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IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

TRAVIS CATES, et al.,

Plaintiffs,

-vs-

JUDGE J. McMANAMON
CASE NO. 167835

CLEVELAND METROPOLITAN
GENERAL HOSPITAL, et al.,

Defendants.

- - - -

Deposition of RICHARD BLINKHQRN, JR., M.D., taken as if upon cross-examination before Aneta I. Fine, a Registered Professional Reporter and Notary Public within and €or the State of Ohio, at the MetroHealth System, 3395 Scranton Road, Cleveland, Ohio, at 10:00 a.m. on Thursday, ,January 4, 1990, pursuant Lo notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

- - - -

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On behalf of the Defendant,
Mary-Blair Matejczyk, M.D.;

ALSO PRESENT:
Donna LeCair

- - - -

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

CROSS-EXAMINATION OF

RICHARD BLINKHORN, JR., M.D.

BY MR. KAMPINSKI:

Q. Would you state your full name, please?

A. Richard John Blinkhorn, Jr.

Q. Spell it.

A. B L I N K H O R N.

Q. I'm sorry, H?

A. O R N.

Q. Jr.?

A. Yes.

Q. Where do you live?

A. 2844 Woodhaven Drive, Medina, 44256.

Q. I'm going to ask you a number of questions this morning. If you don't understand any of them, please tell me, I will be happy to rephrase any question *you* don't understand. When you respond to my questions please do so verbally. She's going to take down everything that's said, she

can't take down a nod of your head, okay?

A. *Yes.*

Q. How old are you?

A. *33.*

Q. You are a physician?

A. Yes.

Q. And if you would, sun me through your educational background starting with college?

A. I went to Davidson College.

Q. Where is that at?

A. It's in Davidson, North Carolina.

Q. When did you go there?

A. 1974 through 1978.

Q. All right. And what degree did you receive'?

A. BS in chemistry.

Q. Okay. What did you do after that?

A. I went to medical school.

Q. Where at?

A. Bowman-Gray, Winston.

Q. Spell it.

A. Bowman, B O W M A N - Gray. That's in Winston-Salem, North Carolina.

Q. Okay. And how long did you go to school there?

A. I was there from 1978 to 1982.

Q. When did you graduate from high school, by the

way?

A. '74.

Q. All right. So you went straight from high school, went to college, to medical school?

A. Right.

Q. Okay. Did you receive your M.D. degree then from Bowman-Gray?

A. Yes.

Q. What did you do after that?

A. I started my internship.

Q. Where at?

A. Cleveland Metro.

Q. When did you start there?

A. 1982.

Q. All right. Directly from medical school to Cleveland Metro?

A. (Indicating).

Q. And your internship lasted how long?

A. One year. '82 to '83.

Q. Okay. Did you specialize in anything in that year?

A. In that year?

Q. Yes.

A. Internal medicine.

Q. Okay. What did you do after that?

A. I did two years of residency to complete the residency program.

Q. Here?

A. I did a year of --

Q. Here at Cleveland Metro?

A. Yes.

Q. Have you been here since '82?

A. Yes.

Q. Go ahead. Two years of residency?

A. Then I was the chief resident of medicine. Then I did two years of infectious disease fellowship and then I joined the staff.

Q. And wnen was that?

A. July of 1988.

Q. Okay. And your position now would be what, just a staff --

A. Staff physician.

Q. And are you an employee of Cleveland Metro'?

A. Yes.

Q. And I take it you were during the time you saw Mr. Cates?

A. Yes.

Q. When were you Boarded?

A. It was during my chief resident year so that's the '85, '86 academic year.
Q. Qkay. Was that the first time you were eligible? Did you pass it?
A. Yes.
Q. Do you intend or have you taken the infectious disease Boards?
A. Not as yet.
Q. When do you become eligible or are you eligible?
A. Well, I'm eligible as soon as my fellowship is completed. I'm eligible now.
Q. Okay.
A. It's only given every two years.
Q. Okay. Are you saying you did not have an opportunity to take it prior to this time?
A. Right.
Q. Okay. You finished your residency in '86.
A. I finished my residency in '85 and then I was the chief resident from '85 to '86.
Q. Okay. And you say you are eligible one year after your residency is completed?
A. I took my internal medicine Boards my chief resident year.
Q. Okay.
A. Which was given every year.

Q. All right.
A. And then I completed my infectious disease fellowship the year I came on staff, July of '88.
Q. Qkay. So the first opportunity you would have to take the internal, I'm sorry, infectious disease Boards would be in 1990?
A. There may have been a test administered soon after I finished my fellowship but I didn't sit for that.
Q. Okay. All right. What is infectious disease, Doctor? What does %he specialty of infectious disease deal with?
A. It deals with the pathology of infections and how they relate to the body.
Q. Now, do you have private patients that you see here or are you called in on consults for other physicians or how does that -- or is it both?
A. I do both.
MR. ZELLERS: Chuck, are we talking about now or back in 19 -- early '88?
Q. Well, if there is a difference tell me what the difference is.
A. Before I came on staff I had no private patients, I did consultation work.

Q. Okay.

A. And then when I joined the staff in July of '88 I then had private patients of my own.

Q. Okay. But you still do consultation?

A. Correct.

Q. Okay. What is your relationship to the other infectious disease physician in this case, Dr. Bender?

MR. ZELLERS: Bender.

Q. Were you both --

A. At the time of this case she was the first year infectious disease fellow and I was the second year fellow.

Q. When you say at the time of this case, are you talking now about late '87?

A. Right. '87, '88.

Q. She was the first year infectious disease fellow?

A. Yes.

Q. You have two infectious disease at that time?

A. Two.

Q. Just yourself and her?

A. (Indicating).

Q. You have to answer verbally.

A. Yes. I'm sorry.

Q. How is it that one of you would see any given patient? Would it be whoever was on call at the time or would you be assigned in a rotational order or how did that work?

A. In that year the way it worked was the first year fellow was on the inpatient consultation service from July through November.

Q. Explain that to me.

A. And the second year --

Q. I --

A. The second year fellow then took over the consultation service from December through

do from July to November?

A. Rest. Research work.

first year fellow was on consult from what months?

A. July through the end of November.

would have only started being a fellow in July?

