

County of Lorain.)

Abstract	Keywords	Progress
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IN THE COURT OF COMMON PLEAS

Model	Results	Significance
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Sandra Johnson,)
Administratrix, et al.,)

Plaintiffs)

vs.) Case No. 98 CV 122198

Akbar Naeem, M.D.,)

et al.,)

Defendants.)

Scenario	Scenario	Scenario
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DEPOSITION OF RICHARD J. BLINKHORN, JR., M.D.

Friday, June 23, 2000

Abstract

The deposition of RICHARD J. BLINKHORN, JR., M.D., the witness herein, called on behalf of the plaintiffs for examination under the Ohio Rules of Civil Procedure, taken before me, Kristin A. Beutler, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at MetroGeneral Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, commencing at 2:00 p.m., on the day and date above set forth.

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1 RICHARD J. BLINKHORN, JR., M.D.

2 the witness herein, called by counsel on behalf of the
3 plaintiffs for examination under the Rules, having
4 been first duly sworn, as hereinafter certified, was
5 deposed and said as follows:

6 EXAMINATION

7 BY MR. DEMSEY:

8 Q. I'm Richard Demsey, I represent the estate of Mose
9 Johnson.

10 I'm going to ask you some questions about your
11 background and about your work in this particular case. If
12 you don't understand any question that I ask you, you'll ask
13 me to repeat it or rephrase it, fair enough?

14 A. True.

15 Q. Excellent. Same goes for, should Mr. Spisak or Ms.
16 Petrello ask you a question, same ground rules, give your
17 answers out loud. Nods of the head, gestures, don't fly,
18 because the court reporter can't get that down. Uh-huh and
19 huh-uh is not good, might be mistaken as yes versus no.

20 A. Fine.

21 Q. Have you had a deposition taken before?

22 A. Yes.

23 Q. How many times would you say you've been deposed?

24 A. Probably somewhere between 5 and 10.

25 Q. All medical-legal matters?

1 A. Yes.

2 Q. Yes, medical-legal matters?

3 A. Yes.

4 Q. Were they all medical malpractice matters?

5 A. As opposed to like --

6 Q. Well, my client gets hurt in 2 car accident and
7 develops an infection while in the hospital and comes under
8 the care of Dr. Blinkhorn.

9 A. Right.

10 Q. And, Doctor, tell me what happened to my client while
11 he or she was under your care in the hospital as opposed to--

12 A. That wouldn't be a deposition, would it?

13 Q. You could give 2 deposition before trial.

14 A. Oh, I don't think -- the only depositions I've given
15 have been for medical-legal issues as an expert witness or a
16 treating physician. Is that what you're getting at, treating
17 physician?

18 Q. Treating physician versus medical malpractice, giving
19 an opinion.

20 A. Right, so if I was 2 treating physician --

21 Q. You could --

22 A. But that's the deposition.

23 Q. Right.

24 A. Right, so that wouldn't be medical-legal.

25 Q. Let's see. They'd all be medical-legal technically. I

1 guess what I want to know is how many of them have involved
2 medical malpractice, where somebody said to you, did this
3 doctor or this hospital or this nurse or this person,
4 whomever, deviate from the accepted standard of care, was
5 their care and treatment appropriate, that kind of thing.
6 Were they all medical malpractice?

7 A. I think so.

8 Q. Any on behalf of the defendant before this case?

9 A. Yes.

10 Q. Any on behalf of the plaintiff?

11 A. Yes.

12 Q. How would that break out, most plaintiff, most
13 defendant?

14 A. It would probably be three or four out of five would be
15 for the defendant, and the other would be plaintiff work.

16 Q. And over what span of time would you say that you had
17 done those?

18 A. Probably 10, 12 years.

19 Q. So that's between 5 and 10, so that's like one, one and
20 a half per year, ballpark?

21 A. Yes, probably.

 Q. You didn't get them all lumped together in the last
 five years?

 A. No, thank God.

 Q. You charge for your time?

1 A. Yes.

2 Q. And what do you bill, how much an hour?

3 A. It's 150 an hour to review records, it's 200 an hour
4 for a deposition, and it's 300 an hour if I have to come into
5 the courtroom.

6 Q. So I will pay and issue a check for your time today.
7 Will you please make sure that I -- I'll write it down,
8 because I don't have a card with me.

9 A. That's fine.

10 Q. Let me give you that now, just so that I don't forget.

11 A. Usually I send it up to them and it's up to them.

12 Q. Send it to them, your time in deposition? Prep time is
13 different, you can charge them for that, fair enough, then
14 they'll know where to send it. It will be 200 an hour?

15 A. True.

16 Q. Did I have you state your full name?

17 A. No.

18 Q. How about that, I know you introduced yourself, go
19 ahead.

20 A. Richard J. Blinkhorn, Junior.

21 Q. I've got your CV here. You drive up here from Medina
22 every day?

23 A. Yes.

24 MR. DEMSEY: Off the record.

25 (Off the record discussion.)

1 Q. You've been asked to give an opinion in this case or
2 opinions in this case about the care and treatment or the
3 survivability of Mose Johnson based upon a particular disease
4 process that he had going on in his body, is that correct, or
5 were you just --

6 A. I was asked to review the records for the care
7 rendered, diagnosing this process, the letters in there, and
8 I wrote a report.

9 Q. Here's your report dated March 24th, 2000. So you
10 reviewed the autopsy report and death certificate, you looked
11 at Dr. Naeem's office records, you looked at the Elyria
12 Memorial Hospital ER records of November 10, '96, and some
13 excerpts from November 23, '96. I take it you have not seen
14 the entire chart?

15 A. Well, I don't know. This is what I've seen.

16 Q. Excerpts is what you say in your report. You've read
17 Dr. Z I V O T, it's Z I V, like Victor, O T.

18 Do you know him through University?

19 A. I don't think so.

20 Q. Did you read his supplemental report?

21 A. I don't know what report this is.

22 Q. You read his deposition?

23 A' No, I just got that.

24 Q. June 15th it was sent, you received it June 20th?

25 A. Yes.

1 Q. So you haven't had a chance to review that yet?

2 A. Nothing like having a stamp so that we can --

3 Q. Right. June 20th, you haven't had a chance to review
4 Dr. Zivot's depo. You received Dr. Watts' report, the
5 cardiologist?

6 A. Right.

7 Q. And you read Mrs. Johnson's deposition?

8 A. True.

9 Q. Do you have expertise in family medicine or in internal
10 medicine, the type of medicine that Dr. Naeem practices? In
11 other words, do you hold yourself out as an expert in that
12 field as well, or are you simply -- in other words, are you
13 going to address standard of care of a family practice or
14 internal medicine specialist, or do you say that's not my
15 area, I'm here to talk about the, well, what you're prepared
16 to testify to?

17 MR. KWARCANY: Objection to the form of the
18 question, but go ahead.

19 A. My training is internal medicine, that's my specialty,
20 my subspecialty is infectious disease. I'm a concerned
21 expert on both, I practice both disciplines.

22 Q. Now, it's my opinion that the -- I'm sorry, it's my
23 understanding based upon your March 24, 2000 report that you
24 are going to testify as to certain things, and we'll talk
25 about that in a moment.

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Q. The opinions that you're going to give in this case are as follows, and it's contained in your report: Mr. Johnson succumbed to a myocardial abscess which ruptured into the pericardium?

A. True.

Q. You don't believe that the bacterial pericarditis due to Staph aureus was diagnoseable prior to Mr. Johnson's hospitalization on November 23, '96?

A. True.

Q. And given the development of purulent pericarditis complicating a dilated cardiomyopathy, you do not believe earlier treatment would have averted this patient's death?

A. True.

Q. Those are the opinions of yours that have been provided to me in terms of the opinions that you will be offering at trial. The reason I'm taking your deposition today is to find out if there's anything beyond what you have already told us you hold as an opinion that you're going to give or offer as an opinion at trial?

A. Correct.

Q. This would be it, on your report of March 24?

MR. KWARCANY: Objection.

A. You asked me two things. See, you haven't asked me any questions.

1 Q. I'm asking you if you hold any other opinions in this
2 case or are prepared to give other opinions in this case?

3 A. If there are questions that ask for my opinion that I
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1 Q. It represents a batch, right?

2 A. Sure.

3 Q. Okay.

4 (Plaintiff's Exhibit 3 was marked.)

5 Q. Exhibit 1 is the letter that Doug Fifner sent to you
6 asking you to get involved in this case, that's the initial
7 letter; am I correct? Was there an earlier one?

8 A. It might help to look at all of them, maybe you're
9 right.

10 Q. It's interesting that I would have all this before
this, but it must be, they're dated differently.

So on February 3rd, 2000, he sent you Plaintiff's
Deposition Exhibit 1?

14 A. Right.

15 Q. He said after -- there were records there, and he
16 indicated that he wants you to call him to advise of your
17 preliminary findings, and I assume you did that?

18 A. Okay.

19 Q. Because he then says, "Thank you for reviewing the
20 above captioned case, and here's the following materials,"
21 and he says, "There's two issues that I would like you to
22 consider. First, was the patient's Staph aureus pericarditis
23 diagnoseable before November 23, '96?" And you, I assume,
24 you wrote no?

25 A. True.

Q. Second, he writes, "Would earlier treatment of the
pericarditis have averted this patient's death?" You also
wrote "No."

A. True.

Q. Then after that, of course, you generated the notes in
Exhibit 3, after reviewing the materials in the second
letter?

A. True.

Q. So the first letter asking you to look into the matter
was February 3rd, second letter with the two questions that
you were asked to answer was February 4, and you generated
your office notes after that, and then several weeks later,
what is it, about five, six weeks later, maybe seven weeks,
you prepared the letter dated March 24?

A. True.

Q. Okay. In there you said that you have reviewed the
materials that we went over before?

A. I reviewed those materials.

Q. Those materials that are here. And based on this
review you said you're prepared to testify to the following,
and you listed Item Numbers 1, 2, and 3?

A. Correct.

Q. Have you reviewed anything since your March 24, 2000
letter? Here's the materials that you have reviewed.

A. No.

1 Q. Are there any other opinions that you intend to offer
2 at the time of trial in this case?

3 MR. KWARCIAANY: Objection. I think it's an
4 unfair question to ask of the doctor, for the reason he
5 stated previously, but go ahead. Based upon his
6 conversations with me this afternoon, for example,
7 Richard, which summarized what Dr. Zivot had to say at
8 his deposition, as well as Dr. Watts, yes, he has a few
9 more opinions.

10 Q. Whatever your opinions are, for example, if you had an
11 opportunity to speak with counsel, and I realize you didn't
12 get a chance to read Dr. Zivot's deposition, but you may have
13 received some highlights, I won't doubt the accuracy as
14 relayed by counsel, but based upon materials you have
15 reviewed, based upon conversations with counsel, are there
16 other opinions, any other opinions than those set forth in
17 your report that you intend to offer at the time of trial?

18 A. Answers to your questions this afternoon will be my
19 opinions that I would also stand behind at trial..

20 Q. I understand that. But the purpose of this deposition
21 is to find out what opinions you hold in this case and that
22 you plan to offer at the time of trial.

23 A. True, but I also know the ground rules here are you ask
24 the questions. I could ask you, what other questions would
25 you like to know from me, because I can't predict what you

1 want to know from me. This is discovery, I thought you are
2 supposed to ask me questions and I tell you what I think.

3 Q. For example, Dr. Watts put all his opinions in his
4 report.

5 MR. KWARCIAANY: Objection, I don't know if
6 that's necessarily true or not, based upon what I heard
7 this morning, but in any event, Richard, this is an
8 exercise in futility, this is a chicken versus egg
9 argument. Why don't you just ask him some questions?
10 Don't ask him to predict what you may ask him, I may
11 ask him at trial, Doug may ask him at trial, let's move
12 on with this, if we can, because we're getting nowhere.

13 MR. DEMSEY: Okay. The way it's usually done,
14 Dale, in fairness, is the expert gives a report then
15 you question him about the opinions in the report. I
16 just want to know if there's other reports -- if there
17 are other opinions you're going to ask him at trial,
18 tell me, I don't want to get into a fishing expedition,
19 we'll be here all afternoon.

20 MR. KWARCIAANY: He is going to tell you Dr.
21 Naeem did not deviate from the standard of care, he is
22 going to tell you what he thinks the Staph aureus was
23 due to in this particular case, and I haven't thought
24 of the other questions that I or Doug may ask or
25 Colleen or Les may ask in this case.

1 MR. DEMSEY: Fair enough.

2 Q. The opinions were related to the Staph aureus and
3 whether or not it was survivable, that's essentially what was
4 in your report. 'That's what I was asking, I didn't know if
5 you were going to talk about what anybody else did, what the
6 hospital did. Do you have any criticisms of Dr. Naeem?

7 A. No.

8 Q. For example, the care and treatment of Mr. Johnson, he,
9 Dr. Naeem, was the family physician for Mose Johnson, that's
10 your understanding?

11 A. True.

12 Q. Based upon your review of the chart of Dr. Naeem in his
13 care and treatment of Mose Johnson, what did that physician-
14 patient relationship consist of, what's your understanding of
15 what took place over time, between the two of them?

