State of Ohio,)
)
County of Lorain.)

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IN THE COURT OF COMMON PLEAS

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Sandra Johnson,)
Administratrix, et al.,)
)
Plaintiffs)
)
vs.) Case No. 98 CV 122198

Akbar Naeem, M.D.,)
et al.,)
)
Defendants.)

- - -

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

Friday, June 23, 2000

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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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APPEARANCES:

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

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

EXAMINATION

BY MR. DEMSEY:

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

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

A. True.

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

A. Fine.

Q. Have you had a deposition taken before?

A. Yes.

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

A. Probably somewhere between 5 and 10.

Q. All medical-legal matters?

A. Yes.
Q. Yes, medical-legal matters?
A. Yes.
Q. Were they all medical malpractice matters?
A. As opposed to like --
Q. Well, my client gets hurt in a car accident and develops an infection while in the hospital and comes under the care of Dr. Blinkhorn.
A. Right.
Q. And, Doctor, tell me what happened to my client while he or she was under your care in the hospital as opposed to--
A. That wouldn't be a deposition, would it?
Q. You could give a deposition before trial.
A. Oh, I don't think -- the only depositions I've given have been for medical-legal issues as an expert witness or a treating physician. Is that what you're getting at, treating physician?
Q. Treating physician versus medical malpractice, giving an opinion.
A. Right, so if I was a treating physician --
Q. You could --
A. But that's the deposition.
Q. Right.
A. Right, so that wouldn't be medical-legal.
Q. Let's see. They'd all be medical-legal technically. I

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

A. I think so.

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

A. Yes.

Q. Any on behalf of the plaintiff?

A. Yes.

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

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

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

A. Probably 10, 12 years.

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

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?

A. Yes.
Q. And what do you bill, how much an hour?
A. It's 150 an hour to review records, it's 200 an hour for a deposition, and it's 300 an hour if I have to come into the courtroom.
Q. So I will pay and issue a check for your time today. Will you please make sure that I -- I'll write it down, because I don't have a card with me.
A. That's fine.
Q. Let me give you that now, just so that I don't forget.
A. Usually I send it up to them and it's up to them.
Q. Send it to them, your time in deposition? Prep time is different, you can charge them for that, fair enough, then they'll know where to send it. It will be 200 an hour?
A. True.
Q. Did I have you state your full name?
A. No.
Q. How about that, I know you introduced yourself, go ahead.
A. Richard J. Blinkhorn, Junior.
Q. I've got your CV here. You drive up here from Medina every day?
A. Yes.

MR. DEMSEY: Off the record.

(Off the record discussion.)

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

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

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

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

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

Do you know him through University?

A. I don't think so.

Q. Did you read his supplemental report?

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

Q. You read his deposition?

A. No, I just got that.

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

A. Yes.

Q. So yoc haven't had a chance to review that yet?
A. Nothing like having a stamp so that we can --
Q. Right. June 20th, you haven't had a chance to review Dr. Zivot's depo. You received Dr. Watts' report, the cardiologist?
A. Right.
Q. And you read Mrs. Johnson's deposition?
A. True.
Q. Do you have expertise in family medicine or in internal medicine, the type of medicine that Dr. Naeem practices? In other words, do you hold yourself out as an expert in that field as well, or are you simply -- in other words, are you going to address standard of care of a family practice or internal medicine specialist, or do you say that's not my area, I'm here to talk about the, well, what you're prepared to testify to?
MR. KWARCIANY: Objection to the form of the question, but go ahead.
A. My training is internal medicine, that's my specialty, my subspecialty is infectious disease. I'm a concerned expert on both, I practice both disciplines.
Q. Now, it's my opinion that the -- I'm sorry, it's my understanding based upon your March 24, 2000 report that you are going to testify as to certain things, and we'll talk about that in a moment.

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. wnat 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. KWARCIANY: Objection.

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

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

A. If there are questions that ask for my opinion that I

Q. It represents a batch, right?
A. Sure.
Q. Okay.
(Plaintiff's Exhibit 3 was marked.)
Q. Exhibit 1 is the letter that Doug Fifner sent to you asking you to get involved in this case, that's the initial letter; am I correct? Was there an earlier one?
A. It might help to look at ell of them, maybe you're right.
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?
A. Right.
Q. He said after -- there were records there, and he indicated that he wants you to call him to advise of your preliminary findings, and I assume you did that?
A. Okay.
Q. Because he then says, "Thank you for reviewing the above captioned case, and here's the following materials," and he says, "There's two issues that I would like you to consider. First, was the patient's Staph aureus pericarditis diagnoseable before November 23, '96?" And you, I assume, you wrote no?
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.

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

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

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

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

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

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

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

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

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

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

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

MR. DEMSEY: Fair enough.

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

A. No.

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

A. True.

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

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

Q. You don't know?

A. No.

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

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

Q. What happened to Mr. Johnson?

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

aureus which had ruptured into the pericardium.
Q. When did his Staph aureus enter his body?
A. Unknown.
Q. From an infectious disease standpoint, is there a window, in other words, you could say he'd had it since he was two years old, or, again, to a reasonable degree of medical probability, more likely than not, would you say that he had had it for a couple months, a year?
A. No way.
Q. Couple weeks?
A. Not very long.
Q. Minutes before he entered the hospital on the 23rd?
A. It's impossible to know exactly, because there's nothing in his history that enables anyone to predict. exactly when he got it.
Q. How do you know if a patient has an infection before you actually culture them, what are some early signs or signs and symptoms that you would look for as a, let's not put on the hat cf infectious disease specialist, because when you're in your ID hat, when you're wearing your ID hat it's probably been identified or you're trying to figure out which it is, maybe, and they bring somebody to you?
A. Not necessarily.
Q. But I'm asking you to put on the hat of an internal medicine specialist like Dr. Naeem. How does the internal

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

A. They're the same.

Q. Okay.

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

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

A. That's where people shake.

Q. How do you spell that?

A. R I G O R S .

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

A. True.

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

A. It car. suggest someone might be infected.

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

A. Cultures don't always tell you either.

Q. Why is that?

A. Because not all infections are associated with positive 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 Θ 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?