A. Correct.

Q. All right. Who trains the fellows?

A. The attendings.
Q. When you say the attending are you talking about an attending infectious disease specialist or if it's an orthopedic patient an attending ortho?
A. The infectious disease attending staff is responsible for the instruction of their fellows.
Q. Okay. There's then an infectious disease attending staff here at Metro?
A. lies.
Q. And you are a part of that staff now?
A. Yes.
Q. All right. Or how many were there on that staff in '87?
A. Six.
Q. Qkay. And these are all physicians who trained yourself and the other fellow?
A. Correct.
Q. A11 right. Would there be any set program for any individual one of these staff physicians to train you at any month or during any phase of your training? How did that work?
A. The attending infectious disease staff rotate on and off the inpatient consultation service on a monthly basis throughout the year.

Q. Okay. So each of them had two months?
A. Not necessarily.
Q. Depending on -- well, if there is six of them there's 12 months?
A. If they're divided up evenly then they'd all have two months but they're not.
Q. Explain that to me.
A. For example, some of the physicians are more research-oriented. Therefore they would only do one month.
Q. Okay.
A. And other physicians are more clinically-oriented, they would do more than one month.
Q. Would there be some type of schedule reflecting which of the staff physicians was the quote, "attending," end quote, in any particular month for consultation?
A. Yes.
Q. Do you know who was the attending in November of '87?
A. It's Dr. Tomford.
Q. Tomford?
A. T O M F O R D.
Q. Okay. And who was it in December?
A. Dr. Spagnuolo, S P A G N U O L O.

Q. I'm sorry, S P A G?
A. N U O L O.
Q. Okay. And who was it in January?
A. Dr. Wolinsky, W O L I N S K Y.
Q. Okay. Why is it you remember these?
A. Because they always had fixed rotations. It was easy to remember.
Q. Okay. I mean did you check before the deposition today who the attendings were in those months?
A. No. That's just the way the rotation was.
Q. Well, who would it have been in February then? Now we're talking about '88.
A. Well, now that would have been a hard month to remember because one of the younger staff members would have possibly picked up that month and I'd have to look that one up. But for the summer months through January it was a fixed rotation.
Q. Well, who would have been in October for example?
A. Wolinsky.
Q. Okay. So the three of them would have covered those six months?
A. Right.

Q. Explain to me how it is a patient who comes under the care of an infectious disease physician here at Metro is managed in terms of the day-to-day management by the fellow as opposed to the attending or the interrelationship of the two. How does that work or how did it work in '87?

A. The fellow carries a beeper. All the consultations come in for staff patients and some private patients through the beeper. The fellow then goes and evaluates the patient.

Q. Okay.

A. Every day the attending sits down with the fellow and the other members of the consult team which includes medical residents and medical students, and reviews all the new consults of the day. In addition, all the consults that have been done for that month are also reviewed. Following that review, we then get up and go round in the hospital and see the patients.

Q. Together?

A. Together.

Q. Okay. And when a new month came along you would do that or would that be done with the new

attending then?
A. Correct.
Q. Would that be only for new consults or would it be for patients who had continuing consultation?
A. That included both new and the patients that were still being followed by the service.
Q. All right. For example, if somebody was in for two, three weeks, how often would the attending be involved with that person?
A. The attending hears about that case every day.
Q. From the fellow?
A. From the fellow or the resident that's following the case.
Q. Okay.
A. The attending may not see the patient every day depending on the circumstances.
Q. Okay. Does the attending when he sees the patient dictate any patient notes, doctor's orders, anything of that nature?
MR. ZELLERS: If you know,
Q. Well, typically?
A. Generally no.
Q. Why not?
A. Because the documentation on the medical record is handled by the fellow.

Q. But what you're telling me is that it is typically reviewed with the fellow, by the fellow with the attending?
A. Correct.

read a note that's written by a fellow in assuming that he has reviewed that treatment plan or what he's put in that note with the attending before he puts it down?
A. Generally, yes.
MR. ZELLERS: Chuck, all your questions are relating to infectious disease?
MR. KAMPINSKI: Yes. That's correct.
Q. Okay. Did you go througn the charts before coming here this morning to determine what your involvement was?
A. I have reviewed them in somewhat of a cursory fashion to refresh my memory about the case.
Q. Well, did you have an independent recollection about Mr. Cates before reviewing them?
A. Yes.
Q. When did you first become involved in the care of Mr. Cates?
A. The first recollection that I have of

involvement is during the January admission.

Q. Well, when you say the first recollection, does that mean that you may have been involved before but you just don't recall?

A. That's correct.

Q. What were you doing -- well, were you doing research from July to January?

A. No. I was on the inpatient service in December.

Q. What is that?

A. The inpatient consult service, infectious disease.

it down by day, one of you. There were different points in December.

MR. KAMPINSKI: Okay. Maybe I just don't understand.

Q. I thought before you told me that the first year fellow, and that is Dr. Bender, was the fellow that would have been involved in the consultations up through December?

A. End of November.
Q. Oh, end of November. Okay. So that you then took over for her in December?
A. Correct.
Q. When in December?
A. December 1st.
MR. KAMPINSKI: All right. Well, what were you talking about, Mike?
MR. ZELLERS: I don't think that's right. I think that you saw -- I mean my understanding is that Dr. Bender finished out the patient on the 1st and the 2nd and that you would have picked up after that but you're the witness.
THE WITNESS: Well, he didn't ask me what happened to Mr. Cates in December, he asked me if I had any contact with Mr. Cates before January and I said I didn't recall any.
Q. Oh, all right. You took over the service December 1st?
A. Correct.
Q. But you didn't get involved in his care?
A. No.
Q. Did you ever receive any phone calls regarding him in December?

A. I don't remember any.

Q. If you would have and if *you* would have given any medical advice would that have been noted in

MR. ZELLERS: By him?

MR. KAMPINSKI: That's correct, by him.

A. Probably not.

Q. Why not?

A. Because it was an over-the-phone consultation and In those circumstances I generally wouldn't have written a note.

Q. Do you recall any over-the-phone consultation?

A. I don't recall any.

Q. You are aware of the note that was written by Dr. Matejczyk?

A. Yes.

Q. Do you have any recollection of her calling you regarding Mr. Cates on December 30?

A. I don't remember.

Q. Are you aware of the content of that note?

A. I have seen the note.

MR. ZELLERS: Is that in the chart?