16 A. I don't have any opinions about that.

17 Q. You don't know?

18 A. No.

19 Q. You just looked at, what, the visit of November 2 and
20 thereafter?

21 A. I looked at the record that I documented here to render
22 opinions regarding what happened to Mr. Johnson.

23 Q. What happened to Mr. Johnson?

24 A. Mr. Johnson came into the hospital on November 23, 1996
25 and died within hours due to myocardial abscess due to Staph

1 aureus which had ruptured into the pericardium.

2 Q. When did his Staph aureus enter his body?

3 A. Unknown.

4 Q. From an infectious disease standpoint, is there a
5 window, in other words, you could say he'd had it since he
6 was two years old, or, again, to a reasonable degree of
7 medical probability, more likely than not, would you say that
8 he had had it for a couple months, a year?

9 A. No way.

10 Q. Couple weeks?

11 A. Not very long.

12 Q. Minutes before he entered the hospital on the 23rd?

13 A. It's impossible to know exactly, because there's
14 nothing in his history that enables anyone to predict. exactly
15 when he got it.

16 Q. How do you know if a patient has an infection before
17 you actually culture them, what are some early signs or signs
18 and symptoms that you would look for as a, let's not put on
19 the hat of infectious disease specialist, because when you're
20 in your ID hat, when you're wearing your ID hat it's probably
21 been identified or you're trying to figure out which it is,
22 maybe, and they bring somebody to you?

23 A. Not necessarily.

24 Q. But I'm asking you to put on the hat of an internal
25 medicine specialist like Dr. Naeem. How does the internal

1 medicine specialist know if somebody has an infection, what
2 are some of the signs that would be recognizable to someone
3 like that as opposed to somebody who specializes, like you?

4 A. They're the same.

5 Q. Okay.

6 A. Fever, chills, rigors, sweat, I have cough, I have pain
7 when I urinate, I have abdominal pain. It depends on where
8 the infection is.

9 Q. I wasn't familiar with the third word you used, rigors?

10 A. That's where people shake.

11 Q. How do you spell that?

12 A. R I G O R S .

13 Q. It could be one or any combination of those as
14 indications of possible infection?

15 A. True.

16 Q. Are there any type of tests that are performed, labs
17 that can tell you whether or not somebody has infection,
18 blood work, for example?

19 A. It can suggest someone might be infected.

20 Q. Unless you culture for a particular infection, the
21 blood work doesn't tell you, if it's just a routine?

22 A. Cultures don't always tell you either.

23 Q. Why is that?

24 A. Because not all infections are associated with positive
25 blood cultures or positive cultures of any sort.

Q. Is the infection of Mr. Johnson associated with a positive blood culture?

A. Can be.

Q. And again, so that we're clear, that's Staph aureus?

A. Correct.

Q. Tell me a little bit about Staph aureus; what is it, what's the nature of it, how does it exist, can you give me a little history, just teach me a little bit about it?

A. Well, it's bacteria, it's a bacteria that's presently referred to as a cocci, based on its appearance.

Q. Spell that.

A. C O C C I. We describe them as, we call them round, but in fact they're third dimensional, so they're spheres.

Q. Is that like Staphylococcus or streptococcus, are those the cocci?

A. True, they're different, though.

Q. I understand. The two that I just named are different?

A. True. So the organism is in that sort of group, and then its bacteria are placed under genus and species, and Staphylococcus is the genus, so there's a whole family of Staphylococci, one of which is called Staphylococcus aureus, based on its unique characteristics.

Q. What does Staphylococcus genus, aureus species mean, what is that species, what is the aureus species? Is there some way to teach that to me in a lay term, what it is?

1 A. Well, there is, but again, this is an organism that's
2 had books, treatises, written on it.

3 Q. Mutations?

4 A. Libraries could be filled with stuff on Staph aureus,
5 so I would say in general it's a very common bacteria that
6 can cause severe infections in a variety of places.

7 Q. If one has -- well, is it true that people carry all
8 manner of bacteria in their body?

9 A. And on their body.

10 Q. And on their body?

11 A. True.

12 Q. And we're immune to most of them, if not all of them?
13 I don't want to be too simplistic here, but the one that we
14 carry, I mean, it's just part of being a living organism,
15 each living organism carries bacterium; is that a fair
16 statement?

17 A. I'm not aware of any exceptions to that.

18 Q. Fair enough. On this planet, at least, right?

19 Is Staph aureus one of them?

20 A. One of what?

21 Q. The bacterium or bacteria that we carry on our bodies
22 or in our bodies?

23 A. We can.

24 Q. When we do, are we always sick, or are we sometimes
25 able to carry it? You have bacteria in your body right now

1 and on your body, and you're not sick from it; would that be
2 a fair statement?

3 A. I hope.

4 Q. Well, I mean, in fairness, you know what I'm saying,
5 you don't need treatments or antibiotics or meds, right?
6 That's what I'm getting at.

7 A. Me specifically, or are you like making an example?

8 Q. No, you.

9 A. I hope that's true.

10 MS. PETRELLO: I hope so too, for the sake of
11 the rest of the room.

12 Q. Let's pick Dale.

13 A. I don't know Dale's medical history.

14 MR. DEMSEY: See, Dale, you're in trouble, you
15 better go get checked out, we can wait. No, okay.

16 Q. Really, all I'm asking is if one of the, what would you
17 call those, bacteria, that are on and in our bodies that
18 don't require treatment?

19 A. Let's talk about what you mean by "in our body." On
20 our body, I think, is apparent. In our body, now we've got a
21 little problem here. Do you mean in my bloodstream, do you
22 mean in my brain, do you mean in my gut, do you mean in my
23 urinary tract? They're all very different.

24 If you say I have some bacteria on my skin because I'm
25 part of this plane',, okay, we all do, the answer to that is

no, I'm not sick, my skin is normal. That doesn't mean that I am immune, as you had suggested to this, because if I go like this and cut my skin and those bacteria get in, I get an infection on my hand from the same organism that right now is not causing a problem.

If you say, I have bacteria in my bloodstream, that's okay, no, that's not okay. I wouldn't be walking around with bacteria in my bloodstream and be well.

Q. Fair enough. Once bacteria gets into the bloodstream, then it's time for some kind of treatment?

A. It's a problem.

Q. Requiring medical intervention?

A. True.

Q. Is Strep A one of those forms of bacteria that one carries on their body?

MR. KWARCIAANY: Objection.

MS. PETRELLO: Objection.

Q. Staph A, excuse me.

A. Staph aureus?

Q. Is that different than Staph A?

A. Well, if you want to refer to it as that, I'll accept that.

Q. No, because I've heard Staph A and Strep A.

A. Just so we're on the same page, I don't refer to it that way, but if that's what we mean by that, it's okay with

1 me.

2 Q. Let me start again. Which one did Mr. Johnson have?

3 A. Staph aureus.

4 Q. Staph aureus. I've just heard that term.

5 A. It's okay, we can agree to call it that if that's what
6 you mean by it.

7 Q. No, it might mean something else, I don't know.

8 A. Okay.

9 Q. Staph aureus, is Staph aureus a bacteria that exists on
10 people's bodies and doesn't affect them?

11 A. On occasion.

12 Q. And is there a reason that it would be there versus
13 wouldn't, some real world example you can give me, or is it
14 just --

15 A. The answer is, if we stand out on the street corner and
16 we culture everyone that walks by, it is said that one out of
17 four people that you culture will have Staph aureus on their
18 skin; but if we did it again tomorrow, it wouldn't
19 necessarily be the same one out of four, so that you can have
20 it on your skin transiently, it goes away.

21 Q. How does it get there?

22 A. It's part of being in this world.

23 Q. It too is a living organism?

24 A. Yes.

25 Q. So it's airborne, we don't know?

1 A. In rare circumstances it may go through the air.

2 Q. Handshake, human contact?

3 A. It's contact, yes. It's generally thought to be skin
4 to skin.

5 Q. And then is it true that the way it gets into someone's
6 body is through an opening in the skin?

7 A. Most of the time.

8 Q. Can somebody have it on their skin, take a bite of
9 their cheeseburger, and take it into the bloodstream that
10 way?

11 A. It's possible.

12 Q. But not likely?

13 A. Depends on the circumstances. Staph aureus also
14 produces substances we call toxins. If you go to a picnic
15 and you eat something and you get sick within an hour, you
16 just ingested Staph aureus toxin that was on the food that
17 you ate.

18 Now, if you have a heavy load of Staph aureus that you
19 ate, yes, it's going to get in your bloodstream too, you're
20 going to be sick, Staphylococcal food poisoning, that's a
21 little different. So when you say it's likely, it's likely
22 in that setting. Is it common? No.

23 Q. How, in your opinion -- and again, just to a reasonable
24 degree of medical probability, because I'm sure you can't
25 tell me absolutely positively this is the exact spot where it

1 went into Mr. Johnson's body and the exact time it went into
2 his body, but to a reasonable -- unless you can of course do
3 so -- but to a reasonable degree of medical probability, how
4 did it get into Mr. Johnson's body, even if generally?

5 A. In Mr. Johnson's case, it cannot be known by anyone
6 without making things up.

7 Q. Because?

8 A. Because there is absolutely no clinical evidence to
9 tell us how it got in there, which the literature and
10 infectious disease people know is very common.

11 Q. The literature and infectious disease people know what
12 is very common?

13 A. That at least a quarter of all people who have serious
14 Staphylococcal infection in the bloodstream, you can never
15 tell how it got there.

16 Q. How do you tell. on the other 75 percent?

17 A. The other 75 percent may have some other focus of
18 infection that was associated with the organism getting into
19 the bloodstream.

20 Q. Which he didn't?

21 MR. KWARCIAANY: Objection.

22 Q. Or did he, did Mr. Johnson?

23 MR. KWARCIAANY: Well, whatever the autopsy
24 shows, Doctor.

25 A. I am not aware in his case that it is possible to know

1 at all how it got into his body.

2 Q. Okay. Or when?

3 A. Or when.

4 Q. Can it be in someone's body for an extended -- well,
5 let me ask this question a different way.

6 Sometimes you kind of smile when I ask a question. I
7 don't claim to be expert in these areas, so if the question
8 seems a little silly, bear with me and just please give me
9 your best answer.

10 A. It's a bad habit of mine, sorry. I'm not laughing at
11 you.

12 Q. I don't think you intend to be disrespectful, you
13 strike me as a good guy.

14 A. I'm not.

15 Q. I didn't think so. You wouldn't have introduced
16 yourself --

17 A. I smile because I hear questions that I can't answer
18 with a yes or no, like the food thing.

19 Q. I understand, absolutely. So is there a time period
20 that the Staph aureus could have been in Mr. Johnson's body,
21 he could have been carrying that bacteria, bacterium?

22 A. That's okay. That's one.

23 Q. So multiple Staph aureus, or Staph aurei would be
24 bacteria? I'm just being precise.

25 A. I think we call them Staphylococci.

1 Q. Staphylococci are the Staph aureus multiple?

2 A. True.

3 Q. I just didn't want my word to be confused with multiple
4 variations, other genus, or --

5 A. Got it.

6 Q. -- or variations of that particular genus, other
7 species within that genus, okay.

8 How long, what is the window, If there is a window,
9 that it could have been in his body before his death, how
10 long can that be in there?

11 A. We have to talk about what we mean by "in his body," in
12 his bloodstream, in his heart, in his bones, in his brain,
13 they're different.

14 Q. Well, then let's work backwards. The Staph aureus was
15 the organism that infected his pericardium?

16 A. True.

17 Q. And it was, it caused what has been described, if I'm
18 not mistaken, as bacterial pericarditis?

19 A. True.

23 Q. No other organisms that you're aware of or other
21 bacteria?

22 A. Uh-huh.

23 Q. Right?

24 A. Uh-huh.

25 Q. That's a yes, no other, correct?

1 A. In the pericardium?

2 Q. Correct.

3 A. True.

4 Q. Are there any other bacteria or infectious disease that
5 caused or contributed to cause his death?

6 A. Not that I'm aware of.

7 Q. Is there anything else that caused or contributed to
8 cause his death? And I understand that systems fail once the
9 chain of events is placed into motion, so you could --

10 A. True.

11 Q. Obviously I'm not looking for when he stopped breathing
12 that contributed to cause his death, I'm talking about
13 underlying contributing causes, anything else in your opinion
14 that contributed to cause his death?

15 A. The myocardial abscess.

16 Q. And the myocardial abscess came about as a result of
17 what?

18 A. It is impossible to know without pure speculation.

19 Q. What is a myocardial abscess as it relates to Mose
23 Johnson? Give me the, what's the word I'm looking for,
21 clinical picture, medical picture, what?

22 A. It describes an abscess, and an abscess is a collection
23 of pus that's --

24 Q. It was on his heart?

25 A. And when we say myocardial abscess, it means it's in

1 heart muscle, it's within the muscle of the heart, which the
2 heart is essentially an organ of muscle with some other
3 things holding it together and electrical conduction. So
4 myocardial abscess is a collection of pus in muscle.