A. Well, there is, but again, this is an organism that's had books, treatises, written on it.
Q. Mutations?
A. Libraries could be filled with stuff on Staph aureus, so I would say in general it's a very common bacteria that can cause severe infections in a variety of places.
Q. If one has -- weil, is it true that people carry all manner of bacteria in their body?
A. And on their body.
Q. And on their body?
A. True.
Q. And we're immune to most of them, if not all of them? I don't want to be too simplistic here, but the one that we carry, I mean, it's just part of being a living organism, each living organism carries bacterium; is that a fair statement?
A. I'm not aware of any exceptions to that.
Q. Fair enough. On this planet, at least, right?
Is Staph aureus one of them?
A. One of what?
Q. The bacterium or bacteria that we carry on our bodies or in our bodies?
A. We can.
Q. When we do, are we always sick, or are we sometimes able to carry it? You have bacteria in your body right now

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

A. I hope.

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

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

Q. No, you.

A. I hope that's true.

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

Q. Let's pick Dale.

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

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

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

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

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

no, I'm not sick, my skin is normal. Thai 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 riot 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. KWARCIANY: 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

me.

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

A. Staph aureus.

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

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

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

A. Okay.

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

A. On occasion.

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

A. The answer *is,* if we stand out on the street corner ar we culture everyone that walks by, it is said that one out four people that you culture will have Staph aureus on thei skin; but if we did it again tomorrow, it wouidn't necessarily be the same one out of four, so tnat you can hav it on your skin transiently, it goes away.

Q. How does it get there?

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

Q. It too is a living organism?

A. Yes.

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

A. In rare circumstances it may go through the air.
Q. Handshake, human contact?
A. It's contact, yes. It's generally thought to be skin to skin.
Q. And then is it true that the way it gets into someone's body is through an opening in the skin?
A. Most of the time.
Q. Can somebody have it on their skin, take a bite of their cheeseburger, and take it into the bloodstream that way?
A. It's possible.
Q. But not likely?
A. Depends on the circumstances. Staph aureus also produces substances we call toxins. If you go to a picnic and you eat something and you get sick within an hour, you just ingested Staph aureus toxin that was on the food that you ate.

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

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

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

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

Q. Because?

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

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

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

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

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

Q. Which he didn't?

MR. KWARCIANY: Objection.

Q. Or did he, did Mr. Johnson?

MR. KWARCIANY: Well, whatever the autopsy shows, Doctor.

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

at all how it got into his body.
Q. Okay. Or when?
A. Or when.
Q. Can it be in someone's body for an extended -- well, let me ask this question a different way.
Sometimes you kind of smile when I ask a question. I don't claim to be expert in these areas, so if the question seems a little silly, bear with me and just please give me your best answer.
A. It's a bad habit of mine, sorry. I'm not laughing at you.
Q. I don't think you intend to be disrespectful, you strike me as a good guy.
A. I'm not.
Q. I didn't think so. You wouldn't have introduced yourself --
A. I smile because I hear questions that I can't answer with a yes or no, like the food thing.
Q. I understand, absolutely. So is there a time period that the Staph aureus could have been in Mr. Johnson's body, he could have been carrying that bacteria, bacterium?
A. That's okay. That's one.
Q. So multiple Staph aureus, or Staph aurei would be bacteria? I'm just being precise.
A. I think we call them Staphylococci.

Q. Staphylococci are the Staph aureus multiple?
A. True.
Q. I just didn't want my word to be confused with multiple variations, other genus, or --
A. Got it.
Q. -- or variations of that particular genus, other species within that genus, okay.
How long, what is the window, If there is a window, that it cocld have been in his body before his death, how long can that be in there?
A. We have to talk about what we mean by "in his body,'' in his bloodstream, in his heart, in his bones, in his brain, they're different.
Q. Well, then let's work backwards. The Staph aureus was the organism that infected his pericardium?
A. True.
Q. And it was, it caused what has been described, if I'm not mistaken, as bacterial pericarditis?
A. True.
Q. No other organisms that you're aware of or other bacteria?
A. Uh-huh.
Q. Right?
A. Uh-huh.
Q. That's a yes, no other, correct?

A. In the pericardium?
Q. Correct.
A. True.
Q. Are there any other bacteria or infectious disease that caused or contributed to cause his death?
A. Not that I'm aware of.
Q. Is there anything else that caused or contributed to cause his death? And I understand that systems fail once the chain of events is placed into motion, so you could --
A. True.
Q. Obviously I'm not looking for when he stopped breathing that contributed to cause his death, I'm talking about underlying contributing causes, anything else in your opinion that contributed to cause his death?
A. The myocardial abscess.
Q. And the myocardial abscess came about as a result of what?
A. It is impossible to know without pure speculation.
Q. What is a myocardial abscess as it relates to Mose Johnson? Give me the, what's the word I'm looking for, clinical picture, medical picture, what?
A. It describes an abscess, and an abscess is a collection of pus that's --
Q. It was on his heart?
A. And when we say myocardial abscess, it means it's in

