephalopathy can be more difficult to evaluate without a patient's cooperation.

Q. You read Dr. Conomy's deposition testimony, correct?

A. I did.

Q. And do you take issue with him at all that in order for this stroke to have occurred there must have been a stenotic cerebral vascular process going on with Mrs. Speicher?

A. I would not argue that point with him, no.

Q. Okay. Did you find any evidence of a

stenotic cerebral vascular disease present in Linda Speicher in the records?

A. Well, only by reasoning retrospectively from the massive insult that she developed as to what, you know, reasoning backwards from taking the insult and then reasoning back as to what might have been the path of physiological mechanism by which it occurred.

Q. Absent your reasoning, did you actually find any evidence of that stenotic cerebral vascular process?

A. No, there was no -- The only way you would have done that would be through an imaging procedure, she could have had an MRA magnetic residents angiogram, she could have had a formal angiogram, none of those were done.

Q. Did you read Dr. Ammerman's report?

A. His report, yes, I don't believe he's had a deposition yet.

Q. He has not, you read his report, correct?

A. Correct.

Q. Do you disagree with his report?

A. Yes.

Q. And what specifically do you disagree with?

A. Just let me pull it out.

Q. It's pretty --

A. It's terse. Okay.

Q. Let me ask the question differently --

A. Sure.

Q. -- I'll withdraw that question. I'll just read to you the last sentence which, one of the last sentences which states "The patient subsequently saccum to her master CVA secondary to the middle cerebral artery thrombosis and not pulmonary embolism or the affects thereof," agree or disagree?

A. That's the statement with which I disagree.

Q. All right. Is your disagreement based upon the fact that that would simply be a medical impossibility with this patient?

MR. MISHKIND: Objection to form, but go ahead, Doctor.

A. It's a complex sentence, so when he says that the patient saccum to her stroke and not the pulmonary embolism I absolutely disagree with that and that's not an issue I think of possibility or impossibility, it's just simply a question of what happened.

Now the other part of this I think you

may be alluding to is whether she had middle cerebral artery thrombosis of if it was a hypotensive ischemic insult and I think that's, is that what you're asking me?

Q. That's essentially what we're gonna to get to so.

A. All right.

Q. And just so I can ask you specific question in that regard. Is the fact of a middle cerebral artery thrombosis just an impossibility with this patient?

MR. MISHKIND: Objection to the form, but go ahead, Doctor.

A. I don't think it's an impossibility, and to some extent I would defer to the experts on that who obviously disagree. I'd want to know what he means by "thrombosis." If he's taking about an insitu clotting of the blood in that blood vessel, that's a pretty rare event. My understanding and again this is out of my field of expertise, but my understanding is in a low-flow state blood can clot, so it can still tie all this together if the situation as we know it was a period of time it sustained low blood pressure, then allowing low flow through that artery thereby allowing the blood the clot insitu there, that's

thrombosis. I presume he means that as opposed to thromboembolism a blood clot arising from someplace else and getting stuck in the artery.

Q. Why do you assume that?

A. Well, because he says thrombosis and not embolism.

Q. Okay. Very good.

A. That thrombosis to me implies insitu blood clotting as opposed to embolization which is a clot forming someplace else breaking off, traveling and getting stuck.

Q. All right. Doctor, now knowing that Dr. Conomy's opinion is that of stenotic cerebral vascular process must have been going on, do you still feel that you're qualified to render an opinion as to what exactly was the cause of the stroke?

A. Well, I think what precipitated the stroke was the period of sustained hypotension, I think that's, that's what lead to the stroke. Now whether mechanistically that was because she had a pre-existing narrowing of the blood vessel or whether she as a result of the hypotension clotted the blood vessel I would certainly defer and let the neurology experts argue that.

Q. Okay. You just hold on one second

here, I'm looking through my notes.

MR. KURI: Pat, do you have anything else while I'm looking here?

MR. MURPHY: Just a couple quick ones, Doctor, and I'll stay on the phone as long as I have. I thought of a couple more questions, so I'll ask 'em.

REDIRECT EXAMINATION

BY MR. MURPHY:

Q. Can you identify for me the names of any other attorneys in the Cleveland area that you consulted with on medical-legal cases?

A. Eric Kennedy.

Q. Okay. Anybody else come to mind or not?

A. Not off the top of my head.

Q. Very good. In the Cincinnati area have you ever worked with or consulted with a Jim Triona or a David Lockemeyer?

A. No.

Q. If on February 1, 2001 Dr. Dean Rich found that Jean Speicher was short of breath and had had ongoing shortness of breath since her discharge from Barberton.