5 Q. Where was it located?

6 A. In the left ventricular wall.

7 Q. Which portion of the left ventricular wall?

8 A. We can refer to the records if we need that.

9 Q. Please, if you could.

10 A. It appears to be close to what's described as the left
11 circumflex artery. It says, "At focr centimeters from its
12 origin, purulent fluid pours from the myocardial tissue from
13 a cyst-like cavity" -- do you want me to keep going?

14 Q. Yes, thank you.

15 A. "... that measures 1.3 centimeters in maximum
16 dimension."

17 3. So there's an infected area on the outside of the left
18 ventricle or oozing from the outer portion of the left
19 ventricle or inside the left ventricle, inside the heart's
20 chamber?

21 A. Let's describe the heart as a muscle, tne inside of
22 which is circling blood, it's a cavity. Think of the heart
23 as a balloon and the balloon itself is muscle, so it's
24 thicker, has to bump blood out, if we just imagine one
25 chamber.

1 Q. Fair enough.

2 A. The left ventricle is the muscle describing that part
3 of the balloon that's on the left, but there's another
4 chamber which we call the right, so we're talking about in
5 the muscle, which is wall. You can't have it inside the
6 heart, because that's in the blood, so there's no abscess
7 that squirted out of there.

8 Q. What I meant by inside was, if we were to somehow be
9 able to take a look at this while it's developing, let's say
10 the day before or that day that he died, if we went inside
11 and we were to take a peek on the outside of the left
12 ventricle, would we see that pussy area? If we went inside
13 the balloon and looked, would we see there -- where would we
14 see it?

15 A. At the end you see it because it ruptures with what's
16 known as the free wall, and the free wall is surrounded by
17 the pericardium. At the end when it comes out you would see
18 it, because it's now a big hole in the muscle eroded away,
19 necrotic.


20 Q. Which way did it go, from the outside in?

21 4. No, it's in the muscle and it grows in the muscle, like
22 a three-dimensional little sphere, and as it's growing in
23 those directions it reaches the epicardium, which is the
24 outside part of the wall, and goes into the pericardial
25 space. The inside is called the endocardium, it could

1 conceivably go in that direction also.

2 Q. So when the Staph A, is "attacks" a fair word, attacks
3 the wall of the heart or the muscle --

4 A. I suppose.

5  -- the tissue, or when it --

6 A. Lands there.

7 Q. When it lands there, does it, in your opinion, land on
8 the inside, does it land on the outside, was it suspended in
9 fluid inside the pericardium then it came in contact with the
10 heart wall and decided to do its nasty thing, or was it in
11 the blood and came into the heart that way, that's what I'm
12 getting at, which way?

13 A. For it to land inside muscle --

14 Q. From inside the heart -- go ahead, I'm sorry.

15 A. It can get there one of two ways, basically. It can
16 get there via the bloodstream, because the heart has a
17 muscle, has a blood supply, coronary arteries. So it can go
18 through the bloodstream, land in the muscle, set up shop
19 there, grow.

20 It can also get there from a valve. If you have a
21 patient who has endocarditis, meaning infection of the
22 interior structures of the heart, which usually means the
23 valves or the apparatus, infection on the valve sitting there
24 attached to muscle can erode, can erode through the valve
25 into the muscle that way. And there's no evidence in this

1 case that there is disruption of the valvular architecture,
2 so we're left with, in all probability, it got into the
3 muscle via the bloodstream.

4 Q. Which means that the Staph, of course, the Staph aureus
5 did not originate or set up shop or just -- well, let me back
6 up. Again, I want to paint this simplistically, so I can
7 understand it and follow the path of this. Do they travel in
8 groups, is it just one, what happened here when it got to his
9 heart, and did it start on the outside and work its way in?

10 A. You're pointing to your arm; you mean on the outside of
11 his heart?

12 Q. On the outside of the skin.

13 A. I think I said it's impossible to know with certainty
14 how it gained access into his bloodstream.

15 Q. Time out for just a second. Can you say to a
16 reasonable degree of medical probability, all things being
17 equal, just more likely than not, 50 point zeros, as many as
18 you want, one over 49 point equal number of nines, just more
19 likely than not, this is how I think this got into Mr.
20 Johnson's body, the Staph aureus got into Mr. Johnson's body?
21 I understand you can't say with certainty, can you simply say
22 more likely than not it would be my opinion as an infectious
23 disease expert that it came from his skin, that it came from
24 he'd been carrying it since he was two, whatever, more likely
25 than not?

1 MR. KWARCIANY: Let me object to the form of the
2 question, but go ahead.

3 A. When infectious disease people see cases like Mr.
4 Johnson's where it is impossible for anyone to know exactly
5 how it got into his bloodstream, it is the belief to a
6 reasonable degree of medical probability that it got from
7 somehow on his skin into his bloodstream.

8 Q. And are there -- you said, for example, one could cut
9 themselves and an infectious process could set up there at or
10 near the cut, requiring maybe some medical attention. It
11 depends on what it is, of course, but would the most likely
12 avenue be a cut or a puncture, or would there be something
13 else that your profession says, you know, it went in through
14 the eye, it went in through the nose, the mouth, genitally,
15 rectally, a laceration, even an insignificant laceration, a
16 paper cut, whatever? What does your profession hold in a
17 more likely than not belief of how it does get in from the
18 skin?

19 A. In the circumstances where you see the patient and you
20 cannot know, then there is no answer to that, because you
21 cannot know. If you said, oh, you had a cut a week ago, that
22 must be it, then that's not --

23 Q. A likely spot?

24 A. Yes. Now, sometimes I can tell you I've seen patients
25 where you went head to toe, more than one doc, couldn't

1 figure it out, and they say, well, you know, why does your
2 thumb have that bruise on it? Well, I hit it with a hammer a
3 week ago. Well, that must be it, but you don't really know,
4 and that's what we're describing with him. I'm already
5 setting up saying I cannot know, my profession cannot know.
6 If somebody says hey, look, I got this a week ago and look,
7 it was red, now I got a scab.

8 Q. I understand when you say we can't know with him.
9 There was no spot on his body as revealed by autopsy that you
10 could point to, is that what you're telling me?

11 A. There's no part on his body, there was no clinical
12 history that he gave, there's no clinical history his wife
13 gave. This poor man didn't have any history that I could see
14 from anybody that allowed anything other than pure guess to
15 answer that question, that's why I am being careful.

16 Q. And you have no idea how it got inside his body
17 whatsoever?

18 A. Based on the records, true.

19 Q. And based on your expertise, could you say to a
20 reasonable degree of medical probability how it got into his
21 body?

22 A. No.

23 Q. Could it come in when he got his blood work following
24 his November 2 visit? There was a puncture placed in his
25 body on that date.

1 MR. KWARCIAANY: Objection. Is that possible?

2 Objection.

3 A. Anything is possible.

4 Q. Certainly, that's a known opening in the skin on that
5 day?

6 A. True.

7 Q. What about when he received his shot of Toradol on
8 November the 10th at Elyria Memorial Hospital, could it have
9 come in then?

10 MR. KWARCIAANY: Objection.

11 A. Anything is possible.

12 Q. Certainly it's possible that he got an insignificant
13 paper cut that wouldn't show up on autopsy and it could have
14 come in that way too, or no?

15 A. it's possible.

16 Q. Is it possible that it was in his bloodstream the day
17 he died? You know it was, actually, because it was found on
18 autopsy.

19 Q. Was it the autopsy, or was it a culture when he came
20 in?

21 Q. You know what, you might be right. It was there --
22 well, okay. We know that he died of it, it was found and it
23 was either by culture when he came in or it was
24 postoperatively, I mean postmortem, is that the proper --

25 MR. SPISAK: When you say died of it, I'm not

1 sure.

2 Q. Well, died of complication from the Staph aureus
3 infection, that's what he died from, the pericarditis, right?

4 A. Yes.

5 MR. SPISAK: The abscess you're talking about?

6 MR. DEMSEY: And the rupture at the abscess
7 site.

8 A. True.

9 Q. It is conceivable that the Staph aureus was in his body
10 the day before?

11 A. Yes.

12 Q. It's conceivable it was in there two weeks earlier?

13 A. No.

14 MR. KWARCIAANY: Objection.

15 Q. It's not conceivable?

16 A. Not to me.

17 Q. Why not?

18 A. Because he wasn't sick, and he wasn't sick for two
19 weeks. Staph aureus is not an organism that is a subtle
20 pathogen. When it gets there, you know it's there.

21 Q. If I had Staph aureus in my body right now, would I
22 know it?

23 A. I believe so.

24 Q. Why do you say that?

25 A. I believe everybody at this table would know it,

1 because you would be sick.

2 Q. How?

3 A. You would be rigoring in front of me, sweat pouring off
4 you, saying, you know, I don't really feel good.

5 Q. What do you think is the significance of the elevated
6 white blood count on November 2?

7 A. It's a stress reaction.

8 Q. To what?

9 A. Could be a stress reaction to infection, could be a
10 stress reaction to myocardial injury, could be a stress
11 reaction because he's dying, all those sort of things. A
12 white count of 110,000 in a setting like his, we say this is
13 Likely infection. If he came in with a white count of 40,000
14 and he wasn't feeling too good because he was tired, it could
15 be leukemia. His case, it's a marker of infection and stress
16 reaction.

17 Q. What does the standard of care call for when you find a
18 sign of infection via a white blood count?

19 MR. KWARCIAANY: Objection. Talking about a
20 12,000 versus 40,030, or generally, or what?

21 MR. DEMSEY: Just talking about elevated white
22 blood count.

23 MR. KWARCIAANY: Could be marginally elevated,
24 could be -- I'm going to object.

25 MR. DEMSEY: Call the judge right now and find

1 out if you're permitted to testify for the doctor.

2 MR. KWARCIANY: Your questions are --

3 MR. SPISAK: He can do that, I don't mind.

4 MR. DEMSEY: Thank you.

5 MR. SPISAK: Just teasing.

6 MR. KWARCIANY: I will refrain from making
7 comments, Mr. Demsey, if you clarify your question.

8 MS. PETRELLO: It is confusing.

9 MR. KWARCIANY: Otherwise, I think, in my
10 opinion, they're unfair to the doctor, and that is the
11 reason that I am objecting.

12 MR. DEMSEY: Just say objection.

13 MR. KWAKCIANY: With that, you may proceed, and
14 I will do my best to keep my mouth shut.

15 MR. DEMSEY: I appreciate that.

16 Q. Doctor, if you don't understand my question, you'll ask
17 me to repeat it or rephrase it, won't you?

18 A. Yes, I will..

19 Q. I do appreciate that.

20 A white blood count of -- well, strike that for a
21 moment, let me gather my thoughts here for a second. I'll
22 try to come back to that.

23 Let me back up to where I was before with this Staph
24 aureus in Mr. Johnson's body, more likely than not traveled
25 through the bloodstream, set up shop, lodged in the muscle of

2 ruptured and he crashed. Fair statement?

3 A. And he died.

4 Q. And he died.

5 A. True.

6 Q. How did it travel through the bloodstream to that
7 point, do we know what its itinerary was, where it went, or

10 A. Well, we know when the organism lands in the
11 bloodstream, since it's in the bloodstream, it's there, it's
12 a dynamic thing. The organism multiplies very fast, it's
13 multiplying within minutes, turning over, growing, making
14 more and more of itself.

15 Q. In the bloodstream?

16 A. Yes, it likes the bloodstream, it's warm, it has lots
17 of nutrients, grows well there. We grow it in the lab on
18 what's called blood agar.

19 Does it stick together when it grows, or do they send
20 little --

21 A. It's on a microscopic level, you don't see it going
22 through your bloodstream in like clumps. And it's there,
23 it's multiplying, it's dispersed. Once it gains access to
24 your bloodstream, it travels. Once it gets back to the heart
25 it's pumped everywhere, it's multiplying all the time, it's

1 in your bloodstream the whole time. You stick a needle in
2 your blood and you draw blood out, it's there, stick a needle
3 in your blood an hour later, it's there, two hours later, 30
4 minutes later, it's everywhere. Where it lands and sets up
5 shop depends on a lot of different things.

6 Q. Okay.

7 A. A frequent place for it to land is an area of
8 abnormality, you have abnormal joints, you have arthritis,
9 for reasons that are unclear, but probably due to the fact
10 that in those areas where there is scarring or damage there's
11 nooks and crannies where it can hide and elude your white
12 cells, which are trying to eat it as it's going through the
13 bloodstream, literally, and kill it.

14 Q. This is great, now I'm getting a mental picture. I
15 think more with the left side of my mind.

16 A. There's a battle going on in your blood stream in that
17 level. The organism can land in an abnormal spot, it can
18 hide from your body's ability to kill it, which Staph aureus
19 is notable for, then once it lands in that spot it starts
20 growing and it grows into abscesses damaging tissue. Cells
21 come in, damage tissues, cells come in, the organism is
22 growing and you get an abscess.

23 Q. So I think what you're telling me here is that it went
24 to his heart because that was the damaged area?

25 A. What I'm saying is, in his heart, if there is a damaged

1 area there, as is suspected from ischemia or an infarct, that
3 be big, but that's a damaged area. The organism can land
there and start growing, hide from the body's immune
5 response, cause abscess, cause that part of the body to
liquefy into pus. And if that ruptures out of the heart,
7 then blood from inside the heart and that pus can get out
into the pericardium, which is around the heart, and then
9 you're dead.