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

Q. Where was it located?

A. In the left ventricular wall.

Q. Which portion of the left ventricular wall?

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

Q. Please, if you could.

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

Q. Yes, thank you.

A. "-- that measures 1.3 centimeters in maximum dimension."

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

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

Q. Fair enough.
A. The left ventricle is the muscle describing that part of the balloon that's on the left, but there's another chamber which we call. the right, so we're talking about in the muscle, which is wall. You can't have it inside the heart, because that's in the blood, so there's no abscess that squirted out of there.
Q. What I meant by inside was, if we were to somehow be able to take a look at this while it's developing, let's say the day before or that day that he died, if we went inside and we were to take a peek on the outside of the left ventricle, would we see that pussy area? If we went inside the balloon and looked, would we see there -- where would we see it?
A. At the end you see it because it ruptures with what's known as the free wall, and the free wall is surrounded by the pericardium. At the end when it comes out you would see it, because it's now a big hole in the muscle eroded away, necrotic.
Q. Which way did it go, from the outside in?
A. No, it's in the muscle and it grows in the muscle, like a three-dimensional little sphere, and as it's growing in those directions it reaches the epicardium, which is the outside part of the wall, and goes into the pericardial space. The inside is called the endocardium, it could

conceivably go in that direction also.

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

A. I suppose.

Q. -- the tissue, or when it --

A. Lands there.

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

A. For it to land inside muscle --

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

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

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

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

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

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

Q. On the outside of the skin.

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

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

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

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

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

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

Q. A likely spot?

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

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

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

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

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

A. Based on the records, true.

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

No.

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

MR. KWARCIANY: Objection. Is that possible? Objection.

A. Anything is possible.

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

A. True.

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

MR. KWARCIANY: Objection.

A. Anything is possible.

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

A. it's possible.

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

A. Was it the autopsy, or was it a culture when he came in?

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

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

sure.

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

A. Yes.

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

MR. DEMSEY: And the ruptcre at the abscess site.

A. True.

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

A. Yes.

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

A. No.

MR. KWARCIANY: Objection.

Q. It's not conceivable?

A. Not to me.

Q. Why not?

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

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

A. I believe so.

Q. Why do you say that?

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

because you would be sick.

Q. How?

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

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

A. It's a stress reaction.

Q. To what?

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

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

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

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

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

MR. DEMSEY: Call the judge right now and find

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

MR. KWARCIANY: Your questions are --

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

MR. DEMSEY: Thank you.

MR. SPISAK: Just teasing.

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

MS. PETRELLO: It is confusing.

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

MR. DEMSEY: Just say objection.

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

MR. DEMSEY: I appreciate that.

). Doctor, if you don't understand my question, you'll ask ıe to repeat it or rephrase it, won't you?

ı. Yes, I will..

). ■ do appreciate that.

A white blood count of -- well, strike that for a oment, let me gather my thoughts here for a second. I'll ry to come back to that.

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

ruptured and he crashed. Fair statement?

A. And he died.

Q. And he died.

A. True.

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

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

Q. In the bloodstream?

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

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

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

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

Q. Okay.

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

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

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

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

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

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

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

MR. KWARCIANY: Objection to the word "it."

MR. DEMSEY: Sorry.

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

A. Where in his body?

Q.

A. Blood, heart, bone, brain?

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

A. Yes.

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

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

[illegible] the abscess started to grow, in all

likelihood how long was the Staph aureus in his body?

MK. KWAKCIANY: Objection.

A. Hours.

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

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

Q. Is Staph aureus treatable?

A. Yes.

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

MR. KWAKCIANY: Objection.

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

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

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

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

you an antibiotic and I would have drained
So it but treatable d

Okay. Hypotheticaliy speaking, if t
in Mr. Johnson's bloodstream two weeks bef
did a culture and found it and it had not set up shop in
the heart -- you understand what I mean *by* set up shop?

Q. Was it treatable or curable?

MR. KWARCIANY: Objection.

MS. PETRELLO: Objection.

MR. SPISAX: Me too.

A. It would be treatable. The answer as to
depend on if there were other manifestations.

Q. Such as?

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

Q. Well, no abscess.

MR. KWARCIHNY: Objection

two weeks before it set up shop in his heart and killed him
within hours, it was treatable; was it curable?

MR. KWARCIAMY: Objection.

is he had Staphylococcus aureus bacteremia, meaning in his
bloodstream --

Q. Bacteremia means it's in the biood?

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

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

A. I would give an antibiotic.

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

MR. KWARCIANY: Objection.

Q. Would the antibiotic -- right?

MR. KWARCIANY: Let me just show a continuing objection to this hypothetical question.

MR. DEMSEY: Fair enough.

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

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

MR. KWARCIANY: Objection. Go ahead.

A. Under the scenario of Staph aureus bacteremia without

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

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

A. Correct.

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

MR. KWARCIANY: Objection. Or 90 to 95 percent?

A. I said 90 to 95.

Q. Percent chance of a cure?

A. Percent chance.

Q. Of a cure?

A. Of a cure.

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

THE WITNESS: Correct.

Q. Without clinical focus means there's no abscess set up anywhere?

A. That we know of.

Q. Right?

A. True.

Q. Other than m e abscess in Mr. Johnson's heart, or on it

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

A. No.

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

MR. KWARCIANY: Objection.

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

MR. KWARCIANY: Continuing objection.

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

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

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

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

MR. KWARCIANY: Objection.

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

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

MR. KWARCIANY: Continuing objection.

A. True.

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

A. No.

Q. Have you treated people with Staph aureus?

A. Yes.

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

MR. KWARCIANY: Objection.

A. Probably.

Q. More likely than not?

A. True.

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

MR. KWARCIANY: Objection.

A. True.

Q. So let me ask again, I'm not sure if you said yes or no, have you treated people with Staph aureus bacteremia?
A. Yes.
Q. Nonfocal, in other words, not setting up shop somewhere and causing an abscess?
A. True.
Q. And when you treat them, do you do so in the manner

MR. KWARCIANY: Objection.
A. You know, I don't know that I've ever looked at my own personal series to know what the cure rate is.