A. Yes.

Q. Then in your opinion you under those circumstances what would appropriate standard of care for a reasonable family doctor dictate that he do?

A. Well, most important thing would be that he realize she has a problem that's not been resolved and things that cause progressive shortness of breath are potentially bad things. So the first thing would be to recognize that we have an ongoing problem here and we've got to figure out what it is. Now there are any number of things he could have done to investigate that further, the simplest would have been to get some records from the hospital.

Q. Okay.

A. A discharge summary, for example, by calling the hospital, the report of the echocardiogram or he could have readmitted her. She essentially had the same symptoms for which his father admitted her, he could have readmitted her to the hospital.

One thing that bothers me and one thing he states in his deposition was that if the patient can present the history there's no reason to review any additional records, and in fact you never want to evaluate any patient in isolation, you always want to evaluate a patient in context. One of the defense experts said that when you're in a cross-coverage

situation you're often faced with the problem of evaluating the patient without complete information and you have to do the best you can or not agree with that, but what bothers me in this case is Dean Rich didn't even take advantage of what information he had, he just simply had to look on the preceding page to see the history as presented. That's as classic a history for pulmonary embolism as you will get. History of leg swelling followed by sudden onset of progressive shortness of breath, that's as classic a history for pulmonary embolism as you'll get. Had he simply read his father's note from the previous visit that in and of itself should have greatly raised his suspicion for a diagnosis of PE. Not that it was inappropriate to consider a heart failure and rule that out, but once that's been done and he got that history it's glaring. So even if he says he didn't have available to him the information from the hospital, he still got the history from a week or several days previously from his father's note that he didn't look at and his deposition says he didn't need to look at because the patient could give a history. So we have to take advantage of the information we do have. In this case had he gotten that history the appropriate thing to do obviously would have been to

pursue a cause for her shortness of breath because it's not better, and the thing that jumps out glaringly is pulmonary embolus and he could have done any number of things, he could have readmitted her, he could have gotten an outpatient ventilation perfusion scan, he could have gotten an outpatient leg scan, he could have gotten and inner-outpatient CT pulmonary angiogram, any of those would have been appropriate, and any of those I think on the first would have been positive for the diagnosis.

Q. Okay. As you were responding to my question, you indicated that the congestive heart failure had been ruled out, and was that based on chest x-ray and echo or I'm just trying --

A. Well, in the hospital records by both, but I think Dr. Rich, Dean Rich was asked specifically in his deposition if he knew that that had been ruled out and he said, "yes." I don't know how he knew that.

Q. Okay.

A. But somehow he knew, at least it says that in his deposition that he knew that that had been ruled out.

MR. MURPHY: Okay. That is all I have then.

MR. KURI: Just a couple other follow-ups, Doctor.

CONTINUED DIRECT EXAMINATION

BY MR. KURI:

Q. I'd like to just explore real quickly. You stated that she had a 30 percent chance of having a stroke and a 70 percent chance of not having a stroke I think is how you put it, correct?

A. I'm simply quoting Dr. Conomy.

Q. Put that in some context for me, based on what, I mean 30 percent in relation to other people or that's what she had a 30 percent chance dying from that as opposed to something else, what, can you kind of explain to me what you mean by that?

A. Well, again the context was that by life table she has an average life expectancy of 10 years.

Q. Right.

A. Then you said, okay. Now assume that she has stenosis of the left internal cerebral artery, how would that have affected her survival, and I was just quoting Dr. Conomy's statement that she has cumulative 3 percent per year risk of having a stroke, so 3 percent per year over 10 years is a 30 percent risk of having a stroke. Now she may not die from

that stroke, but over that 10 year period between the age 77 and age 87 there's a 30 percent chance she could have a stroke in the distribution of the left internal corroded artery.

Q. Okay.

A. There's a 70 percent chance that she won't, just by the statistical epidemiologic data that Dr. Conomy was quoting, that's all I was referring to.

Q. Okay. Does that 3 percent cumulative per year based upon your knowledge does that increase or decrease with respect to the severity of the stenotic process?

A. Well, I think what's going to determine motality is the extent of the stroke which may not necessarily be depended on the degree of the stenotic area, and it's going to depend on the location of it and all sorts of different things.