10 Q. It could be in the body for how long?

11 MR. KWARCIAANY: Objection to the word "it."

12 MR. DEMSEY: Sorry.

33 Q. Staph aureus can be, could have been in Mr. Johnson's
14 body for how long?

15 A. Where in his body?

16 Q.

17 A. Blood, heart, bone, brain?

18 Q. Well, before it reached his heart and set up shop and
19 started doing its growth of the abscess; is that a fair
20 statement?

21 A. Yes.

22 Q. Growth of abscess, abscess almost sounds like a void,
23 so to say the abscess is growing, is that logical?

24 A. Yes, because it's a third-dimensional liquid thing.

1. When the abscess started to grow, in all

1 likelihood how long was the Staph aureus in his body?

2 MK. KWAKCIANY: Objection.

3 A. Hours.

4 Q. And the reason you say that is because --

5 A. Because this is a virulent pathogen, it grows so fast
6 that it could set up abscess in his heart within hours. It
7 wouldn't have been in his system longer than a day without
8 him being ill. So my window of disease here is about 24
9 hours, given all the circumstances that I've seen in his
10 record. That's about it.

11 Q. Is Staph aureus treatable?

12 A. Yes.

13 Q. Was there a point in time when the Staph aureus was in
14 Mr. Johnson's body when it was treatable?

15 MR. KWAKCIANY: Objection.

16 A. Well, we have to agree on what we mean by treatable.

17 Q. First of all, we have to know it was there, but then --

18 MR. SEISAK: I didn't hear what the doctor said.

19 A. You don't actually need to know it's there to be
20 treatable, but the point is, when I think treatable, I'm
21 thinking any microbial agent to kill it. If you say it's not
22 treatable, that means I don't have an agent that kills it,
23 okay. If I say there is an abscess with Staph aureus, part
24 of the treatment would be drainage. So if you say I have a
25 Staph abscess on my skin, is it treatable, yes, I would give

1 you an antibiotic and I would have drained

2 So it but treatable de

Okay. Hypothetically speaking, if t

in Mr. Johnson's bloodstream two weeks bef

5 did a culture and found it and it had not yet set up shop in

6 the heart -- you understand what I mean by set up shop?

8 Q. Was it treatable or curable?

MR. KWARCIAANY: Objection.

10 MS. PETRELLO: Objection.

11 MR. SPISAX: Me too.

12 A. It would be treatable. The answer as to c

13 depend on if there were other manifestations.

14 Q. Such as?

15 A. Lung abscess, liver abscess, brain abscess, kidney
16 abscess.

17 Q. Well, no abscess.

18 MR. KWARCIAHNY: Objection

20 two weeks before it set up shop in his heart and killed him

21 within hours, it was treatable; was it curable?

22 MR. KWARCIAAMY: Objection.

24 is he had Staphylococcus aureus bacteremia, meaning in his

25 bloodstream --

1 Q. Bacteremia means it's in the blood?

2 A. Correct. Without any other clinical
3 involvement, period, it would be treatable
4 curable.

5 Q. How would you treat it, how would you cure it?

6 A. I would give an antibiotic.

9 Q. You'd give an antibiotic for Staph aureus bacteremia,
10 which is Staph aureus in the bloodstream?

11 MR. KWARCANY: Objection.

12 Q. Would the antibiotic -- right?

13 MR. KWARCANY: Let me just show a continuing
14 objection to this hypothetical question.

15 MR. DEMSEY: Fair enough.

16

18 A. Well, we've already defined it as Staph aureus
19 bacteremia, so we'd have a culture, and the culture would

22 Q. Curable within what time period, and what residual side

MR. KWARCANY: Objection. Go ahead.

25 A. Under the scenario of Staph aureus bacteremia without

1 other focus, standard would be 14 days of treatment as a
2 start, possibly 28, and we would expect 90 to 95 percent
3 cure, meaning it doesn't come back, doesn't come back at some
4 other focus.

5 Q. "Focus" meaning another location in the body?

6 A. Correct.

7 Q. Another abscess where it landed without us knowing it.
8 When you say -- did you say 96.5 percent cure?

9 MR. KWARCIAANY: Objection. Or 90 to 95 percent?

10 4. I said 90 to 95.

11 a. Percent chance of a cure?

12 A. Percent chance.

13 2. Of a cure?

14 A. Of a cure.

15 MR. SPISAK: May I ask a clarification point,
16 and I'm not trying -- you're talking a Staph aureus
17 bacteremia without clinical focus, is that how you put
18 it?

19 THE WITNESS: Correct.

20 a. Without clinical focus means there's no abscess set up
21 anywhere?

22 A. That we know of.

23 Q. Right?

24 A. True.

25 Q. Other than the abscess in Mr. Johnson's heart, or on it

1 or in it, however you want to call it or describe it, the one
2 that he died from, was there anything in the records or in
3 the autopsy to suggest that he had any other, what's the
4 word, focus, location, abscess, resulting from the Staph A,
5 aureus?

6 A. No.

7 Q. And when you say a 90 to 95 percent chance of a cure or
8 recovery, is that with or without residual impairment?

9 MR. KWARCANY: Objection.

10 Q. In other words, somebody who's had -- let me give a
11 Wild -- I know you'll say this doesn't happen, but the 90 to
12 95 percent chance of a cure, you expect it, you get it, but
13 these people are blind and can never walk again, these people
14 can never hear again, that's what I meant by residual.

15 MR. KWARCANY: Continuing objection.

16 A. In the scenario that we were discussing with Staph
17 aureus bacteremia without any other recognized clinical
18 focus, the cure would be without expected residual.

19 Q. And if there is a reoccurrence, it would be strictly a
20 new episode, some other organism would have to enter the
21 body?

22 A. No, it would mean that it had landed in a site that we
23 could not define clinically, it hid from us, and that we
24 didn't know it was there, and after you stop your treatment
25 it comes out again.

1 Q. The people who have the 90 to 95 percent cure rate, is
2 that a fair phrase, cure rate, do they typically have a
3 relapse or a reoccurrence, or not?

4 MR. KWARCIAANY: Objection.

5 A. Well, by definition we set it up to mean that they
6 would not.

7 Q. When you say 90 to 95 percent cure, you mean get over
8 what they had and not have a reoccurrence?

9 MR. KWARCIAANY: Continuing objection.

10 A. True.

11 Q. Is there literature that you can point me to that would
12 indicate to me how long the Staph aureus bacteria can live in
13 the bloodstream before it sets up shop somewhere?

14 A. No.

15 Q. Have you treated people with Staph aureus?

16 A. Yes.

17 Q. Did Mr. Johnson have Staph aureus bacteremia before it
18 became lodged in the muscle of the left ventricle?

19 MR. KWARCIAANY: Objection.

20 A. Probably.

21 Q. More likely than not?

22 A. True.

23 Q. It was in his bloodstream, we established earlier?

24 MR. KWARCIAANY: Objection.

25 A. True.

1 Q. So let me ask again, I'm not sure if you said yes or
2 no, have you treated people with Staph aureus bacteremia?

3 A. Yes.

4 Q. Nonfocal, in other words, not setting up shop somewhere
5 and causing an abscess?

6 A. True.

7 Q. And when you treat them, do you do so in the manner
8
9
10

11 MR. KWARCIAANY: Objection.

12 A. You know, I don't know that I've ever looked at .my own
13 personal series to know what the cure rate is.
14
15
16
17
18
19

20 Q. I know you hope not, but do you have a good idea in
21 your head if they were significantly less?

22 MR. KWARCIAANY: Continuing objection.

23 A. No, because as you start that exercise, you have to
24 recognize your inability to know with certainty. And if I
25 treat people with Staph aureus bacteremia who have other

1 medical problems that predispose them to have these foci that
2 I can't diagnose, my cure rate will be a lot less. But if I
3 treat healthy, otherwise normal people who have Staph in
4 their bloodstream, yes, I would anticipate that. That's why
5 I say my own series I'd have to look at.

6 Q. Focade, F O C A D E?

7 A. F O C I, plural of focus.

8 MR. KWARCIAANY: You didn't take Latin, did you?

9 MR. DEMSEY: I thought he said focade.

10 MR. SPISAK: Foci.

11 MR. DEMSEY: I thought I heard focade, that's
12 why I spelled it C A D E.

13 A. Is that a word?

14 Q. I didn't think so, that's why I was asking, because I
15 hadn't heard it before.

16 Did Mr. Johnson have risk factors for the Strep A, I'm
17 sorry, the Staph aureus, to set up shop in his body once it
18 got in there? Can you tell if there's a person who's got a
19 certain predisposition if something like this gets in their
20 body, was he a candidate for this bug to set up shop?

21 A. No.

22 Q. Why not?

23 A. Because he didn't have any of those classical risk
24 factors.

25 Q. What about his cardiac history?

1 A. Hypertension?

2 Q. Take a look at his EKG from November 2.

3 A. Okay.

4 Q. You're familiar with it?

5 A. Yes. We can look at it?

6 Q. Yeah, if you could. What did it show, and do you agree
7 with it?

11 Q. Read the interpretation of that. You have to rely on
12 the interpretation because you can't interpret these, or you
13 don't, that's not within your area of expertise?

14 A. I'm not here to testify to those issues.

15 Q. Okay. Based on the fact that, assuming that he had
16 premature ventricular contractions, sinus tachycardia, and
17 abnormal changes that may possibly be due to myocardial

18

20 A. No.

21 Q. Can you clarify what you said earlier?

22 A. I said infarct, I think I said infarct. I think I said
23 myocardial infarction, but maybe I didn't.

24 Q. Would ischemia be a risk factor?

25 A. No.

1 Q. Why not?

2 A. Because it isn't.

3 Q. Can you tell me why ischemia isn't? I don't mean to be
4 disrespectful by asking you again, I'd just like to know the
5 medical reason for that.

6 A. Sure. The answer, without being too facetious, is
7 there's some things I consider God questions, you know, there
8 are rules we follow, one of them is ischemia is not a risk
9 factor for infection from Staph aureus. If we say
10 infarction, cell death, necrosis, yes, that's a risk factor.

Q. So --

A. But it also has to be acute.

Q. Meaning?

14 A. Meaning you're having an acute infarct in your heart.
Let's say, I won't use you as an example, let's say I'm
sitting here.

17 Q. Just say a person.

18 A. Let's say a person has a heart attack today; right now
19 there is a damaged area in the heart which we could all see
20 if we actually took their heart out and looked.

21 Q. It's permanent?

22 A. No, that's an acute injury. Three months from now that
23 acute area is healed, it's got a scar, it is no longer a risk
24 factor for infection because it's now scarred, there's no
25 area there that's a predisposing factor.

1 **3.** Didn't you say earlier that that scar tissue provides
2 nooks and crannies, or did you mean scar tissue under
3 different circumstances?

4 A. Under different.

5 Q. Which, for example?

6 A. Arthritis, inflamed synovial joint.

7 Q. Jagged bony little mountain range, and crevices and
8 nooks and crannies and places for it to hide?

9 A. Right.

10 Q. But with cardiac muscle you wouldn't expect that
11 because it would be smooth?

12 A. True.

13 Q. No hiding places?

14 A. True.

15 Q. When you said scar tissue, that's where I got thrown
16 off.

17 A. Got it.

18 Q. So as I understand it, then, Mr. Johnson was not one of
19 those risks, somebody predisposed to Staph once in the
20 bloodstream, finding a nook and cranny and setting up shop,
21 based upon your review of his record. and based upon your
22 review of the autopsy?

23 A. Prior to his terminal event, true.

24 2. Why did it set up there, again, once it went through
25 his bloodstream, why did it pick that spot, not that it was a

1 conscious decision?

2 MR. KWARCANY: Objection, asked and answered.

3 A. I believe he had a myocardial infarction there.

4 Q. When?

5 A. When he came in.

6 Q. When do you believe he had his myocardial infarction?

7 A. Within 24 hours prior to his arrival.

8 Q. And what did that do anatomically first, and then
9 second, what did it do anatomically as it relates to Staph
10 aureus coming in and doing its nasty thing?

11 A. I think what happens initially is you have an area of
12 dead muscle, that's what an infarct is, it's not getting
13 blood into it. That area of dead muscle then begins to
14 necrose and that pathology is evolving over hours. At some
15 point, Staph aureus arrives into this abnormal area of tissue
16 death and begins turning that area of infarct or death into
17 infected dead tissue.

18 So there are two things that are going forward, the
19 pathology of dead heart muscle, which is heart attack,
20 myocardial infarction, and infection on top of it. And the
21 infection causes that area to liquefy over a matter of hours.

22 Q. Becomes the pussy --

23 A. Becomes an abscess, which then dictates the pathology
24 in that site, and then when it ruptures, that is a fatal
25 event.

1 Q. Is there literature that supports that?

2 A. I'm sure there is.

3 Q. You're not aware of any off the top of your head?

4 A. I am aware that there is literature that says
5 myocardial abscess rupturing is a fatal event, it's almost
6 never diagnosed.