Q. I know you hope not, but do you have a good idea in your head if they were significantly less?
MR. KWARCIANY: Continuing objection.
A. No, because as you start that exercise, you have to recognize your inability to know with certainty. And if I treat people with Staph aureus bacteremia who have other

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

Q. Focade, F O C A D E?

A. F O C I, plural of focus.

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

MR. DEMSEY: I thought he said focade.

MR. SPISAK: Foci.

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

A. Is that a word?

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

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

A. No.

Q. Why not?

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

Q. What about his cardiac history?

A. Hypertension?
Q. Take a look at his EKG from November 2.
A. Okay.
Q. You're familiar with it?
A. Yes. We can look at it?
Q. Yeah, if you could. What did it show, and do you agree with it?

Q. Read the interpretation of that. You have to rely on the interpretation because you can't interpret these, or you don't, that's not within your area of expertise?
A. I'm not here to testify to those issues.
Q. Okay. Based on the fact that, assuming that he had premature ventricular contractions, sinus tachycardia, and abnormal changes that may possibly be due to myocardial

A. No.
Q. Can you clarify what you said earlier?
A. I said infarct, I think I said infarct. I think I said myocardial infarction, but maybe I didn't.
Q. Would ischemia be a risk factor?
A. No.

Q. Why not?
A. Because it isn't.
Q. Can you tell me why ischemia isn't? I don't mean to be disrespectful by asking you again, I'd just like to know the medical reason for that.
A. Sure. The answer, without being too facetious, is there's some things I consider God questions, you Know, there are rules we follow, one of them is ischemia is not a risk factor for infection from Staph aureus. If we say infarction, cell death, necrosis, yes, that's a risk factor.
Q. So --
A. But it also has to be acute.
Q. Meaning?
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.
Q. Just say a person.
A. Let's say a person has a heart attack today; right now there is a damaged area in the heart which we could all see if we actually took their heart out and looked.
Q. It's permanent?
A. No, that's an acute injury. Three months from now that acute area is healed, it's got a scar, it is no longer a risk factor for infection because it's now scarred, there's no area there that's a predisposing factcr.

3. Didn't you say earlier that that scar tissue provides nooks and crannies, or did you mean scar tissue under different circumstances?
A. Under different.
Q. Which, for example?
A. Arthritis, inflamed synovial joint.
Q. Jagged bony little mountain range, and crevices and nooks and crannies and places for it to hide?
A. Right.
Q. But with cardiac muscle you wouldn't expect that because it would be smooth?
A. True.
Q. No hiding places?
A. True.
Q. When you said scar tissue, that's where I got thrown off.
A. Got it.
Q. So as I understand it, then, Mr. Johnson was not one of those risks, somebody predisposed to Staph once in the bloodstream, finding a nook and cranny and setting up shop, based upon your review of his record. and based upon your review of the autopsy?
A. Prior to his terminal event, true.
2. Why did it set up there, again, once it went through his bloodstream, why did it pick chat spot, not that it was a

conscious decision?

MR. KWARCIANY: Objection, asked and answered.

A. I believe he had a myocardial infarction there.

Q. When?

A. When he came in.

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

A. Within 24 hours prior to his arrival.

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

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

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

Q. Becomes the pussy --

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

Q. Is there literature that supports that?
A. I'm sure there is.
Q. You're not aware of any off the top of your head?
A. I am aware that. there is literature that says myocardial abscess rupturing is a fatal event, it's almost never diagnosed.
Q. Are there risk factors for myocardial abscess, such that we can try and. prevent it?
A. Drug abuse, injecting drug abuse.
Q. You misunderstood my question.
A. I'm sorry.
Q. Well, actually, maybe you didn't, I think I asked two questions wrapped into one.

You're saying that people who are intravenous drug users are at risk for myocardial abscess?
A. Yes.
Q. The reason for that being thaz they're more prone to introduce Staph aureus into the body?
A. True, bloodstream.
Q. Staph aureus bacteremia comes about, it's something that people who are intravenous drug users get?
A" They can.
Q. Any evidence that Mr. Johnson was an intravenous drug user?
A. Yes.

Q. What evidence is that?
A. The autopsy on the lung.
Q. On the lung?
A. True.
MR. DEMSEY: Colleen, is this funny?
MS. PETRELLO: No.
MR. CEMSEY: Are you surprised to hear this?
MS. PETRELLO: No.
MR. DEMSEY: You're laughing.
MS. PETRELLO: I'm just smiling, I like to smile.
MR. DEMSEY: A man died who had a wife and child, and I don't think it's funny.
MS. PETRELLO: Ask your questions, Richard.
Q. What evidence on autopsy is there of intravenous drug use?
A. Well, there's a note in his autopsy that he has talc foreign body granulomas. I'm reading from the autopsy.
Q. Please.
A. This is the microscopic description of the respiratory system. It says, "Scattered through the entire lung tissue there are foreign body giant cells which under polarizing lenses show talc crystal. This is seen in all the sections of the lung." Then it goes on to say, "No evidence of pneumoconiosis is present."

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

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

Q. Talc is a powder?

A. Right.

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

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

Q. Allergic?

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

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

The fact that it's in a11 the lung fields says that it's going through the bloodstream. The fact that rhe pathologist comments specifically after writing that about the talc, "No evidence of pneumoconiosis," pneumoconiosis is a description of occupational lung disease of a number of types, suggests that the pathologist is suggesting this is not airborne, this isn't inhalational.