MR. KAMPINSKI: Yes.

MR. ZELLERS: I don't think we could find it in the chart. We had it marked at the deposition and I ended up with the original.

MR. KAMPINSKI: Okay. Where did you get the original?

MR. ZELLERS: From Dr. Matejczyk's outpatient chart, I think we got this at the deposition of Dr. Matejczyk and we marked it at that time.

MR. SEIBEL: Yes.

MR. KAMPINSKI: But you never came up with the chart copy, Though.

MR. ZELLERS: My recollection is no, we didn't find this copy in the chart.

MR. KWMPINSKI: Yes. This is hers, this is not the one that would be in the chart.

MR. ZELLERS: What we're looking at as Defendant's Exhibit 2, 10-3-89 came from Dr. Matejczyk's office chart.

MR. KAMPINSKI: Yes. But I'm saying the original that would have been in the hospital chart has never been found. Is that correct?

MR. ZELLERS: I believe that

there's a copy in the hospital chart without the notation.

MR. SEIBEL: I believe that's true.

Q. Why don't you turn to the hospital record then if you would, the copy that's in the hospital record.

MR. ZELLERS: And I don't know -- go ahead and 3ee if you can find it, Doctor. I have gat a Xerox copy of it. A Xerox copy of It's marked as Defendant's Exhibit 1 on 10-3-89.

MR. KAMPINSKI: Okay. And this was marked as 1 in her depo, wasn't it?

MR. ZELLERS: Yes. These are two of the exhibits from her deposition.

MR. KAMPINSKI: Yes. Okay.

Q. Doctor, the two exhibits we're looking at, 1 and 2, actually 1 is a copy of what was marked, is a copy of what was in the hospital chart, okay. You can look if you want but I think we can all agree that that's correct, right?

MR. ZELLERS: Yes.

Q. Do you know how these sheets are generated, Doctor, these laboratory sheets?

A. No.
Q. All right. These are done typically, though, at a physician's request. In other words, samples are taken, sent to the lab, the lab reports them back, right?
A. Correct.
Q. And you rely on these as a physician, do you not?
A. Yes.
Q. That's why you send them to the lab, right?
A. Right.
Q. Okay. Do you know how they get back into the chart?
A. No.
Q. On the hospital copy, Doctor, there's no writing, is there?
MR. ZELLERS: Well --
A. There's writing but you mean there's no writing by Dr. Matejczyk?
Q. That's exactly what I mean.
A. That's correct.
Q. Now, if we look at Exhibit 2, apparently she's written something reflecting an alleged conversation that she had with somebody, although she doesn't identify who it is. First

of all, why don't you read the note so we're all on the same page.

A. The note says 12-30-87: Do you want me to try and interpret the abbreviations?

Q. Sure.

A. It says, no therapy antibiotics per infectious disease if wound fine. Path report: Rheumatoid nodule, parentheses, exclamation point, close parentheses, wound check excellent, 12-30.

MR. ZELLERS: Just so the record is clear, we're looking at Defendant's Exhibit 2 which Dr. Blinkhorn -- and Defendant's Exhibit 1, both of which were marked on October 3 of '89.

Q. Mow Doctor, would you have given this kind of medical opinion over the phone without seeing the patient, sir?

MR. ZELLERS: Objection. Go ahead.

A. I can't say without recalling whether I was called on this case or not.

Q. I understand that and my question really is a general one, not necessarily relating to this particular note, but generally would you give this kind of medical advice over the phone?

MR. ZELLERS: Objection.

A. What kind of medical advice?

Q. That the patient was not to receive antibiotics if, quote, "wound fine," whatever that means?

MR. ZELLERS: Objection.

A. It would depend on the wound ana the history and the clinical situation of the patient so I can't answer your question in a general sense at all without more specifics.

Q. Well, are you suggesting that *you* would have to see the patient or see the patient's chart?

MR. ZELLERS: Objection.

A. I'm suggesting that I would need more information besides what you have asked me.

Q. All right. Would you have requested more information then from the physician who called *you* with such a request for a consult?

MR. ZELLERS: Objection.

A. Over the phone?

Q. Yes.

A. Generally I would.

Q. All. right. But you have no recollection of receiving this phone call at all?

A. I have no recollection of receiving this.

Q. Is this appropriate advice for a patient who has

been previously admitted for staphylococcal aureus, methicillin resistant?

MR. ZELLERS: Objection.

A. I can't understand that without more specifics.

Q. Well, you saw Mr. Cates when, January?

A. Yes, sir.

Q. Of '88?

A. Yes, sir.

Q. What did you see him for?

A. He was admitted at that time with staphylococcal endocarditis.

Q. Pretty bad, isn't it?

A. Yes, sir, it is.

Q. And when did you first see him?

A. I saw him on January 3, 1988, 7:00.

Q. That's four days after this alleged consult, phone consult, right?

A. Yes, sir.

Q. How did the wound look?

A. At which time?

Q. When you saw him?

A. The time that I saw him the record indicates that the wound was not particularly inflamed.

Q. So that just looking at the wound wouldn't necessarily tell you whether or not there's a

raging infection inside?

MR. ZELLERS: Objection.

Q. Would it?

MR. ZELLERS: What date are you --

MR. KAMPINSKI: January 3 I thought he said.

Q. Right?

A. Right. That's what you're referring to?

Q. Yes.

A. And the question is?

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. Inside?

Q. The knee.

A. Inside what, sir?

Q. The knee. Prosthesis'?

A. Well, the wound would not tell you whether or not there is an infection or not.

Q. Referring then back to this December 30 written note by Dr. Matejczyk, do you know what she means when she says if wound fine?

MR. ZELLERS: Objection.

A. I have no way of knowing what she means by that

without asking her.

Q. Well, she claims that this was told to her by the ID, that is, the infectious disease person, which presumably was you, since you are the one that was on call, right?

what would you Rave meant?

A. I don't know that I said this so -- I can't interpret what she means by this.

Q. Doctor, I'm not quarreling with you. I'm not saying that you said it, she says you said it, okay?

A. As far as I can tell from here she doesn't say who says it.

Q. Was there another ID that she would have spoken to on December 30?

A. It's possible.

Q. Were you on duty December 30?

A. Yes, sir, I was.

Q Rho else was on duty then?