7 Q. Are there risk factors for myocardial abscess, such
8 that we can try and prevent it?

9 A. Drug abuse, injecting drug abuse.

10 Q. You misunderstood my question.

11 A. I'm sorry.

12 Q. Well, actually, maybe you didn't, I think I asked two
13 questions wrapped into one.

14 You're saying that people who are intravenous drug
15 users are at risk for myocardial abscess?

16 A. Yes.

17 Q. The reason for that being that they're more prone to
18 introduce Staph aureus into the body?

19 A. True, bloodstream.

20 Q. Staph aureus bacteremia comes about, it's something
21 that people who are intravenous drug users get?

22 A. They can.

23 Q. Any evidence that Mr. Johnson was an intravenous drug
24 user?

25 A. Yes.

1 Q. What evidence is that?

2 A. The autopsy on the lung.

3 Q. On the lung?

4 A. True.

5 MR. DEMSEY: Colleen, is this funny?

6 MS. PETRELLO: No.

7 MR. CEMSEY: Are you surprised to hear this?

8 MS. PETRELLO: No.

9 MR. DEMSEY: You're laughing.

10 MS. PETRELLO: I'm just smiling, I like to
11 smile.

12 MR. DEMSEY: A man died who had a wife and
13 child, and I don't think it's funny.

14 MS. PETRELLO: Ask your questions, Richard.

15 Q. What evidence on autopsy is there of intravenous drug
16 use?

17 A. Well, there's a note in his autopsy that he has talc
18 foreign body granulomas. I'm reading from the autopsy.

19 Q. Please.

20 A. This is the microscopic description of the respiratory
21 system. It says, "Scattered through the entire lung tissue
22 there are foreign body giant cells which under polarizing
23 lenses show talc crystal. This is seen in all the sections
24 of the lung." Then it goes on to say, "No evidence of
25 pneumoconiosis is present."

1 Q. Was that subjected to some other pathology to determine
2 what it was, or is it strictly what it says it is? Can you
determine what that comes from, or can the coroner determine
4 what that came from?

5 A. Well, let's be very clear about this. I believe the
6 question was is there evidence, I answered yes. I'm not
7 saying that I know this to be true. This finding in his lung
8 of talc crystals scattered throughout the lung is a common
9 finding with people who use intravenous drugs, because talc
10 is frequently used to, the term that's used is "cut" in
11 quotation marks, heroin, morphine, or other substances, as
12 another powder.

13 Q. Talc is a powder?

14 A. Right.

15 Q. Is that the powder that they're referring to, is that a
16 powder, that talc?

A. Let me explain. Talc is a material that comes in
18 different types of form. Talc is what is used to line
19 surgical gloves so you could slide them onto your hands
20 easily. One of the problems with that is it got into
21 people's bodies and they got talc reactions.

22 Q. Allergic?

23 A. Not allergic. Your body says, what's this doing here,
24 it's foreign, and it tries to surround it and tries to get
25 rid of it as a foreign invader in the lung.

1 Talc can get into the lung one of two ways; one is you
2 can inhale it, you work in an area where you're around talc,
3 that's an occupational disease. The other way is it goes
4 through your bloodstream because it's traveling there because
5 it's being injected.

6 The fact that it's in all the lung fields says that
7 it's going through the bloodstream. The fact that the
8 pathologist comments specifically after writing that about
9 the talc, "No evidence of pneumoconiosis," pneumoconiosis is
10 a description of occupational lung disease of a number of
11 types, suggests that the pathologist is suggesting this is
12 not airborne, this isn't inhalational.

13 Q. Isn't inhalational?

14 A. Isn't. That's my interpretation of what I see being
15 written here from my background, expertise.

16 Let's also be very clear. I answered the question
17 based on my background as an infectious disease person who
18 has dealt with Staph aureus and infections related to
19 injecting drug use, I'm not holding myself out as a lung
20 pathologist. A lung pathologist will be able to look at this
21 and answer the question, if asked, do you think this was
22 inhalational or hematogenous, meaning through the blood.

23 It's my interpretation of what I see, which I'm
24 entitled to my opinion, that what I see there suggests that
25 it was hematogenous.

1 Q. Through the blood?

2 A. And I have no other way to know other than seeing that,
3 why that should be there, and it is not pathology that would
4 occur within hours, that requires a chronic host response.
5 It could have been decades ago, it could have been years ago,
6 but it speaks for itself that it's there.

7 Q. Does that leave -- well, if it was decades ago, let's
8 say when he was a teenager, certainly that might explain the
9 absence of needle sites, right?

10 MR. KWARCIAANY: Objection.

Q. If it was years ago?

A. We're not assuming that he doesn't have needle sites, I
13 just don't know that it's true or not. In your scenario,
14 that's conceivably true, yes.

15 Q. The coroner did not -- if the coroner is noting the
16 difference as to whether or not it's airborne and
17 occupational versus -- what's the term again for injected?

18 A. Injecting hematogenous.

19 Q. Hematogenous, airborne versus hematogenous. Your
20 interpretation is that it's hematogenous versus airborne.
21 You're wondering in your own mind was the coroner who was
22 looking at this thinking that this may be there due to
23 intravenous drug use as opposed to occupationally inhaled?

24 A. No, I'm not, I don't know whether he thought anything
25 more about it other than to say that's what he saw, I Just

1 don't know.

2 Q. There's no other explanation for it, hematogenously?

3 A. That I'm aware of.

4 Q. That you're aware of?

5 A. In this man, no.

6 Q. In other people?

7 MR. KWARCIAANY: Objection.

8 A. Not that I'm aware of.

9 Q. I just ask other people because you said in this man.

10 The coroner's report shows no evidence of needle
11 marks?

12 A. Not that I'm aware of.

13 Q. So assuming -- you say my scenario is plausible that if
14 he was one who got talc into his system through his
15 bloodstream, you said it could have been decades ago, how
16 does that relate to what happened to him, is there some --

17 MR. KWARCIAANY: Objection.

18 Q. -- is there a relationship?

19 MR. KWARCIAANY: Objection.

20 A. The question started was, I forget exactly, you asked
21 me something about --

22 Q. I'll think of it in a second.

23 MR. SPISAK: Question was any evidence of drug
24 abuse.

25 MR. DEMSEY: No, no, it was before that. What I

1 asked him was are certain people predisposed, and he
2 said intravenous drug users.

3 THE WITNESS: Right.

4 MS. PETRELLO: Then you asked if there was any
5 evidence if he was.

6 MR. DEMSEY: Notice everybody chimes in bad
7 conduct by the plaintiff, how they all wake up.

8 MS. PETRELLO: Nobody said it was bad conduct.

9 MR. DEMSEY: Colleen's smiling, Dale's smiling
10 over here.

11 MS. PETRELLO: You're reading a lot into this.

12 Q. Go ahead, I asked if there was a predisposition --

13 A. That's how we got there.

14 Q. -- to the bacterial pericarditis due to Staph aureus
15 setting up shop, you said intravenous drug users may have a
16 predisposition. I asked is there evidence of -- I asked you
17 if there was evidence of intravenous drug use, you told me
18 what the talc meant to you, and said, look, I'm not an expert
19 in this area, but this is just my reading, you'd have to ask
20 a pulmonary specialist about that.

21 A. True.

22 Q. You don't hold yourself out as an expert in that area?

23 A. True.

24 Q. You don't plan to offer opinions to a reasonable degree
25 of medical probability about that subject?

1 MR. KWARCIANY: Objection.

2 A. if you ask me the question, is there evidence in this
3 case of injecting drug use, I would answer that, that finding
4 on the pulmonary pathology would raise the question for me.
5 The answer to your question, yes, that would raise a
6 suspicion to me, I would testify to that, yes.

7 Q. That there's a suspicion?

8 A. Yes.

9 Q. Is it a probability, possibility?

10 MR. KWARCIANY: Objection.

11 Q. You're saying there's a possibility this man was a
12 intravenous drug user --

13 MR. KWARCIANY: Objection.

14 Q. -- or are you saying it's probable that he was?

15 MR. KWARCIANY: Objection.

16 A. I don't know, to that question.

17 Q. And did the talc as found in his lung fields, as you
18 have **just** indicated to us, on autopsy, or whether or **not** he
19 was at any time in his life an intravenous drug user, to a
20 reasonable degree of medical probability, cause his death?

21 MR. KWARCIANY: Objection to the form, go ahead.

22 MS. PETRELLO: Objection as well.

23 MR. SPISAK: Would you kindly --

24 Q. Was it a little --

25 A. I think I got it.

1 MR. SPISAK: If you're going to answer it,
2 Doctor, I'm going to ask that it be read back.

3 (Record read.)

4 MR. KWAKCIANY: Objection.

5 MS. PETRELLO: Same here.

6 A. If the talc found in his lung at autopsy is a
7 manifestation of active injecting drug use, then that's how
8 Staph aureus got into his body. Staph aureus caused the
9 infection in his heart, and the infection in his hear-, led to
10 his immediate death. Therefore, there are many who would say
11 the answer to that question is yes.

12 Q. Who are the many who would say?

13 A. I think many reasonable people hearing that scenario
14 would come to the conclusion that it caused his death, as you
15 asked me, I think you asked me cause.

16 Q. How is intravenous drug use responsible for getting
17 Staph aureus into his body?

18 A. Because we know that individuals who are injecting drug
19 users, Number one, have a higher likelihood of carrying Staph
23 aureus on their body all the time, not just transiently.
21 Number 2, we know that the majority of injecting drug users
22 are not using what we would consider to be sterile technique
23 in terms of this process, and therefore, in the mechanics of
24 injecting one's veins with nonsterile fluids and liquids
25 through skin carrying Staph aureus, that they are introducing

1 Staph aureus directly into their bloodstream in the process
2 of using intravenous drugs.

3 Q. Is there anything in his blood tests of November 2,
4 1996 that would indicate that he was an intravenous drug user
5 or that he had any kind of drugs in his system?

6 MR. KWARCIANY: Objection.

7 A. There is no toxicology that I saw. Based on the labs I
8 saw, I don't find anything that would suggest that.

9 Q. Was there anything on the November 23rd labs that they
10 ran on him when he came in crashing, so to speak, that would
11 indicate that he was using drugs or had drugs in his system?

12 MR. XWARCIAWY: Objection.

13 A. With the absence of a toxicology report, the answer
14 would be no, I didn't see anything.

15 Q. And you saw nothing on the autopsy to indicate needle
16 sites, whether it be in the legs or the arms or wherever?

17 A. True.

18 Q. But you are telling me that the use of a needle can
19 lead to Staph aureus being introduced into the bloodstream?

20 A. Yes.

21 Q. The only evidence you have that needles were placed
22 into his body would be his blood work on November 2, this is
23 prior to November 23rd, and the Toradol shot at Elyria
24 Memorial Hospital on November 10?

25 MR. KWARCIANY: Objection.

1 MS. PETRELLO: Objection.

2 A. Now we're skipping from out of context here.

3 Q. I'm asking if there's any evidence you have of needles
4 in his body?

5 A. We used the term "needles" discussing intravenous drug
6 use.

7 Q. I understand.

8 A. Then we moved to the use of needles in the medical
9 arena, which is not associated with the introduction of Staph
10 aureus into the bloodstream, other than to have answered
11 previous when asked that anything is possible.

12 Q. So possibly it could have come in that way?

13 MR. KWARCIAANY: Objection.

14 MS. PETRELLO: Objection.

15 A. Anything is possible.

16 Q. Are you able to state to a reasonable degree of medical
17 probability that Mr. Johnson's death, I'm not: talking about
18 what other people would. say in other professions, I'm just
19 talking about you, what you are able to do, are you able to
20 state within a reasonable degree of medical probability that
21 his death was the result of intravenous drug use?

22 MR. KWARCIAANY: Objection.

23 A. No.

24 Q. And why not?

25 A. Because other than the pathology in his lung, the

1 answer to the question was never asked, that I could find.

2 Q. As I understand it, getting back to my question, was
3 there any evidence of, you're saying sure, look at this talc,
4 that's evidence of, in my mind, Dr. Blinkhorn's mind,
5 evidence of prior intravenous drug use, which could have been
6 decades ago, I don't know when.

7 MR. KWARCANY: Objection, asked and answered.

8 A. If I'm the doctor taking care of him, and you can stop
9 me if you don't want me to answer that --

10 MR. KWARCANY: Doctor, **just** answer the
11 question.

12 A. If I *see* that result in a man who dies with a Staph
13 aureus myocardial abscess hitting him like lightning, I'd
14 say, you know what, I wonder if this is unknown intravenous
15 drug use, and there's two ways to answer that question other
16 than sitting here at a table. I go to my pathologist and
17 say, I want you to review those slides again, does that look
18 to you like the talc we see in the bloodstream from injecting
19 drug use? And then we decide if we raise the question with
20 the family to ask if they were aware of any injecting drug
21 use, because the family may also wish to know what happened
22 to him.

23 Q. Did you see anything in his ongoing chart, his
24 treatment with Dr. Naeem, to suggest he was a noncompliant
25 patient?