Q. Isn't inhalational?

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

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

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

Q. Through the blood?
A. And I have no other way to know other than seeing that, why that should be there, and it is not pathology that would occur within hours, that requires a chronic host response. It could have been decades ago, it could have been years ago, but it speaks for itself that it's there.
Q. Does that leave -- well, if it was decades ago, let's say when he was a teenager, certainly that might explain the absence of needle sites, right?
MR. KWARCIANY: Objection.
Q. If it was years ago?
A. We're not assuming that he doesn't have needle sites, I just don't know that it's true or not. In your scenario, that's conceivably true, yes.
Q. The coroner did not -- if the coroner is noting the difference as to whether or not it's airborne and occupational versus -- what's the term again for injected?
A. Injecting hematogenous.
Q. Hematogenous, airborne versus hematogenous. Your interpretation is that it's hematogenous versus airborne. You're wondering in your own mind was the coroner who was looking at this thinking that this may be there due to intravenous drug use as opposed to occupationally inhaled?
A. No, I'm not, I don't know whether he thought anything more about it other than to say that's what he saw, I Just

don't know.
Q. There's no other explanation for it, hematogenously?
A. That I'm aware of.
Q. That you're aware *of?*
A. In this man, no.
Q. In other people?
MR. KWARCIANY: Objection.
A. Not that I'm aware of.
Q. I just ask other people because you said in this man.
The coroner's report shows no evidence of needle marks?
A. Not that I'm aware of.
Q. So assuming -- you say my scenario is plausible that if he was one who got talc into his system through his bloodstream, you said it could have been decades ago, how does that relate to what happened to him, is there some --
MR. KWARCIANY: Objection.
Q. -- is there a relationship?
MR. KWARCIANY: Objection.
A. The question started was, I forget exactly, you asked me something about --
Q. I'll think of it in a second.
MR. SPISAK: Question was any evidence of drug abuse.
MR. DEMSEY: No, no, it was before that. What I

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

THE WITNESS: Right.

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

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

MS. PETRELLO: Nobody said it was bad conduct.

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

MS. PETRELLO: You're reading a lot into tnis.

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

A. That's how we got there.

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

A. True.

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

A. True.

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

MR. KWARCIANY: Objection.
A. if you ask me the question, is there evidence in this case of injecting drug use, I would answer that, that finding on the pulmonary pathology would raise the question for me. The answer to your question, yes, that would raise a suspicion to me, I would testify to that, yes.
Q. That there's a suspicion?
A. Yes.
Q. Is it a probability, possibility?
MR. KWARCIANY: Objection.
Q. You're saying there's a possibility this man was a intravenous drug user --
MR. KWARCIANY: Objection.
Q. -- or are you saying it's probable that he was?
MR. KWARCIANY: Objection.
A. I don't know, to that question.
Q. And did the talc as found in his lung fields, as you have just indicated to us, on autopsy, or whether or not he was at any time in his life an intravenous drug user, to a reasonable degree of medical probability, cause his death?
MR. KWARCIANY: Objection to the form, go ahead.
MS. PETRELLO: Objection as well.
MR. SPISAK: Would you kindly --
Q. Was it a little --
A. I think I got it.

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

(Record read.)

MR. KWAKCIANY: Objection.

MS. PETRELLO: Same here.

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

Q. Who are the many who would say?

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

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

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

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

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

MR. KWARCIANY: Objection.

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

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

MR. XWARCIAWY: Objection.

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

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

A. True.

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

A. Yes.

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

MR. KWARCIANY: Objection.

MS. PETRELLO: Objection.

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

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

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

Q. I understand.

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

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

MR. KWARCIANY: Objection.

MS. PETRELLO: Objection.

A. Anything is possible.

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

MR. KWARCIANY: Objection.

A. No.

Q. And why not?

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

answer to the question was never asked, that I could find.
Q. As I understand it, getting back to my question, was there any evidence of, you're saying sure, look at this talc, that's evidence of, in my mind, Dr. Blinkhorn's mind, evidence of prior intravenous drug use, which could have been decades ago, I don't know when.
MR. KWARCIANY: Objection, asked and answered.
A. If I'm the doctor taking care of him, and you can stop me if you don't want me to answer that --
MR. KWARCIANY: Doctor, just answer the question.
A. If I *see* thaz result in a man who dies with a Staph aureus myocardial abscess hitting him like lightning, I'd say, you know what, I wonder if this is unknown intravenous drug use, and there's two ways to answer that question other than sitting here at a table. I go to my pathologist and say, I want you to review those slides again, does that look to you like the talc we see in the bloodstream from. injecting drug use? And then we decide if we raise the question with the family to ask if they were aware of any injecting drug use, because the family may also wish to know what happened to him.
Q. Did you see anything in his ongoing chart, his treatment with Dr. Naeem, to suggest he was a noncomplianz patient?

A. No.
Q. Did you see anything to suggest that he was an IV drug user?
A. I never saw the question asked.
Q. Understood. But there can be other signs and symptoms of IV drug use, people abusing substances do show --
A. They can, many don't.
Q. Ask an alcoholic if they drink, they're probably going to tell you no, you know what I'm getting at? So just because the question wasn't asked, I'm asking you from an objective as opposed to subjective standpoint, whether you saw anything pre-autopsy to suggest that Mr. Johnson used any substances illegally?
MR. KWARCIANY: Objection.
A. Short of never seeing that question specifically, no.
Q. And that question specifically would be a subjective response, if it was asked, do you do A or B?
A. True.
Q. A person could say yes, they could say no.
A. True.
Q. No matter what they say to you as a doctor, the objective findings are what you're going to rely on. Certainly you rely on your patient to an extent, but the objective finding would give you information, true?
A. Sure.