A. To the best of my recollection I would have been the only fellow on.

Q. All right. If you were the only fellow on then can we reasonably assume that if she spoke to an

infectious disease person that would have been you?

A. No.

Q. Why not?

A. Because she could have just as easily called Dr. Bender.

Q. Where was Dr. Bender on December 30?

a. To be honest with you, I don't know.

Q. Well, when you went on duty in December and she went off, what did her duties become?

A. She would have done research but she would have been based here at the hospital.

a. So she would have been available at least in theory?

A. Yes.

Q. To be called?

A. Yes.

Q. And it wouldn't be ridiculous for her to have been called since she was the one that had been seeing the patient back in November?

A. That's correct.

Q. Do you believe you were the one that was called December 30?

MR. ZELLERS: Objection.

A. I don't recall.

Q. I heard you the first, second and third time you said that. I asked you if you believe that you were the one that was called?

A. I don't recall.

Q. That's not what I'm asking you, Doctor. I'm asking you if you believe you are the one that was called?

A. I can't answer that because I don't remember. I can't give you a truthful answer, sir.

Q. Is this appropriate advice to give over the phone, Doctor, for an infectious disease fellow or staff physician or anyone who is consulting without seeing the patient?

MR. ZELLERS: Objection.

A. Depends on the circumstances,

Q. Well, on the circumstances that existed with respect to Mr. Cates. And to be fair to you, I assume when he came in in January you reviewed his past record?

A. That's correct.

Q. All right. So you know what the circumstances were regarding Mr. Cates' past history?

A. I knew in January.

Q. All right. You wouldn't have known that when you got a call December 30 because you hadn't

reviewed his case?

A. I don't recall whether 1 got a call.

MR. ZELLERS: Okay.

Q. Listen, I'm not trying to play games with you but I'm faced with a situation where there's another physician who says she called an infectious disease doctor who is not listed here, okay? That's either you or Br. Bender, presumably, all right?

I understand your answers that you don't recall and I'm trying to see if, in fact, it was you, even if you don't: recall if it was you, if this was appropriate advice that you gave. Do you understand what I'm saying?

MR. ZELLERS: Or that was given by someone.

MR. KAMPINSKI: I'm saying if it was him. I'm not saying it was him. I accept what he's saying that he doesn't recall. Let's deal with the advice that was given regardless of who it was.

A. I can't say whether this is appropriate advice if I don't know what the conversation was that transpired between Dr. Matejczyk and the infectious disease individual she spoke with.

Based on what her note says here, I can't answer that question.

Q. What does the report itself tell you about the test that was done on Mr. Cates?

A. All this report tells me is that a swab grew

a

physician whether or not to provide treatment to

A. Absolutely not.

Q. What else would you need to know?

A. You'd need to know the clinical information.

Q. And clinical information such as what?

A. Such as the patient's history, such as the circumstances surrounding why this swab was obtained, and specifically what the, quote, "wound" as printed on here looked like.

Q. Well, I thought you told me a minute ago that that's not necessarily determinative either, that is, how the wound looks?

A. You asked me before whether the wound could tell me whether there was an infection inside the knee. That's not what you just asked me.
Q. Okay. I'm not sure I understand the distinction you are making.
A. Then I don't understand your question.
Q. Okay. Let's work on it so we both understand what we're saying.
A. Okay.
Q. You just said you need to know the clinical information why the swab was obtained, the history and what the wound looked like?
A. Correct.
Q. Okay. Why is that different than the question you responded to earlier when you said that the wound, I think you said looked or didn't look ominous, something to that effect?
A. Didn't look particularly inflamed.
Q. All right. And that that didn't tell you necessarily what was going on inside of the wound?
A. No. I said inside what and you said inside the knee. It tells me that the wound didn't look infected.
Q. Okay. All right. The distinction you are

making then is the surface wound as opposed to what is underneath it. Is that correct?

A. The distinction I'm making is if I'm determining if the wound is infected I look at the wound. If I'm determining whether the knee beneath it is infected, the wound itself is not enough.

Q. Okay. All right. Let's deal with January 3 for a moment. Was the wound infected when you saw it?

A. The wound did not appear to be infected.

Q. All right. What was --

A. He had staph aureus in his bloodstream and in his cerebral spinal fluid.

Q. What was the primary site of it? Did you ever determine that?

A. I don't know.

Q. Were there cultures taken from the prosthesis, from inside the knee joint?

A. There were two samples taken, one each from each knee.

Q. And what did you find?

A. Both aspirates from the knee joints, that being right and left, grew staph aureus.

Q. And in your review of the prior hospitalizations he did have a staph aureus infection, did he

not, in the November 13 hospitalization?
A. Yes, sir, he did.
Q. And the fellow, that is, Dr. Bender at that time indicated that he had developed a septic prosthetic sight knee?
MR. ZELLERS: Objection.
A. I don't believe that's what she indicated.
MR. ZELLERS: Chuck, do you have a question or --?
MR. KANPINSKI: No.
Q. November 14 in the progress notes.
A. Yes, sir.
Q. There is an infectious disease consult. Do you see that?
A. Yes, sir.
Q. And is that -- whose signature is that?
A. That's Dr. Bender.
Q. All right. Under -- on the second page of that is that assess?
A. Yes, sir.
Q. And then underneath that what does that say, suspect?
A. It says probable.
Q. No. There's two.
A. Suggest.

Q. Assess and suggest, and under assess number one says what?
A. Probable septic prosthetic right knee with superficial furuncle over right patella.
Q. Okay. So when I said that she determined that there was probable septic prosthetic right knee I didn't make that up, 1 mean it's in the chart?
MR. ZELLERS: Objection.
A. She didn't determine that that's what it was. She was concerned and said this is probably. That was not her final diagnosis.
Q. What was her final diagnosis?
A. The final diagnosis was that there was a subcutaneous Infection with staph aureus.
Q. Where is that set forth?
A. It says on the discharge face sheet, admitting diagnosis was infected total knee arthroplasty, discharge diagnosis was superficial wound infection.
Q. Can I see that, please? You didn't read everything that's set forth there, did you, Doctor? Why don't we start with admitting diagnosis?
A. I read that.
Q. And then principal discharge diagnosis?