1 A. No.

2 Q. Did you see anything to suggest that he was an IV drug
3 user?

4 A. I never saw the question asked.

5 Q. Understood. But there can be other signs and symptoms
6 of IV drug use, people abusing substances do show --

7 A. They can, many don't.

8 9. Ask an alcoholic if they drink, they're probably going
9 to tell you no, you know what I'm getting at? So just
10 because the question wasn't asked, I'm asking you from an
11 objective as opposed to subjective standpoint, whether you
12 saw anything pre-autopsy to suggest that Mr. Johnson used any
13 substances illegally?

14 MR. KWARCIAANY: Objection.

15 A. Short of never seeing that question specifically, no.

16 Q. And that question specifically would be a subjective
17 response, if it was asked, do you do A or B?

18 4. True.

19 2. A person could say yes, they could say no.

20 4. True.

21 2. No matter what they say to you as a doctor, the
22 objective findings are what you're going to rely on.
23 Certainly you rely on your patient to an extent, but the
24 objective finding would give you information, true?

25 A. Sure.

1 Q. My question is whether you saw anything objectively to
2 suggest that prior to November 23rd?

3 A. Short of seeing that to be consistent, my answer is no.

4 Q. You said he had a myocardial infarction within 24 hours
5 of his death?

6 A. I think.

7 Q. Do you hold that opinion to a reasonable degree of
8 medical probability?

9 A. Yes.

10 Q. Basis for that?

31 A. The records.

12 Q. Right, but anatonically, why do you think that he had a
13 myocardial infarction 24 hours before his death, what is it
14 in the records that tells you that there was an MI?

15 A. Sure.

16 Q. Is this --

17 A. I'm looking for the emergency room,

18 Q. Of November 23?

19 A. Yes, please. There was a note there, said he had an
20 episode similar the night before that went away, so the
21 records will be clear of where I saw that. Here we are.
22 Mine aren't numbered, I don't know if yours are numbered. I
23 believe the top says Lorain County EMS Report Form. Does
24 this look familiar, this is what I'm trying to --

25 Q. 'That's the transport.

1 A. That's what this is, it's the so-called run sheet.

2 MR. KWARCIAANY: Ambulance run sheet.

3 THE WITNESS: Right?

4 A. "Event," it says on one of the lines on here, there's
5 other things here, obviously, events preceding call, that's
6 the standard form. Then it says "Patient at Dr. Naeem's
7 office for TX, treatment, on groin pull and became SOB, short
8 of breath. Patient states this happened yesterday also, but
9 went away with rest." so that's the first thing that caught
10 my eye.

11 Q. May I take a look at that?

12 A. Yes, sure. The second thing that I used to support
13 that is the pathology of myocardial infarction within the
14 initial hours is generally normal, that if I have a heart
15 attack right now and fall out of this chair on the floor, God
16 forbid, and they look in my heart, they won't see anything
17 wrong with it. They might find a coronary artery blocked,
18 but they won't see pathology, because it takes hours for the
19 body's response to tissue death to set, up and. show a change,
20 all right.

21 There's change in his autopsy in the heart that
22 suggests infarction. It's interpreted as such on his death
23 note and that's the interpretation of the event. So if you
24 take those two things together, you say this happened many
25 hours before he is actually dead.

1 Q. Could have been three hours, could have been 24 hours?

2 A. It would be more than three. My time frame, as I've
3 said, is I think it's within 24 hours. I think the event the
4 night before was probably, given the way this unfolded,
5 obviously I have the benefit of hindsight to look at this,
6 not like if I'm standing there with him that night, looks to
7 me that that's what unfolded.

8 The other thing here is this: This is the emergency
9 room form, I didn't think that was it, this actually has the
10 note also on the nursing notes that says, something to bed
11 with shortness of breath since yesterday, so --

12 Q. That's on the November 23 pursing note?

13 A. It's this one, this says at the top, EMH Regional
14 Medical Center, check ambulance and something is written in
15 there, but I have to admit, I'm not sure what they said, and
16 the date on here is November 23, '96 at the bottom.

17 (Plaintiff's Exhibits 4 and 5 marked.)

18 Q. Let me jump back to the question of IV drug use. If he
19 was an IV drug user 20 years ago, does that give the same
20 mode of entry into the body, or would you say it probably
21 came from something else, in other words, if he was not using
22 intravenous drugs?

23 MR. KWARCANY: Objection.

24 A. If there is a remote, years ago, quit, history of drug
25 use, then obviously he's not introducing the drug, the

1 organism, via injecting drugs. He may as a result be a Staph
2 aureus carrier, but then that doesn't, other than being a
3 Staph aureus carrier, doesn't contribute to the acute events.

4 Q. Again, how it got in, we're going to get back to that,
5 who knows, anything is possible?

6 MR. KWARCIAANY: Objection.

7 A. I think what I've testified to is that I believe it's
8 impossible to know exactly how it got in.

9 Q. You do?

10 A. I think.

11 Q. What is ischemic cardiomyopathy, do you know?

12 A. It describes, generally, a problem with the heart where
13 the heart's pump function is impaired due to inadequate blood
14 flow.

15 Q. Can that be a contributing factor to Staph aureus
16 setting up shop in the heart?

17 A. No.

18 Q. Why not?

19 A. It is not one of the cardiac abnormalities that
20 predisposes to bacterial infection of the heart.

21 Q. But if there is some scar tissue or abnormality in the
22 heart and you have this ischemic cardiac myopathy, is the
23 blood-borne bacteria conceivably going to have a better
24 chance to set up there?

25 MR. KWARCIAANY: Objection.

1 A. No.

2 MR. KWARCIANY: We actually went through this
3 about a half hour ago.

4 MS. PETRELLO: We did.

5 MR. DEMSEY: Not in the face of ischemic
6 myocardiopathy.

7 MR. KWARCIANY: We were talking about ischemia
8 in the heart, it's the same subject, Richard.

9 A. Because there's not, the abnormalities that lead to
10 infection in the heart are either an acute inflammatory
11 process or underlying valvular abnormalities such that blood
12 doesn't flow through smoothly.

13 Q. You told me he didn't have that, okay. Inflammatory
14 process leads to infection in the heart, is that what you
15 just said?

16 A. If you have an acute inflammatory process triggered by
17 infection, viral pericarditis, that's a focus of abnormal
18 tissue. That can set up, that can be a focus for bacteria to
19 land on and cause infection.

20 Q. Any evidence that he had that?

21 A. No.

22 Q. What about inflammation of the heart?

23 A. We're talking about now myocardial infarction. I
24 thought, we were talking about ischemic cardiomyopathy.

25 Q. I thought you were talking generally about anything

1 that could inflame the heart tissue, and I wasn't sure that
2 we were breaking it down here.

3 A. So we're on the same page, true, as he comes in with
4 myocardial infarction he has an area of abnormal tissue. I
5 believe as we already went through, the Staph aureus lands
6 there then and this pathology plays out. That's dead tissue.

7 Ischemic cardiomyopathy is a muscle that's not
8 functioning well because it's not getting enough blood to it.
9 Here's an example: You go out and you start running a mile.
10 After a while your muscles tire out because they're not
11 getting enough blood. Your muscles are not abnormal, they're
12 just not getting enough blood flow. Let's say while that's
13 happening you fall down because you're weak and you bruise
14 your muscle. Now you have an area of abnormality in the
15 muscle.

15 That muscle may over hours become compromised. Parts
17 of that muscle may die, let's say, because you fell down, you
18 scratched your knee, and you're a Staph carrier. Staph
19 aureus goes through your bloodstream. There is an area of
20 acute tissue change, boom, you're at risk for abscess.

21 But let's say you're running along, your muscles hurt,
22 and I come running next to you and say, this is a good
23 experiment, I'm going to shoot Staph aureus in your
24 bloodstream, just don't fall down. Will it land in your
25 muscle because you're tired? No.

1 Q. So the heart has to be compromised. You say it was due
2 to an MI?

3 A. I didn't say compromised, there has to be tissue
4 injury.

5 Q. Any other scenario where his tissue could have been
6 injured in the two weeks before?

7 A. In his heart?

8 Q. In his heart.

9 A. Not that I'm aware of.

10 Q. What are other examples besides myocardial infarction
11 where the heart could be compromised to the point where it
12 would be prone to attack by the Staph aureus?

13 MR. KWARCIAANY: Objection.

14 A. Valvular disease.

15 Q. That you told me about and he didn't have?

16 A. Right.

17 Q. What else?

18 A. If you had holes in the heart, so-called septal
19 defects, where there's abnormal flow between chambers, that
20 would be one. If you had somebody who had a viral infection
21 and got pericarditis, inflammation around the heart, those
22 could be complicated by bacterial pericarditis because of the
23 inflammation and the bacteria landing there.

24 Q. When did he develop his focal acute myocarditis?

25 A. Within the 24 hours prior to admission.

1 Q. What is focal acute myocarditis?

2 A. I believe that's a description representing the
3 pathology of infarction and infection.

4 Q. What about his myocardial fibrosis, when did he develop
5 that?

6 A. Fibrosis? Fibrosis means scar that's been there a long
7 time.

8 Q. How did he get it?

9 A. How did he get that? That's part of his ischemic
10 cardiacmyopathy or it's his hypertensicn.

11 Q. But you don't believe that those are focal sites for --

12 A. They aren't.

13 Q. -- Staph aureus?

14 A. They aren't.

15 Q. His pericardial effusion was the fluid around the
16 heart?

17 A. True.

18 Q. Was that in existence longer than 24 hours?

19 4. No.

20 Q. Pre-death?

21 4. That was happening as a terminal event.

22 2. Why do you say that?

23 3. All right.

24 Q. This is fluid that's in the pericardium?

25 A. Correct. All right, first of all, understanding

1 anatomy, the heart has to hang in the center of your chest,
2 if you think about it. The only thing that supports it is
3 the blood vessels coming out of it. And you have this pump,
4 depending on one's activity, it's pumping 60 or more times a
5 minute, once a second, it's hanging there. Now, that's not a
6 very good way to support the heart, so you have to have
7 something around it, and you have a lining, it's called the
8 pericardium. It's a sac, like a balloon. We think of the
9 heart as a balloon inside of a balloon. That's there because
10 it gives some support, and also, if you look at the inside of
11 that, it is a glistening, smooth, slippery surface.

12 Q. Like the synovium?

13 A. Well, sort of, but it's thinner. So that when the
14 heart beats and opens and opens and beats, it slides along
15 that tissue without any irritation. That lining around the
16 heart sits very closely to the heart. So it's known, there's
17 a potential space there, but there's not really a space
18 there.

19 Q. Very small?

20 A. It's so small that you would have to tease it off to
21 see that there's a space. Now, anytime something enters into
22 that sac around the heart acutely, the sac doesn't have a
23 chance to swell out and compensate for that because it's
24 sitting there between your lungs, so the only place for that
25 pressure to go is into the heart. Now the heart can't fill

1 with blood, it can't pump blood, it starts doing this kind of
2 stuff, where it's pumping faster, faster, faster, no blood's
3 getting in, and you die.

4 Acute amounts of fluid in that space, which can be very
5 small, do you in; but if it happens slowly over time, like
6 some disease states, you can have hundreds of cc's in there,
7 hundreds of milliliters of fluid, and you seem to be okay.
8 But you put 20 cc's in there, which is like a tablespoon —

9 Q. Suddenly?

10 A. -- suddenly, and you're in big trouble. And if it's
11 infection that goes in there, you don't survive.

12 Q. Why do you say his pericardial effusion, the hundred.
13 cc's, was acute?

14 A. Because it was pus, and there was rupture of the free
15 wall into that. And he had an event at the very end that was
16 called EMD, electromechanical dissociation. That means there
17 was electrical activity on his EKG suggesting his heart was
18 beating, but nothing was coming out of it. And in the
19 approach to EMD, is there fluid around the heart, that is, in
20 the approach to this, in goes the needle to say this man's
21 dying, it's EMD, stick a needle in there, see if blood comes
22 out, because if it's blood he might survive, if they pull out
23 pus --

24 Q. Because the abscess has already taken — I'm sorry, the
25 rupture of the abscess?

1 A. Yes.

2 Q. You don't believe he had any preexisting effusion
3 causing any kind of strain on the heart prior to --

4 A. That event?

5 Q. -- that event?

6 A. No.

7 Q. It was strictly a rupture of the abscess that led to
8 the hundred cc's of fluid?

9 A. That's what I'm thinking.

10 Q. This was consistent with this process?

11 A. You then have this intense inflammatory response and
12 fluid is pouring in there.

13 Q. How about his cardiac hypertrophy, what is cardiac
14 hypertrophy?

15 A. If you have hypertension, longstanding high blood
16 pressure, the heart has to pump out against a resistance.
17 You have to squeeze out against a high pressure. This is a
18 muscle. If I say to you, you have to lift this weight every
19 day, eventually this muscle gets pretty big. That's what
20 happened with the heart over time, it thickens, it thickens
21 in order to be able to do the load of pumping against a high
22 resistance every single day, day in, day out, for years. So
23 hypertrophy means enlarged muscle.

24 Q. How long do you think he suffered from cardiac
25 hypertrophy?

1 A. If he has hypertrophy as a result of hypertension by
2 definition, 'ne's had it for years, many years, more than 10.