Q. My question is whether you saw anything objectively to suggest that prior to November 23rd?
A. Short of seeing that to be consistent, my answer is no.
Q. You said he had a myocardial infarction within 24 hours of his death?
A. I think.
Q. Do you hold that opinion to a reasonable degree of medical probability?
A. Yes.
Q. Basis for that?
A. The records.
Q. Right, but anatonically, why do you think that he had a myocardial infarction 24 hours before his death, what is it in the records that tells you that there was an MI?
A. Sure.
Q. Is this --
A. I'm looking for the emergency room,
Q. Of November 23?
A. Yes, please. There was a note there, said he had an episode similar the night before that went away, so the records will be clear of where I saw that. Here we are. Mine aren't numbered, I don't know if yours are numbered. I believe the top says Lorain County EMS Report Form. Does this look familiar, this is what I'm trying *to* --
Q. That's the transport.

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

MR. KWARCIANY: Ambulance run sheet.

THE WITNESS: Right?

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

Q. May I take a look at that?

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

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

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

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

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

(Plaintiff's Exhibits 4 and 5 marked.)

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

MR. KWARCIANY: Objection.

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

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

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

MR. KWARCIANY: Objection.

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

Q. You do?

A. I think.

Q. What is ischemic cardiomyopathy, do you know?

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

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

A. No.

Q. Why not?

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

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

MR. KWARCIANY: Objection.

A. No.

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

MS. PETRELLO: We did.

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

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

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

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

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

Q. Any evidence that he had that?

A. No.

Q. What about inflammation of the heart?

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

Q. I thought you were talking generally about anything

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

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

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

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

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

Q. So the heart has to be compromised. You say it was due to an MI?
A. I didn't say compromised, there nas to be tissue injury.
Q. Any other scenario where his tissue could have been injured in the two weeks before?
A. In his heart?
Q. In his heart.
A. Not that I'm aware of.
Q. What are other examples besides myocardial infarction where the heart could be compromised to the point where it would be prone to attack by the Staph aureus?
MR. KWARCIANY: Objection.
A. Valvular disease.
Q. That you told me about and he didn't have?
A. Right.
Q. What else?
A. If you had holes in the heart, so-called septal defects, where there's abnormal flow between chambers, that would be one. If you had somebody who had a viral infection and got pericarditis, inflammation around the heart, those could be complicated by bacteria1 pericarditis because of the inflammation and the bacteria landing there.
Q. When did he develop his focal acute myocarditis?
A. Within the 24 hours prior to admission.

Q. What is focal acute myocarditis?
A. I believe that's a description representing the pathology of infarction and infection.
Q. What about his myocardial fibrosis, when did he develop that?
A. Fibrosis? Fibrosis means scar that's been there a long time.
Q. How did he get it?
A. How did he get that? That's part of his ischemic cardicmyopathy or it's his hypertensicn.
Q. But you don't believe that those are focal. sites for --
A. They aren't.
Q. -- Staph aureus?
A. They aren't.
Q. His pericardial effusion was the fluid around the heart?
A. True.
Q. Was that in existence longer than 24 hours?
4. No.
Q. Pre-death?
4. That was happening as a terminal event.
2. Why do you say that?
3. All right.
Q. This is fluid that's in the pericardium?
A. Correct. All right, first of all, understanding

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

Q. Like the synovium?

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

Q. Very small?

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

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

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

Q. Suddenly?

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

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

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

Q. Becacse the abscess has already taken — I m sorry, the rupture of the abscess?

A. Yes.
Q. You don't believe he had any preexisting effusion causing any kind of strain on the heart prior to --
A" That event?
Q. -- that event?
A. No.
Q. It was strictly a rupture of the abscess that led to the hundred cc's of fluid?
A. That's what I'm thinking.
Q. This was cons stent with this process?
A. You then have this intense inflammatory response and fluid is pouring in there.
Q. How about his cardiac hypertrophy, what is cardiac hypertrophy?
A. If you have hypertension, longstanding high blood pressure, the heart has to pump out against a resistance. You have to squeeze out against a high pressure. This is a muscle. If I say to you, you have to lift this weight every day, eventually this muscle gets pretty big. That's what happened with the heart over time, it thickens, it thickens in order to be able to do the load of pumping against a high resistance every single day, day in, day out, for years. So hypertrophy means enlarged muscle.
Q. How long do you think he suffered from cardiac hypertrophy?

A. If he has hypertrophy as a result of hypertension by definition, 'ne's had it for years, many years, more than 10.
Q. Is that one of the risk factors for a heart attack?
A. Hypertrophy, no. It's atherosclerosis that we're interested in.
Q. And he had severe atherosclerosis?
A. That's what we find at autopsy.
Q. Did you see any workup on him as to his coronary artery disease by Dr. Naeem?
A. He got an EKG and he got a history.
Q. Do you believe Dr. Naeem should have done more after seeing that EKG?
A. That's where I'm drawing the line here, I'm here to testify about the infectious disease aspects of this case.
Q. Okay. So you're not going to comment on whether or not Dr. Naeem should have done more when he had the EKG?
A. True.
Q. Or when he got the blood work back?
A. True.
Q. That would be outside yocr area of expertise?
A. True.

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

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

MS. PETRELLO: You can.

EXAMINATION

BY MR. SPISAK:

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

A" Yes.

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

A. I would expect that he would have symptoms.

Q. Okay. You wou dn't expect him to be asymptomatic, I would. assume?

A. No.

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

A. Of infection?

Q. Yes.

A. True.
Q. We don't know from the records whether Mr. Johnson had a fever or didn't have a fever on November 10, correct?
A. Do I need to look?
Q. Take my word for it for the sake of my question, let's assume that we don't know one way or the other.
A. I don't have an independent recollection of the records, but --
Q. That's fine. If hypothetically, however, he did have an infection, knowing everything else that we know, it cannot be said with any certainty, can it, that that infection was the result of a Staph aureus infection?
MR. KWARCIANY: Do you understand the question?
Q. Maybe that wasn't very clear. If he had a fever on November 10, number one, does the mere Pact that he has a fever necessarily mean that he has infection in and of itself?
A. No, not in and of itself.
Q. All right. But let's assume *for* the sake of my question that he had a fever and that it was the result of infection, okay. You can't say with any probability that that infection was the result of a Staph aureus bug as opposed to anything else, can you?
A. No.
a. I didn't think so, all right.