A. Superficial wound infection.
Q. Well, it's got something else there, doesn't it?
A. There's another diagnosis that was lined out as being incorrect.
Q. Who wrote that?
A. That's written by the medical records reviewers. They come through and they write diagnoses in the chart based on their understanding of the chart record. The attending physician prior to signing the chart then reviews these and if there is any inaccuracies those are corrected by the attending physician. She indicates here that by lining through this statement that that's an incorrect final discharge diagnosis.
Q. When did she line through that, Doctor?
A. I have no way of knowing.
Q. So that's not Dr. Bender putting that down, that's the physician, that's Dr. Matejczyk putting that down?
MR. ZELLERS: Objection. If you know.
A. I don't know who put this down but I do know based on the subsequent events in January that Dr. Bender's impression of this case at that

time from personal communications was that this was a superficial infection, subcutaneous infection.

Q. Run that by me. Slow down.

A. When I became involved with his case in January, and discussed it at that time with Dr. Bender who had cared for him in November, her impression at that time was that this was a subcutaneous infection with staph aureus and that this was not a prosthetic knee infection.

Q. Once again, do you know if that's her writing there?

A. Whose writing?

Q. Dr. Bender's.

A. Where?

MR. ZELLERS: Where it says superficial wound breakdown?

MR. KAMPINSKI: Yes.

A. I don't have any way of knowing whose writing that is to be honest with you.

Q. Well, is Dr. Bender's signature on that page anywhere?

A. No.

Q. Is the treatment for a superficial -- what did you call it?

A. She calls it a superficial wound breakdown.
Q. Different than an infected total knee each of which grew staph aureus, methicillin resistant?
MR. ZELLERS: Objection.
Q. Is the treatment different, Doctor, or do you treat the organism?
A. The duration of treatment would be different.
Q. And how would it be different?
A. A prosthetic knee infection would generally not be treated with antibiotics alone.
Q. Well, let's deal with the superficial. You are looking now at the discharge summary?
A. Yes.
Q. You wanted to see what was set forth there?
A. Yes.
Q. And what was set forth?
A. Specifically --
Q. As it relates to whether or not it was infected total knee or whether it was superficial?
A. This does not have a final discharge diagnosis on it.
Q. At all?
A. No, sir.
Q. Does it have any diagnosis?
A. It has an admitting diagnosis which is only

provisional.

Q. Let me see this a second. And that's infected right total knee arthroplasty?

A. Correct.

Q. And this indicated that it's draining purulent

MR. ZELLERS: Objection.

Q. What does that mean?

A. That means liquid that has the appearance of pus.

Q. Is that significant to you as an infectious disease doctor?

MR. ZELLERS: Objection.

A. With regard to?

Q. With regard to whether it's an infected right total knee or whether it's superficial?

A, I can't tell based on that whether the prosthetic knee is infected.

Q. Getting back to my earlier question, Doctor, how do you treat staph aureus that is methicillin resistant?

MR. ZELLERS: Objection, You gave him two superficial or --

MR. KAMPINSKI: I asked if it mattered.

A. It matters in terms of where the infection is how you treat it.
Q. And I'm talking now from an infectious disease standpoint as opposed to the orthopedic standpoint.
A. I am not sure there's a difference.
Q. Well, the difference would be, I guess, from an orthopedic standpoint you might consider removing the knee, right, the prosthesis?
A. If it's infected.
Q. Okay. Well, I suppose that's also from an infectious disease standpoint?
A. Correct.
Q. Because obviously a foreign body is a place where these organisms can grow, right?
MR. ZELLERS: Objection.
A. That's correct.
Q.
that, right, so that you would deal with that as an infectious disease physician? In other words, you might make recommendations to the

A. Assum

Q. Yes. I understand.
A. Then the standard of care would be to give antibiotics and to remove it with rare exception.
Q. Okay. If it's not infected it can become infected, can't it?
A. That's correct.
Q. And getting back to I guess the second part of my question, how would you treat staph aureus that's methicillin resistant if it was just superficial?
A. I might not treat it if it was just superficial.
Q. Well, would you continue --
A. I might use a topical antibiotic.
You would want to make sure you got rid of it, wouldn't you?
I would make sure that I got rid of the infection.
Q. That's what I meant.
A. I may not get rid of the organism. An organism can colonize a site without causing infection, so therefore I wouldn't necessarily treat just a culture result that shows staph aureus.
Q. Is staph aureus that's methicillin resistant particularly difficult to treat?

A. It's difficult in the sense that there are limited antibiotics which we can use. Specifically Vancomycin.
Q. Qkay. And is Vancomycin effective in treating it?
A. Yes.
Q. Did you, in fact, treat it with Vancomycin in the January admission?
A. Yes.
Q. For how long?
MR. ZELLERS: Objection.
A. He was treated the entire month of January and I need to have %he next line to know when it was discontinued.
MR. ZELLERS: Do you need him to look that up?
MR. KAMPINSKI: I'd like to know that. Do we have that?
MR. ZELLERS: We have got the volumes here.
A. We need Volume 6. It was continued through February 11.
Q. Need the next volume?
A. I'm sorry?
Q. Need the next volume?

A. Vancomycin was discontinued on February 19.
Q. Did you continue any other antibiotics after that?
A. Me specifically?
Q. Or anybody on the infectious disease unit or anybody caring for Mr. Cates?
A. It appears that whoever was caring for him at that time put him on Ciprofloxacin.
Q. And what is that as it relates --
A. That is a relatively new oral antibiotic which has activity against methicillin resistant staph.
Q. And how long was *he* continued -- well, let me make it easy, on any kind of antibiotic for this infection as a result of that admission in January?
A. I don't know that.
Q. Well, wouldn't the record tell you?
A. It might.
Q. Didn't you continue with his care?
A. No.
Q. Who took it over?
A. Well, he went from the medical service to the Highland View Hospital Rehab Service. They assumed his care.