3 Q. Is that one of the risk factors for a heart attack?

4 A. Hypertrophy, no. It's atherosclerosis that we're
5 interested in.

6 Q. And he had severe atherosclerosis?

7 A. That's what we find at autopsy.

8 Q. Did you see any workup on him as to his coronary artery
9 disease by Dr. Naeem?

10 A. He got an EKG and he got a history.

11 Q. Do you believe Dr. Naeem should have done more after
12 seeing that EKG?

13 A. That's where I'm drawing the line here, I'm here to
14 testify about the infectious disease aspects of this case.

15 Q. Okay. So you're not going to comment on whether or not
16 Dr. Naeem should have done more when he had the EKG?

17 A. True.

18 Q. Or when he got the blood work back?

19 A. True.

20 Q. That would be outside your area of expertise?

21 A. True.

22 MR. DEMSEY: Since they have some questions, not
23 to hold this up, I want to look through my notes, I may
24 have some more, why don't you go ahead, Colleen,
25 please.

1 MR. SPISAK: Do you want me to go first?

2 MS. PETRELLO: You can.

3 EXAMINATION

4 BY MR. SPISAK:

5 Q. Doctor, I don't think I have many questions by way of
6 follow-up. I want to go back to some of the questions that
7 were being asked about a patient who has -- let me just find
8 my notes here. We talked in terms if a patient had a Staph
9 aureus bacteremia without a clinical focus, and then you
10 talked about treatment that would be rendered, et cetera, et
11 cetera, and cure rates. Do you recall that general context?

12 A' Yes.

13 Q. Here's my question: If a patient did have a Staph
14 aureus bacteremia, I trust, if I understood you correctly,
15 that that patient would manifest clinically a pretty
16 seriously ill patient; would he not?

17 A. I would expect that he would have symptoms.

18 Q. Okay. You wouldn't expect him to be asymptomatic, I
19 would. assume?

20 A. No.

21 Q. Certainly, if we look at Mr. Johnson's situation and if
22 we look at, say, a week to two weeks prior to his death, we
23 had no such indications in his situation, did we?

24 A. Of infection?

25 Q. Yes.

1 A. True.

2 Q. We don't know from the records whether Mr. Johnson had
3 a fever or didn't have a fever on November 10, correct?

4 A. Do I need to look?

5 Q. Take my word for it for the sake of my question, let's
6 assume that we don't know one way or the other.

7 A. I don't have an independent recollection of the
8 records, but --

9 Q. 'That's fine. If hypothetically, however, he did have
10 an infection, knowing everything else that we know, it cannot
11 be said with any certainty, can it, that that infection was
12 the result of a Staph aureus infection?

13 MR. KWARCIAANY: Do you understand the question?

14 Q. Maybe that wasn't very clear. If he had a fever on
15 November 10, number one, does the mere fact that he has a
16 fever necessarily mean that he has infection in and of
17 itself?

18 A. No, not in and of itself.

19 Q. All right. But let's assume for the sake of my
20 question that he had a fever and that it was the result of
21 infection, okay. You can't say with any probability that
22 that infection was the result of a Staph aureus bug as
23 opposed to anything else, can you?

24 A. No.

25 a. I didn't think so, all right.

1 MR. SPISAK: That's all I have.

2 MS. PETRELLO: Well, he stole my thunder, so I
3 don't have too many.

4 EXAMINATION

5 BY MS. PETRELLO:

6 Q. If one has a fever, are there any symptoms or signs
7 associated with fever, other than the thermometer reading?

8 A. Well, some patients have a sensation of feeling warm,

10 a manifestation that they have chills. They may have sweats,
11 they may have what we had already said was rigors, where it's
12 a chill rather than sort of like goose bumps, you actually
13 shake. They may have other symptoms associated with the
14 fever that point to the focus of the infection, headache, for

16 pneumonia, joint swelling and pain for septic arthritis.

17 Q. You said that the patient may sense a feeling of being

19 they usually feel warm?

20 A. Yes.

True.

23 Q. Is there ever a time when you can have a fever and when

1 A. 'The end stage of septic shock is sometimes referred to
2 as cold shock. And people who have extremely low blood
3 pressure, on occasion those individuals will feel cold.

4 Q. Can you get flushed, red in the face, flushed feeling
5 if you have a fever?

6 A. Yes.

7 Q. Do these symptoms vary with the level of the fever, for
8 example, a 96 fever versus, let's just say a 103 fever?

9 A. Yes.

10 Q. The higher the fever, the more of a sign or symptoms
11 you would expect to see?

12 A. In general.

13 Q. Would you even expect to see any symptoms if you had a
14 fever of about 96?

15 A. Depends on the individual. Some people are very
16 sensitive to their temperature, the majority would not be.

17 Q. Am I correct in assuming that there's really no cutoff
18 or no fever number that you would say, okay, above a hundred
19 you're going to have symptoms, below a hundred you won't?

20 A. True.

21 MR. DEMSEY: What was that, there is not a
22 cutoff?

23 Q. There's no specific fever number or temperature which
24 you are reading, I should say. As a fever is coming
25 downward, for whatever reason, would you expect the person to

feel cold?

2 A. They usually are sweating.

3 Q. But they still feel warm?

4 A. People refer to that as, my fever broke, I had a
5 drenching sweat, and they're warm, and they throw off the
6 covers.

7 MS. PETRELLO: No further questions.

8 MR. DEMSEY: I promise I'll be brief.

9 RE-EXAMINATION

BY MR. DEMSEY:

Q. There was something on the autopsy I wanted to ask you
about, if you have that. Page 6 of 11 halfway down,
13 "Cardiovascular system continued while sectioning," do you
14 see that, "left circumflex at four centimeters from its
15 origin. Purulent fluid pours from the myocardial tissue from
16 a cyst-like cavity that measures 1.3 centimeters in maximum
17 dimension. The myocardial tissue around this cavity is
18 brownish, very soft and congested, and this area extends to
19 the pericardium." What are they talking about right there?

20 A. What does that mean? Abscess.

21 Q. Is that, the left circumflex artery, is that an artery
22 or is that the left ventricle that we're talking about, or is
23 this another area of abscess?

24 A. All right. Let me see if I can give you a picture.

25 Think of the left ventricle as an inverted cone or like an

1 ice cream cone, but a big fat one, okay. They're referring
2 to an artery, left circumflex. Then there's an artery that
3 comes down the middle called the left anterior descending,
4 just describes where it's moving, comes down over the top of
5 that inverted cone. Usually off of that is called the
6 circumflex artery. That artery comes off and it sort of
7 wraps around towards the backside of the ventricle.

8 Q. Where, the right, left?

9 A. Left, we're on the left now, forget the right. We
10 could bring a model out, but if you get the notion that you
11 have the LAD going down the front and circumflex starts
12 wrapping around the side reaching toward the back, towards
13 the RV, then there's also a right-sided artery, but that's
14 what they're describing. They're using the circumflex here
15 because that's where they found the abscess. If you don't
16 use the outside of the heart, there's no landmarks without
17 showing you a picture, so they're using the arteries to give
18 you a visual. It's not coming down the anterior wall, it's
19 coming around near the circumflex, so that gives a visual.

20 What he gets into here, first of all, he has a cyst-
21 like cavity, that means this is an abscess, and then adjacent
22 to this, which he says around this cavity is brownish and
23 very soft. Now he's describing muscle that is dying,
24 injured, necrotic. Muscle is normally red, beefy red, like a
25 steak. Muscle that is dead, dying, turns brown.

1 So what he's telling us here is an area of abnormal
2 muscle, which is brownish and soft, it's starting to become
3 mushy, and in the middle of that is this cavity which is the
4 abscess. So the picture I get when I see that is, here is
5 this area of mushy, dying muscle, in the middle of which this
6 infection is causing liquefaction of that abscess, out it
7 comes, and it's traveling with the pathology of infarction.
8 So you have the pathology of both right there.

9 Q. So the abscess is not in the left circumflex?

10 A. In the artery?

11 Q. In the artery.

12 A. No.

13 Q. I guess I'm confused, because it says, "While
14 sectioning the left circumflex four centimeters from its
15 origin, purulent fluid pours from the myocardial tissue." So
16 the myocardial tissue would be the LV?

17 A. Right.

18 a. That's where you say the abscess was?

19 A. True.

20 Q. Was it just coming out of the section of the left
21 circumflex?

22 A. No. See, the arteries are traveling just above the
23 muscle.

24 Q. Okay.

25 A. Not really sort of in them, but sort of like right on

1 the top. So they're coming down the heart here trying to
2 open that little, teeny artery to see what it looks like
3 inside, you know, is it blocked, can I actually find a clot,
4 can I find airway. Boom, all of a sudden a mushy area opens
5 right in front of them.

6 Q. If they did find abscess in the circumflex artery,
7 would that change your opinions?

8 A. Well, they can't.

9 Q. Because?

10 A. Well, we're talking about something traveling down the
11 side of the heart like a spaghetti noodle, that's about the
12 size of it. So right off the bat it's not a focus of
13 arteritis.

14 Q. Are you saying that the area of abscess was larger than
15 the artery itself?

16 A. Oh, yes. I think they're using that to tell us where
17 this is, because otherwise without a landmark you wouldn't,
18 you'd say LC free wall. Well, is that on the apex on the
19 free wall, lateral surface, anterior surface? I think he's
20 using that to tell us I'm traveling four centimeters from the
21 origin of this which is anatomically solid. He can put a
22 ruler down there and say four centimeters from here, boom,
23 there's an abscess. If he doesn't use that as a landmark,
24 you can't --

25 Q. I thought we were four centimeters up and he found

1 abscess there, but that's where he was when he observed, at
2 its focal site?

3 A. Right.

4 Q. Mr. Spisak asked you, let's assume that he had a fever
5 on November 10. You can't say with certainty that it was the
6 Staph aureus bug, and you said no, I can't?

7 A. True.

8 Q. Could it possibly have been the Staph aureus bug if you
9 had a fever?

10 MR. KWARCIAANY: Objection.

11 MR. SPISAK: Objection.

12 A. Yes, anything is possible.

13 Q. Do you know the standard of care for emergency
14 departments and/or emergency department physicians relative
15 to taking vitals when someone comes in? Must you take
16 vitals, is there a protocol for you to do that?

17 A. I'm not here to testify for the standard of care.

18 Q. Did you ever work in an emergency department?

19 A. In my training.

20 Q. Were you trained to take vitals if a patient came into
21 the emergency room?

22 MR. KWARCIAANY: Objection.

23 MS. PETRELLO: Objection.

24 MR. SPISAK: Objection.

25 A. As a medical student, have you been trained to take

1 vital signs?

2 MS. PETRELLO: Objection.

3 A. Yes.

4 Q. Were you trained to do it whenever a patient came into
5 the emergency room?

6 MR. SPISAK: Note my objection.

7 A. No.

8 Q. Are there times, is that because someone else would do
9 it?

10 A. There are circumstances where the vital signs are kind
11 of not very important at the time.

12 Q. Such as?

13 A. Shock, shot in the chest and no blood pressure, trauma,
14 I came in and my arm was broken in half. Those are some
15 examples where it might not be so important in the acute
16 phase to know.

17 Q. How about a person like Mr. Johnson who comes in and
18 says ,I got some right groin pain, and they give him Toradol
19 and it doesn't seem to help, give him 60 milligrams, doesn't
20 seem to help, would you want that person's vitals?

21 MR. KWARCIAANY: Objection.

22 MS. PETRELLO: Objection.

23 A. I'm not here to testify to the standard of care.

24 MR. SPISAK: That is the second time you heard
25 that.

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should have taken a temperature on November 2 as part of the physical exam?

A. Well, I have no criticisms of his care of Mr. Johnson.

Q. Standard of care --

Q. Standard of care calls for it to be done in a physical exam?

A. No.

Q. How about on follow-up visit after he knew that he had an elevated white blood count, albeit slightly above normal or low abnormal at twelve nine, or 12,900, should he have taken a temperature as follow-up to that?

A. Not necessarily.

Q. Whether or not the standard of care would have required him to do that, is that outside your area of expertise?

MR. KWARCANY: Objection.

A. Well, I have said I have no criticisms of his care. I see nothing in the record that indicated he needed to take his temperature.

1 MR. KWARCIAANY: We'll waive.
2 - - -
3 (Deposition concluded at 4:20 p.m.)
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CERTIFICATE

- - -

State of Ohio,)
)


County of Cuyahoga.)

I, Kristin A. Beutler, RPR, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, RICHARD J. BLINKHORN, JR., M.D. Was by me first duly sworn to testify the truth, the whole truth and nothing but the truth, in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the evenr. of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio on this 12th day of July, 2000.



Kristin A. Beutler, RPR, Notary Public
in and for the State of Ohio. My
commission expires Sepeember 26, 2001

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February 3, 2000

Dr. Richard Blinkhorn
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland OH 44109-1998

SUBJECT: E/O Mose Johnson v. Mohammed Naeem, M.D.
OUR FILE: 0228-40-97
DOCKET: Lorain County: 97-CV-118106

Dear Dr. Blinkhorn:

Thank you for advising that you are willing to review this matter on behalf of my client, Mohammed Naeem, M.D.