MR. SPISAK: That's all I have.

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

EXAMINATION

BY MS. PETRELLO:

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

A. Well, some patients have a sensation of feeling warn, a manifestation that they have chills. They may have sweats, they may have what we had already said was rigors, where it's a chill rather than sort of like goose bumps, you actually shake. They may have other symptoms associated with the fever that point to the focus of the infection, headache, for pneumonia, joint swelling and pain for septic arthritis.

Q. You said that the patient may sense a feeling of being they usually feel warm?

A. Yes.

True.

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

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

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

A. Yes.

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

A. Yes.

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

A. In general.

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

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

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

A. True.

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

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

feel cold?

A. They usually are sweating.

Q. But they still feel warm?

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

MS. PETRELLO: No further questions.

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

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, "Cardiovascular system continued while sectioning,'' do you see that, "left circumflex at four centimeters from its origin. Purulent fluid pours from the myocardial tissue from a cyst-like cavity that measures 1.3 centimeters in maximum dimenion. The myocardial tissue around this cavity is brownish, very soft and congested, and this area extends to the pericardium." What are they talking about right there?

A. What does that mean? Abscess.

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

A. All right. Let me see if I can give you a picture. Think of the left ventricle as an inverted cone or like an

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

Q. Where, the right, left?

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

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

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

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

A. In the artery?

Q. In the artery.

A. No.

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

A. Right.

Q. That's where you say the abscess was?

A. True.

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

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

Q. Okay.

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

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

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

A. Well, they can't.

Q. Because?

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

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

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

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

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

A. Right.

Q. Mr. Spisak asked you, let's assume that he had a fevei on November 10. You can't say with certainty that it was tl Staph aureus buq, and you said no, I can't?

A. True.

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

MR. KWARCIANY: Objection.

MR. SPISAK: Objection.

A. Yes, anything is possible.

Q. Do you know the standard of care for emergency departments and/or emergency department physicians relative to takıng vitals wnen someone comes in? Must you take vitals, is there a protocol €or you to do that?

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

Q. Did you ever work ir an emergency department?

A. In my training.

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

MR. KWARCIANY: Objection.

MS. PETRELLO: Objection.

MR. SPISAK: Objection.

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

vital signs?

MS. PETRELLO: Objection.

A. Yes.

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

MR. SPISAK: Note my objection.

A. No.

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

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

Q. Such as?

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

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

MR. KWARCIANY: Objection.

MS. PETRELLO: Objection.

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

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

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 he 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. KWARCIANY: Objection.

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

MR. KWARCIANY: We'll waive.

- - -

(Deposition concluded at 4:20 p.m.)

- - -

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

ATTORNEYS AT LAW
FIFNER & ASSOCIATES

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

*ALSO LICENSED
MISSOURI
ILLINOIS

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-I18106

Dear Dr. Blinlthorn:

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

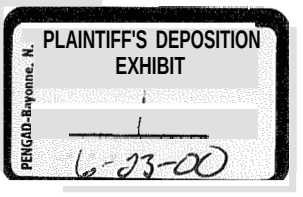
In order to assist you in your review of this claim, I am herewith enclosing:

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.



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Yours Very Truly,

FIFNER & ASSOCIATES

Douglas K. Fifner

DKF:ds
Enclosure

ATTORNEYS AT LAW
FIFNER & ASSOCIATES

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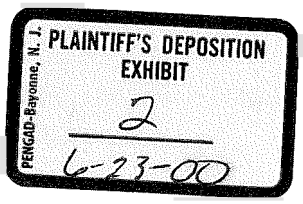

February 4,2000

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-I18106

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.

There are two issues I would like you to consider. First, was this patient's staph aureus pericarditis diagnosable before 11/23/96? NO Second, would earlier treatment of the pericarditis have averted this patient's death? NO 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

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FEB 08 2000

Johnson v Naeem

HBP

Ice

9/22/94 Sore throat, fever since 9/17 98.9
Rate Strep Ks → Amox

8-3-95 Bad cold
Sinus-Ks → Biaxin

6-15 No show

6-20 F/U

9-8 F/U

12-28 Bronch Ks → Biaxin

11-2-96 Periodic health exam

11-11-96 Pain R buttock - down back of R leg
Tender sciatic notch SLRT pos. R

ED - EMH

11/10/96 R hip pain x 6 d

23-96 EMH

1215

since yesterday

Diaphoretic 38.5 139-36 134/64

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

Streptokinase → CCU (1340)

WBC 40,300 TP 8.1 Cr 1.6

Alb 2.4

CCU: Intubated. CHB → V fib

EMD → CPR ~45 min.

Pericardiocentesis → copious purulent fluid

Echo: Severe LV dysfxn. Dilated LV EF 10%

ECG: ST elevation all leads.

Time of Death 3:35 pm

Spoke to: Sandra Johnson, wife

Leg pain: No SOB. No sweats. 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 Hosp.