Q. So that's when you ceased seeing him for this problem?
A. As I recall. Do you know the answer to this question?
Q. No, I do not, Contrary to what you heard about lawyers we don't always know questions we ask, especially in discovery depositions.
MR. ZELLERS: That's it.
A And he appears to be on antibiotics, either Vancomycin or Ciprofloxacin in October of '88.
Q. And that was commenced in January of '88?
A. Correct.
Q. Is that because of the organism itself?
a. It's because the patient refused to have his prosthetic knee removed. Therefore we had no hopes of ever eradicating this infection from the joint since it had seeded there after his endocarditis.
Q. Okay. Did it seed there before the endocarditis?
A. There's no evidence for that.
Q. Where did it come from?
A. I don't know.
Q. Could it have come from the prosthetic device?
MR. ZELLERS: Objection.

A. It's possible.

Q. Well, in terms of probability, isn't it probable that that's where it came from, Doctor?

MR. ZELLERS: Objection.

A. No.

Q. Where is it probable that it came from?

A. I don't know.

Q. Isn't it more probable that an infection that first presents itself on November 13 -- by the way, it was the same strain that occurred?

A. We don't know that.

Q. There was no comparisons on it? Wasn't it the same strain, Doctor?

A. They have the same sensitivity pattern. That doesn't mean it's the same strain.

Q. Well, it probably Is, isn't it?

A. I can't say that. To determine that it's the same strain requires special types of testing that are only done in research labs for epidemiologic purposes.

Q. Let's assume it was for the sake of argument.

A. I can't assume it's the same strain.

Q. Well, I'm asking you to assume it for the sake of answering the following questions. Is it therefore more likely than not that it seeded in

the knee in the prosthetic device sometime during the hospitalization or sometime between the hospitalization commencing in November of 1987 and the hospitalization which commenced on January 3 of '88?

MR. ZELLERS: Objection.

A. We know it seeded there because when he came in in January the culture from this aspirate grew. When it seeded there I don't know.

Q. Well, all right. So we know it seeded there sometime before then?

A. Correct.

Q. All right. What was he in the hospital for on December 22, '87?

MR. ZELLERS: Objection.

A. Are you referring to the outpatient visit?

Q. Is that what it was, outpatient?

A. My recollection of that is only from looking at the records very briefly before.

Q. Were you consulted at all?

A. I don't recall.

Q. Why don't you look at, I guess it's the operative note for December 22. You got that?

A. Is this what you're referring to?

MR. KAMPINSKI: I assume you handed

him the right thing.

MR. ZELLERS: I handed him the outpatient records for December 1987.

MR. KAMPINSKI: All right.

MR. ZELLERS: I want you to show him what you want him to look at so you can look at the same things.

Q. (Indicating).

A. All right.

Q. What we're looking at is an OR intraoperative note, it's under ASU progress notes, ASU being Ambulatory Surgical Unit?

A. I think so.

Q. Okay. And that's for surgery done and then the patient can leave the hospital, right?

A. Yes.

Q. Okay. Is there an admission physical or anything that goes with that or do you know?

A. I don't know what their operating practices are.

Q. Well, let's see what you have there to make sure it's -- what was done during that procedure, Doctor?

MR. ZELLERS: Objection. Only because all he is going to do is read from the notes. He wasn't there, he wasn't involved.

A. The note says --
Q. You are now referring to the operative report?
A. I'm sorry, operative note. The dictated operative note under procedure says a three inch ellipse was made removing scar tissue.
Q. Well, the reason -- they closed an open wound, right?
A. It said there was an incision made around the one centimeter open wound after cultures were taken. Approximately a three inch ellipse was made removing scar tissue.
Q. And a three inch ellipse means what?
A. My understanding of that type of incision is that it's an incision used to excise a previous wound.
Q. I don't understand what you're saying.
A. An ellipse is a geometric figure that has this configuration. I can't -- I can show you with my finger but I don't believe she can copy that. An ellipse simply means a type of incision that you make around a previous linear wound in order to remove it in toto.
Q. Why would you do that?
MR. ZELLERS: Objection.
A. I wouldn't do it personally not being a surgeon,

and the circumstances why Dr. Matejczyk did that were not communicated to me. All I have is the record that is in front of us.

Q. All right. And you weren't called in to do anything on that occasion?

A. Not that I recall.

Q. All right. And you would have been on the ID service at that tine, right?

A. That's correct.

Q. She did take a culture, did she not?

A. It says here that there was -- there were cultures taken.

Q. A11 right. And that corresponds with Exhibit 1 and 2 that you have in front of you?

A, Yes, sir.

Q. The wound was closed, was it not, Doctor?

MR. ZELLERS: On December 22?

MR. KAMPINSKI: Yes.

A. Yes.

Q. And is that appropriate if you have an infection to close a wound over it?

MR. ZELLERS: Objection.

Q. Just in general?

MR. SEIBEL: Objection.

A. Depends on the type of infection whether to

close the wound over it.

Q. How about staph aureus, methicillin resistant?

A. Doesn't matter what the organism is, has to do with where the infection is and the type of wound.

Q. How about this type of wound, an infection in the knee?

A. This type of wound was not described as being infected.

Q. I didn't ask you to assume that the description is accurate, I just asked you if, in fact, it's appropriate to close a wound with an infection?

MR. ZELLERS: Objection.

A. And I answered that question that it would depend on the type of wound whether it was acceptable.

Q. Okay. And you're modifying type of wound by --

A. Site, mechanism of injury, appearance, et cetera.

Q. All right. Let me ask you something different, Doctor. If a wound such as Mr. Cates had on his right knee was draining pus, was swollen, did look infected, would it be appropriate not to treat it?

MR. ZELLERS: Objection.

MR. SEIBEL: Objection.

A. I couldn't answer that without being there and seeing it myself.

Q. Well, if you were given that description?

A. If I was given that description.

Q. Pes, sir.

A. That the wound was infected.

Q. Well, I mean would you conclude from the description that I gave you that it was infected, and that is, that it was draining pus that it was swollen?

A. I wouldn't conclude that unless you told me that the wound was infected. Your description could just as well be a superficial infection that wouldn't require antibiotics.

Q. All right. And that would be true even if I told you that this person had previously been discharged less than a month earlier with a staph aureus infection resistant to methicillin?

A. Well, we're dealing with hypotheticals here.

Q. Well, maybe we are and maybe we aren't but why don't you assume what I'm saying is right?

MR. ZELLERS: Do you understand the question?