Q. Well just talk about, forget about the extent of the stroke --

A. Okay.

Q. -- just, let's talk about the stroke.

A. The thing patients fear the most is that they have a stroke and don't die. If you poll patients they'd rather have a heart attack than a stroke 'cause they have the big heart attack they die

and that's it, they have the big stroke and they're paralyzed on one side of their body and they live another five years.

Q. Okay.

A. So strokes aren't necessarily fetal events they're very morbid events and very debilitating certain affect the quality of life.

Q. I understand what you're saying. I guess I'm not sure that --

A. I can't answer your question I don't think.

Q. Okay. Let me restate it again and you tell me if you can or can't answer it and that will be fine, but does the extent of the sclerotic disease increase or decrease that 3 percent cumulative per year statistic that Dr. Conomy referred to if you know?

A. Logically I would say yes. If you're starting with a very low grade stenosis it's going to take longer to develop into the significance to stenosis, on the other hand if you're starting with a high-grade stenosis then it's going to take less time. Some times interestingly enough if a stenosis develops gradually you can go on to completely occlude an artery and there is collateral circulation that has a

chance to develop and you may not get a stroke at all, so it's a little difficult to predict.

Q. The process, you're talking about the same thing with the heart and the heart attack and vessels?

A. Correct.

Q. Okay.

A. There is excellent collateral flow in the brain, what really is a problem is if there is a sudden event as opposed to a gradual event.

MR. KURI: Okay. I don't believe I have anymore questions for you at this time. Thank you.

MR. MURPHY: Nor do I, Dr. Bibler. Appreciate your time. Mr. Holmes --

COURT REPORTER: Holmes, yes, sir.

MR. MURPHY: Hi, this is Pat Murphy speaking again. At this point I'm not going to order the deposition be written up, I may as this case develops down the line.

COURT REPORTER: All right.

MR. MURPHY: And, Howard, whatever you want to do vis-a-vis signature is certainly fine with me.

MR. KURI: I am going to go ahead and

order it.

MR. MURPHY: Oh, you are, okay.

COURT REPORTER: Who is this speaking?

MR. KURI: Bill Kuri.

COURT REPORTER: Okay. Yes, sir.

MR. KURI: Do you have the information you need from me?

COURT REPORTER: Yes. I think we got a notice sent today, faxed to us today, so we have that.

MR. KURI: Okay.

COURT REPORTER: Thank you.

MR. MURPHY: Thank's for covering the deposition, Mr. Holmes, tonight.

COURT REPORTER: No problem.

MR. MURPHY: And thank's for making yourself available tonight, Doctor, by phone.

DR. BIBLER: You're welcome, and I would like to read and sign.

MR. MISHKIND: This is Howard Mishkind, and Mr. Court Reporter I will take a copy of the deposition. We could also reflect that the doctor rather than having seven days, since we're off on the trial if we can agree

28 days for the doctor to read the depo, I don't think it's gonna to take him that long.

MR. MURPHY: Whatever it takes is fine.

MR. MISHKIND: And I will take a copy and also if you send e-transcripts?

COURT REPORTER: Yes, sir.

MR. MISHKIND: My e-mail is hmishkind@BeckerMishkind.com.

MR. KURI: Okay.

MR. MISHKIND: All right. Very good.

MR. KURI: Thank's everybody.

MR. MISHKIND: All right. Thank you, Doctor, I will talk with you soon.

DR. BIBLER: Very good. Thank you everybody.

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Mark Bibler

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(At 8:10 p.m., the deposition was concluded)

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C E R T I F I C A T E

STATE OF OHIO :
: SS
COUNTY OF HAMILTON:

I, Terence M. Holmes, the undersigned, a duly qualified and commissioned notary public within and for the State of Ohio, do hereby certify that before the giving of his aforesaid deposition, the said MARK BIBLER, M.D. was by me first duly sworn to depose the truth, the whole truth, and nothing but the truth, that the foregoing is the deposition given at said time and place by said MARK BIBLER, M.D.; that said deposition was taken in all respects pursuant to agreement and stipulations of counsel hereinbefore set forth; that said deposition was taken by me in stenotype and transcribed into typewriting by me; that the transcribed deposition was submitted to the witness for his examination and signature; that I am neither a relative of nor attorney for any of the parties to this cause, nor relative of nor employee or any of their counsel, and have no interest whatever in the result of this action.

IN WITNESS WHEREOF, I hereunto set my hand and official seal of office at Cincinnati, Ohio this 2nd day of January, 2004.

My commission expires:
July 28, 2007

Terence M. Holmes
Terence M. Holmes
State of Ohio