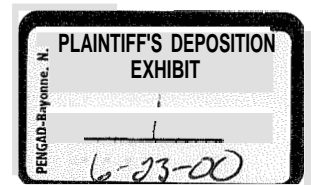
In order to assist you in your review of this claim, I am herewith enclosing:

1. Copy of report of Richard Watts, M.D.
2. Copy of report of Plaintiffs expert, Joel Zivot, M.D.
3. Copy of Plaintiffs deposition transcript.

As we discussed, I am interested in your frank and candid opinion regarding the care and treatment rendered by Dr. Naeem and whether or not that care and treatment met with accepted standards of care.

In addition, I am interested in ascertaining whether or not Plaintiff's current condition is in any way related to any of the treatment rendered (or not rendered) by Dr. Naeem. Any other comments which you wish to add would be most appreciated. If you feel you need additional records in order to fully, fairly and completely evaluate this claim, please advise and I will be happy to provide you with these records forthwith.

After you have had an opportunity to review these records and prior to the preparation of your written report, I ask that you please call me to advise your preliminary findings.



Subject: E/OMose Johnson v. Mohammed Naeem, M.D.

Page: 2

Yours Very Truly,

FIFNER & ASSOCIATES

A handwritten signature in dark ink, appearing to read "Douglas K. Fifner". The signature is written in a cursive, slightly slanted style.

Douglas K. Fifner

DKF:ds
Enclosure

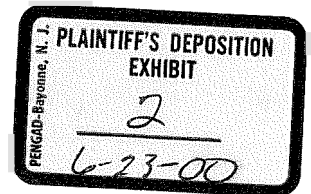
ATTORNEYS AT LAW

FIFNER & ASSOCIATES

DOUGLAS K. FIFNER
ELAINE S. FIFNER
DALE L. KWARCANY*
GREGORY J. COSTA

*ALSO LICENSED
MISSOURI
ILLINOIS

February 4, 2000



Dr. Richard Blinkhorn
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland OH 44109-1998

SUBJECT: E/O Mose Johnson v. Mohammed Naeem, M.D.
OUR FILE: 0228-40-97
DOCKET: Lorain County: 97-CV-118106

Dear Dr. Blinkhorn:

Thank you for reviewing the above-captioned case on behalf of my client, Mohammed Naeem, M.D. Enclosed for your evaluation are the following materials:

- ✓ 1. Autopsy Report and Death Certificate.
- ✓ 2. Office records of Dr. Naeem.
- ✓ 3. Elyria Memorial Hospital ER records dated 11/10/96.
- ✓ 4. Excerpts from the Elyria Memorial Hospital records for the patient's terminal admission of 11/23/96.
- ✓ 5. Report of Plaintiffs expert, Joel Zivot, M.D.
- ✓ 6. Report of Defendant's cardiology expert, Richard Watts, M.D.
- ✓ 7. Deposition of decedent's wife, Sandra Johnson.
- 8. Deposition of Defendant, Mohammed Naeem, M.D.

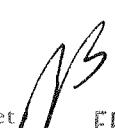
NO
NO
There are two issues I would like you to consider. First, was this patient's staph aureus pericarditis diagnosable before 11/23/96? Second, would earlier treatment of the pericarditis have averted this patient's death? Please call me after you have reached your tentative conclusions. Once again, thank you for your willingness to assist us.

Yours Very Truly,

FIFNER & ASSOCIATES


Douglas K. Fifner

DKF:ds
Enclosures

 FEB 08 2000

Johnson v Naem

ice
9/22/94

Sore throat, fever since 9/17
throat thrush → Amox
98°

HBP

3-8-95 B&C cold

Sinusitis → Bactrim

6-15 No show

6-20 F/U

9-8 F/U

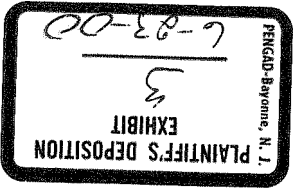
11-28 Bactrim → Bactrim

11-2-96 Periodic health exam

11-11-96 Pain R buttock - low back of R leg
Tender scapula neck SLRT pos. knee

ED - EMH

11/10/96 R hip pain x 6 dx



23-96 EMT

1215

since yesterday

Diaphoretic

38.5 139-36 $\frac{134}{64}$

ECG = Acute MI Rx: Lasix, Heparin, ASA, Lopressor

Streptokinase → CCA (1340)

WBC 40,800

TP 8.1

Cr 1.6

Alb 2.4

CCA: Intubated. CHB → V fib

EMD → CPR ~45 mins.

Pericard.ocentesis → copious purulent fluid

Echo = Severe LV dysfunction. Dilated LV EF 10%

ECG: ST elevation all leads.

Time of Death 3:35 pm

Eprou. ta : Sandra Johnson, wife

leg pain : No SOB. No sweat. No fever No chills.
No N. No V.

Nov 23 : Trouble breathing.
No chest pain.
No shoulder pain.

Went to Naeem's office ~ 1230
→ Ambulance to Hqy.

Spoke w / Ritner

* No hint beforehand → "lightning strike"

* Unfortunately doomed at onset w/
myocardial abscess rupturing into pericardium

PLEASE PRINT CLEAR
USE BALLPOINT PEN

Lora County EMS Report Form

SQUAD NAME Life Cue 94 ☐ BASIC ☒ ADVANCED ☐ PARAMEDIC
RUN # 96691 DATE 11-23-96
41648-5 De Naem Office E Board 324-6513
NUMBER (location of incident) STREET CITY PHONE
Johnson, Most T 44 9/8/52 286-50-9030 SEX ☒ M ☐ F
LAST (victim name) FIRST MID AGE/DOB SS#
41648 515 51 Elyria OH 44035
NUMBER (victim home address) STREET CITY STATE/ZIP
CHIEF COMPLAINT SOB
ALLERGIES NKA
MEDICATIONS Kelafen, Lasacet, N/A/VAC
PAST HISTORY Chin pull
EVENTS PRECEDING CALL At Dr Naem office for Tx on Chin pull and
became SOB. Pt states this happened yesterday also but went
PRIVATE PHYSICIAN Naem HOSPITAL away with most

CALL RECEIVED 1144
THROUGH CHD 911
DISPATCHED 1145
P.D. NOTIFIED ON SCENE
ENROUTE TO SCENE 1145
ARRIVED AT SCENE 1149
LEFT SCENE 1159
AT HOSPITAL 1202
LEFT HOSPITAL
MILEAGE 0
STARTING 54
ENDING 54
IN SERVICE
IN STATION

TIME	B.P.	PULSE	RESP.	O2 SAT.	TEMP	RESPIRATORY EXPANSION	MYA	SEATBELT WORN	PUPILS
<u>1150</u>	<u>100</u>	<u>143</u>	<u>44</u>	<u>87%</u>	<u>32</u>	<input checked="" type="checkbox"/> NORMAL <input type="checkbox"/> SHALLOW <input type="checkbox"/> RETRACTIVE <input type="checkbox"/> NONE	<input checked="" type="checkbox"/> MYA <input type="checkbox"/> AIR BAG DEPLOYED	<input type="checkbox"/> EXTRICATION NEEDED	<input checked="" type="checkbox"/> EQUAL <input type="checkbox"/> UNEQUAL
						BREATH SOUNDS <u>Clear</u>	Area of impact and location of patient		RIGHT <input type="checkbox"/> MIDPOSITION <input type="checkbox"/> DILATED <input type="checkbox"/> CONSTRICTED <input type="checkbox"/> REACTIVE <input type="checkbox"/> NON-REACTIVE
						<u>Bilateral fields</u>			LEFT <input type="checkbox"/> MIDPOSITION <input type="checkbox"/> DILATED <input type="checkbox"/> CONSTRICTED <input type="checkbox"/> REACTIVE <input checked="" type="checkbox"/> NON-REACTIVE

VERBAL RESPONSE	MOTOR RESPONSE	EYE OPENING	SKIN COLOR	SKIN TEMPERATURE	CAPILLARY REFILL
<input checked="" type="checkbox"/> ORIENTED <input type="checkbox"/> CONFUSED <input type="checkbox"/> INAPPROPRIATE <input type="checkbox"/> INCOMPREHENSIBLE <input type="checkbox"/> NONE	<input checked="" type="checkbox"/> ALERT <input type="checkbox"/> VERBAL <input type="checkbox"/> PAIN <input type="checkbox"/> UNRESPONSIVE	<input checked="" type="checkbox"/> SPONTANEOUS <input type="checkbox"/> TO VOICE <input type="checkbox"/> TO PAIN <input type="checkbox"/> NONE	<input checked="" type="checkbox"/> NORMAL <input type="checkbox"/> CYANOTIC <input type="checkbox"/> PALE ASHEN <input type="checkbox"/> FLUSHED <input type="checkbox"/> MOTTLED	<input checked="" type="checkbox"/> NORMAL <input type="checkbox"/> COOL <input type="checkbox"/> MOIST <input type="checkbox"/> HOT <input type="checkbox"/> DRY	<input checked="" type="checkbox"/> IMMEDIATE <input type="checkbox"/> DELAYED <input type="checkbox"/> JVD

COMMENTS Found Pt walking out of Examining Room to lobby. Advised
Pt to sit down while EMT was getting vitals. Pt very diaphoretic with resp.
at 44, spo2 87%. Placed on O2 mask to get Pt placed on monitor, IV x 2
unsuccessful. Gave breathing tx, 3rd attempt for IV during
transport and was successful. Vitals, contacted MC orders
transported, 5 incident. Pt denies Asthma or any respiratory
He Pt did state some "little pressure mid sternum now radiating
No Hx of Cardiac, Due to short transport, No 2nd set of vitals given.

AIRWAY	FRACTURES	POSITION	WOUND	CARDIAC
<input type="checkbox"/> AIRWAY <input type="checkbox"/> SUCTION <input type="checkbox"/> BAG/MASK/DEMAND <input type="checkbox"/> COMBITUBE O2 <u>100%</u> <u>NC</u> ET <u>32</u> <u>UPLINE</u>	<input type="checkbox"/> BACKBOARD FULL/HALF <input type="checkbox"/> C-COLLAR <input type="checkbox"/> SPLINT AIR/BOARD <input type="checkbox"/> TRACTION <u>R</u> <input type="checkbox"/> HEAD BLOCKS <input type="checkbox"/> KED <input type="checkbox"/> OTHER	<input type="checkbox"/> PRONE <input type="checkbox"/> SUPINE <input type="checkbox"/> ON SIDE <input type="checkbox"/> FEET ELEVATED <input checked="" type="checkbox"/> HEAD ELEVATED <input type="checkbox"/> SITTING	<input type="checkbox"/> BLEEDING CONTROLLED <input type="checkbox"/> PRESSURE DRESSING <input type="checkbox"/> ELEVATED <input type="checkbox"/> DIGITAL PRESS <input type="checkbox"/> MAST	<input checked="" type="checkbox"/> ECG MONITOR <input type="checkbox"/> PACING <input type="checkbox"/> CARDIOVERSION <input type="checkbox"/> DEFIBRILLATION <input type="checkbox"/> CPR <u>See attached</u>

DRUGS	DOSE	ROUTE	TIMES GIVEN

ECG: Attach # strips in chronological order with victim name, interpretation and time run
RECEIVING HOSPITAL EmH
AS PER: ☐ HOSPITAL
☐ PHYSICIAN
☐ VICTIM/SPONSOR
☐ OFFICER
☒ CMED
☐ PROTOCOL
☐ OTHER
ER Physician Carroll
WHITE COPY - HOSPITAL
CANARY COPY - RESEARCH (leave at hospital)
Crew Members/Numbers
1. In Chief
2. Mike Snodgrass
3. EFD
4. Broster
5. Mike Snodgrass
6. EFD

PLAINTIFF'S DEPOSITION
EXHIBIT
4
6-23-00

EMERGENCY DEPARTMENT MEDICAL RECORD

		CT <input checked="" type="checkbox"/> X-RAY <i>Post-CT</i>		<input type="checkbox"/> RAD <input type="checkbox"/> ED
		EKG <i>3-26-92</i>	TIME DONE <i>12:31</i>	TIME TO MD <i>12:35</i>
		DISPOSITION		
		<input checked="" type="checkbox"/> ADMISSION <input type="checkbox"/> TRANSFER <input type="checkbox"/> DISCHARGE <input type="checkbox"/> OR <input type="checkbox"/> DOA/DAA <input type="checkbox"/> AMA <input type="checkbox"/> LWBS <i>Admitted - CCU</i>		
		ADMISSION REQUEST TIME:	ROOM NUMBER: <i>CCU #</i>	
		CONDITION ON D/C <input type="checkbox"/> STABLE <input type="checkbox"/> IMPROVED <input type="checkbox"/> AMBULATORY <input type="checkbox"/> NOT IMPROVED		
DX <i>Acute myocardial infarction</i> DX <i>Chronic pulmonary embolism</i> PHYSICIAN SIGNATURE <i>Chen</i>		PHYSICIANS ASSISTANT		
<input type="checkbox"/> CASE REVIEWED AND DISCUSSED				
<input type="checkbox"/> DR.		<input type="checkbox"/> DR.		
ANSWERED:				

EMH ER FS1 11/23/96 12:14