A. I'm getting lost because of all the ifs and --

do you want her to read it or do you want --

Q. Let me restate it. Is it appropriate to not treat a wound such as Mr. Cates had if --

A. I never saw Mr. Cates' wound so I can't say such as Mr. Cates had.

Q. You saw it in January?

A. I didn't see it in December when the surgical incision was made.

Q. I didn't say you did.

A. But you asked me.

MR. ZELLERS: Let him finish his question and then you either can answer or you can't.

Q. Is it appropriate to not treat a wound if, in fact, that wound is in the right knee and is on a patient who had been discharged within a month with staph aureus resistant to methicillin when that wound was swollen and had pus coming out of it?

MR. ZELLERS: Objection.

MR. SEIBEL: You mean the right knee?

MR. KAMPINSKI: Isn't that what I said?

MR. SEIBEL: Yes.

MR. KAMPINSKI: I think that's what I mean.

MR. SEIBEL: Okay.

A. E can't comment on that.

Q. Why not?

A. Because you said when it was swollen, had pus coming out of it. I have no indication that khat's the case,

Q. I'm asking you to assume that.

MR. ZELLERS: We're not looking at the records now. He is asking you a hypothetical question.

A. If the wound was superficial it may, in fact, be appropriate not to give anything other than topical therapy.

Q. Okay.

A. And a superficial wound can be red and have pus coming out of it and not indicate a deeper infection.

Q. There's no question he had a deep infection when he came in in January, January 3rd?

A. He had endocarditis.

Q. That's the infection getting around the heart?

A. That's a high grade bloodstream infection involving a heart valve.

Q. But it seeded in the knee, in the prosthesis?
A. It seeded in both knees.
Q. No question he had it on January 3rd then, correct?
A. Correct.
Q. In your opinion would he have had it December 30?
MR. ZELLERS: Objection.
A. I have no way of knowing whether he had it December 30.
Q. When did it occur, January 2nd?
MR. ZELLERS: Objection.
A. When did what occur?
Q. The infection?
A. In his bloodstream?
Q. Yes.
A. I have no way of knowing when it occurred.
Q. How long does it take to get into the bloodstream from a prosthetic device? Do you know?
A. I can't answer that question. I can't answer that question. I'm not sure anyone can.
Q. Do you have any opinion as to how long it had been there prior to January 3rd?
A. In his bloodstream?

Q. In his body?
A. He is colonized with staph aureus all the time.
Q. Yes.
A. As far as in his body. If you mean how long it was in his blood, I don't know how long it was in his blood.
Q. How long was it in his knee prosthesis in your opinion?
A. I have no way of knowing.
Q. You don't have an opinion as to that?
A. No.
Q. The culture that was done on the 22nd --
A. Yes, sir.
Q. -- the report itself up here says ORTH 05:12 12-30. Do you see that?
A. Yes, sir.
Q. Does that mean that's the date it reached the chart or do you know what that means?
A. I don't know what it means.
Q. The tests themselves that were reflected on this exhibit that is Exhibit 2 were done on the 22nd when he was in the hospital for this procedure that we were discussing earlier?
A. Yes, sir.
Q. This outpatient procedure. There was no culture

done, was there, inside the knee but rather just a swab was done. Am I correct in that?

A. According to the records, that's correct.

Q. All right. So the only thing we can tell is what was on the surface by the swab?

A. Correct.

Q. All right. So that doesn't tell us one way or another what was underneath the surface, does it?

A. No.

Q. So we can only guess based upon the results that came back from this swab test, right?

MR. ZELLERS: Objection.

A. No.

Q. We can't guess?

A. No.

Q. We can't tell anything?

A. That's correct.

Q. You can tell some things though, can't you?

A. All I can tell is that that swab grew staph aureus.

Q. What does that tell you?

A. Nothing.

Q. Then why take the swab?

A. Because if there is an infection it tells me

what to treat.

Q. Well, how do you tell if there is an infection if you get staph aureus that is the same staph aureus --

A. I don't know that it's the same staph aureus.

Q. But you don't know that it's not?

A. Correct.

Q. I mean you get a lab result that says you have staph aureus resistant to methicillin which is the same exact thing you got earlier, right, in Wovember?

A. I'd have to look back. I will take your word for it.

Q. And you as a physician, I mean you look for the obvious, you don't ignore the obvious, do you?

A. This isn't the obvious.

Q. It's not obvious?

a. No.

Q. Moderate growth staph aureus, right? Did I read that right?

A. Yes, sir.

Q. Does it say penicillin resistant?

A. Yes, sir.

Q. Oxacillin resistant?

A. Yes.

Q. Cefazolin resistant?
A. Yes, sir.
Q. Erythromycin resistant?
A. Yes, sir.
Q. Is that a good staph?
A. You can't tell the qualities of a staph based on its resistance pattern.
Q. It tells you how tough it is to treat, doesn't it?
A. It tells you that.
Q. Why don't you take a look back and see if this is the same sensitivity pattern, the resistance pattern as we had in November.
A. No, it isn't.
Q. It's different?
A. Yes, sir.
Q. How is it different?
MR. ZELLERS: What page are you looking at?
A. I'm looking at specimen dated November 13, right knee drainage, specimen received swab. Specimen Number 1152.
Q. What page of the chart, I'm sorry?
A. The pages, they're not numbered.
Q. Okay.

A. And then the next page says culture grows heavy growth staph aureus.

Q. Give me a moment.

MR. ZELLERS: Let him find where you are at. This is it right here.

MR. KAMPINSKI: No, it's not.

a. 1152.

MR. ZELLERS: He's numbered his pages.

Q. Yes. If you look at --

A. Then you see that his nose is actually --

Q. Just for one second, Doctor. This is a different page, I mean physically a different page than what you have shown me here.

A. Correct.

Q. Why is that?

A. I don't know.

MR. ZELLERS: This looks like a summary adding 11-16. Does this Rave 11-16?

THE WITNESS: Well, the date here is 11-13.

Q. I see exactly what you're saying to me and what I'm saying so you can understand what I'm talking about is this physically is a different page.

A. Correct, Many times with multiple culture results the result will be repeated on several lab sheets.

MR. ZELLERS: Yours looks like a cumulative one with 11-16 added to it.

MR. KAMPINSKI: There should be another one I have. Just hold on to that and let me see if I can find that one.

Q. Okay. I'm sorry. Go ahead, Doctor.

A. The organism that came from around the knee during the November admission had a different sensitivity pattern than the organism that grew out at the December operative visit.

Q. Well --

A. But the nose indicating his staph carrier status was the same organism as we found in that operative visit.

Q. Well, where's the one that came out of his knee?

MR. ZELLERS: On what day?

MR. KAMPINSKI: Well, I asked him the previous admission so let him tell me what day.

Q. You never pointed out the nose.

A. We never got staph from the knee itself on the November admission. The wound, the superficial

wound Specimen Number 1152, dated November 13 is a swab and showed staph aureus.

Q. 1152?

A. Yes, sir. That's these numbers here.

Q. Okay.

A. That's the page. That's the same page.

Q. Okay. So that's right here?

A. That's it.

Q. Okay. And how does that relate to the --

A. That species is resistant to Clindamycin whereas the one on 12-22 is sensitive to Clindamycin.

Q. Is that different?

A. That has a different sensitivity pattern.

Q. Well, when it says resistant and sensitive could that be the same?

A. No.

Q. Just being read differently?

A. No.

Q. What is the difference between the two?

A. One is sensitive to Clindamycin based on the disk sensitivity pattern that we use and one is not.

Q. Was there still evidence of growth of staph when he was discharged from the knee?

MR. SEIBEL: What day of

discharge?

MR. KAMPINSKI: In November. Well, December actually.

A. 1 don't know.

Q. Why don't you take a look.

A. I wouldn't be able -- you mean did it look like there was still infection there or was there a swab that showed it was still there?

Q. Was there a swab that showed it was still there. Obviously you didn't see him so --

A. No, sir.

Q. I understand.

A. Let's see. He was discharged December 2. There's a swab in here from the 17th but I don't see the result.

Q. Of November?

A. Of November. Sorry, November 17 of the knee area but I don't see the result. At least I haven't found the result yet. This says 11-17, right knee area Specimen Number 13561.

MR. KAMPINSKI: Which volume was that?

MR. SEIBEL: I don't know which volume of the original chart it was.

MR. ZELLERS: Let's see if we can

find it.

It's got 11-21 at the top.

MR. SEIBEL: It's in the microbiology section.

A. Here it is.

Q. Okay. Go ahead.

A. It says no growth in three days.

Q. All right. That was November 17?

A. Yes, sir.

Q. Were there any done after that?

A. I can't find any record that there was.

Q. And he was in, I'm sorry, for another two weeks after that?

A. He was admitted on November 13. He was discharged on December 2.

Q. So that there were no additional swabs or aspirates done to determine if there was growth prior to his discharge after November 17, is that correct, at least from the record?

A. Correct.

Q. Well, how do we know if he had any growth in the knee joint or even superficially after November 17 --

MR. ZELLERS: Objection.

Q. -- prior to his discharge or don't we?

A. There's no record of any further specimens after November 17.
Q. Well, how can you stop antibiotics if you don't know if there is any growth?
A. Because the culture result will not guide your duration of therapy for a superficial wound infection.
Q. And in your opinion, two weeks of I.V. antibiotics in this case was appropriate?
A. I can't comment on that because I never saw this man's wound.
Q. Okay. So you don't have any opinion one way or the other on whether the therapy, the antibiotic therapy that he was provided in November, in the November admission was appropriate or not. Would that be fair?
A. Yes.
Q. Okay. If it was not superficial it would not have been appropriate, would it?
MR. ZELLERS: Objection.
A. You'd have to be more specific. If it were not superficial what then? You said if it were not superficial it would not be appropriate, what --
Q. The treatment would not have been appropriate, that is, stopping the antibiotic therapy. Would

it, Doctor?

A. It depends on what else it might have been, whether that wauld be appropriate or not.

Q. What else it might have been. Well, if it was staph aureus resistant to methicillin, then the treatment would not have been, then it would not have been appropriate to stop the treatment?

MR. ZELLERS: Objection.

A. I can't agree with that without knowing specifically what it is we're treating.

Q. Now you have got me totally confused. Presumably we're treating staph aureus resistant to methicillin?

A. I don't treat staph aureus resistant to methicillin. We treat patients who have infections with this organism. Depending on the infection would determine the appropriateness of your therapy.

MR. ZELLERS: Do you mean the site?

A. The site and the nature of the infection.

Q. How about in the knee, Doctor, if there was staph aureus resistant to methicillin in the knee, then the cessation of the antibiotic on November 27 would not have? been appropriate for Mr. Cates, would it?

MR. ZELLERS: Objection.

A. Assuming that there is a staph aureus infection in the knee then 14 days of antibiotics would not be considered appropriate.

Q. Okay. If it were superficial would it be appropriate?

A. I'd have to see the wound.

Q. Okay. It still might not be appropriate depending on how it looked?

A. I can't comment on whether it would be appropriate or not without seeing the wound.

Q. Okay. And you don't know why he was back on the 22nd, do you, other than what is set forth in that --

A. Other than what is set forth in the record, no, sir.

Q. Or the 30th when presumably an ID was called?

A. That's correct.

Q. Could an oral antibiotic have been used for this staph aureus that was methicillin resistant --

A. When?

Q. -- effectively? Well, generally to get rid of the organism?

A. You can use oral antibiotics *for* this organism to eradicate infections with this organism.

Q. You can?
A. Yes.
Q. Would it be effective if it was seeded in the knee?
A. In eradicating the infection?
Q. Yes, sir.
A. No.
Q. Could you control it that way?
A. Depends what you mean by control it.
Q. I am not sure what I mean. I mean --
A. It would not be considered acceptable medical practice to treat a prosthetic knee infection with an oral antibiotic without removing the prosthesis,

MR. KAMPINSKI: Okay. That's all I have, Doctor.

MR. SEIBEL: No questions.

MR. ZELLERS: We will not waive signature.

RICHARD BLIHKHORN, JR., M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named RICHARD BLINKHORN, JR., M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

_____

Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 27, 1991

LAWYER'S NOTES

PAGE	LINE	