Spoke w/ father

* No hint beforehand → "lightning strike"

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

PLEASE PRINT CLEAR
USE BALLPOINT PEN

Lorain County EMS Report Form

SQUAD NAME: LifeCare 94 — [ ] BASIC [ ] ADVANCED [ ] PARAMEDIC — RUN # 96691 — DATE 11-23-96

~~#4648~~ 5 Dr Naeem Office E Broad 324-6513
NUMBER (location of incident) STREET CITY PHONE

Johnson, Most T 44 9/8/52 286-50-9030 SEX [x] M [ ] F
LAST (victim name) FIRST MID - AGE/DOB SS#

4648 51st St Elyria OH 44035
NUMBER (victim home address) STREET CITY STATE/ZIP

BACKGROUND

CHIEF COMPLAINT: SOB
ALLERGIES: NKA
MEDICATIONS: Relafen, Loscet, Norvasc
PAST HISTORY: Groin pull
EVENTS PRECEDING CALL: Pt at Dr Naeem office for Tx on Groin pull and became SOB. Pt states this happened yesterday also but went away with rest.
PRIVATE PHYSICIAN: Naeem HOSPITAL

CALL RECEIVED	1144
THROUGH	~~CH091~~
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
1150	169/100	143	44	87%	5/2

RESPIRATORY EXPANSION: [x] NORMAL [ ] SHALLOW [ ] RETRACTIVE [ ] NONE
BREATH SOUNDS: Clear Bilat all fields *

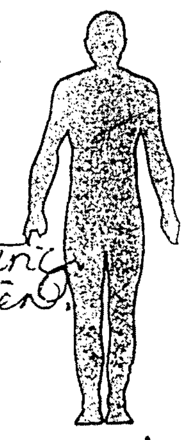
MVA (crossed out): SEATBELT WORN [ ] AIR BAG DEPLOYED [ ] EXTRICATION NEEDED [ ]
Area of impact and location of patient

PUPILS: [x] EQUAL [ ] UNEQUAL
RIGHT / LEFT: MIDPOSITION, DILATED, CONSTRICTED, REACTIVE [x] [x], NON-REACTIVE

ASSESSMENT

VERBAL RESPONSE	MOTOR RESPONSE	EYE OPENING	SKIN COLOR	SKIN TEMPERATURE	CAPILLARY REFILL
[x] ORIENTED	[x] ALERT	[x] SPONTANEOUS	[x] NORMAL	[x] NORMAL	[x] IMMEDIATE
[ ] CONFUSED	[ ] VERBAL	[ ] TO VOICE	[ ] CYANOTIC	[ ] COOL	[ ] DELAYED
[ ] INAPPROPRIATE	[ ] PAIN	[ ] TO PAIN	[ ] PALE ASHEN	[x] MOIST	[ ] JVD
[ ] INCOMPREHENSIBLE	[ ] UNRESPONSIVE	[ ] NONE	[ ] FLUSHED	[ ] HOT	
[ ] NONE			[ ] MOTTLED	[ ] DRY	

COMMENTS: O/A found Pt walking out of Examining Room to lobby. Advised Pt to sit down while Fire was getting Cot. Pt very diaphoretic with resp. at 44, SpO2 87%. Placed on O2, moved to cot. Pt placed on monitor, IV x2 unsuccessful, Gave breathing Tx. 3rd ~~start~~ attempt for IV during transport and was successful. Vitals, Contacted MC, No orders, Transported without incident. Pt denies Asthma or any respiratory Hx. Pt did state some "little pressure" Mid sternum Non-Radiating. No Hx of Cardiac. Due to short transport, No 2nd Set of Vitals given.



TREATMENT

AIRWAY	FRACTURES	POSITION	WOUND	CARDIAC
[ ] AIRWAY	[ ] BACKBOARD FULL/HALF	[ ] PRONE	[ ] BLEEDING CONTROLLED	[x] ECG MONITOR
[ ] SUCTION	[ ] C-COLLAR	[ ] SUPINE	[ ] PRESSURE DRESSING	[ ] PACING
[ ] BAG/MASK/DEMAND	[ ] SPLINT AIR/BOARD	[ ] ON SIDE	[ ] ELEVATED	[ ] CARDIOVERSION
[ ] COMBITUBE	[ ] TRACTION R L	[ ] FEET ELEVATED	[ ] DIGITAL PRESS	[ ] DEFIBRILLATION
O2 ___ LPM VIA NC	[ ] HEAD BLOCKS	[x] HEAD ELEVATED	[ ] MAST	[ ] CPR
ET ___ SZ ___ UPLINE	[ ] KED	[ ] SITTING		See attached
	[ ] OTHER			

[ ] D5W [ ] LR [x] NS — [ ] 1000 [x] 500 [ ] 250
GAUGE 18 SITE (L) AC
TIME ATTEMPTS x3
DRIP RATE TKO BLOOD DRAWN [x]

DRUGS	DOSE	ROUTE	TIMES GIVEN

ECG: Attach # strips in chronological order with victim name, interpretation and time run

TRANSPORT

RECEIVING HOSPITAL: EMH

AS PER: [ ] HOSPITAL [ ] PHYSICIAN [ ] VICTIM/SPONSOR [ ] OFFICER [ ] CMED [x] PROTOCOL [ ] OTHER

Crew Members/Numbers
1. In charge: Tina Brostek
2. Mike Snodgrass
3. EFD
4.
5.
6.

ER Physician: Carroll

WHITE COPY - HOSPITAL CANARY COPY - RESEARCH (leave at hospital)

PLAINTIFF'S DEPOSITION EXHIBIT 4 6-23-00
PENGAD-Bayonne, N.J.

EMH REGIONAL MEDICAL CENTER — EMERGENCY DEPARTMENT MEDICAL RECOR

MODE OF ARRIVAL: ☐ AMBULATORY ☐ WHEELCHAIR ☐ AMBULANCE ☐ CARRIED

INITIALS: RL NURSE: Ronnie Bo

MEDICAL HISTORY ☐ NONE: hypertension

MEDS: ☐ NONE: Propecia

ALLERGIES ☐ NONE

PREGNANT	DATE OF LMP	LAST DT	WT.
☐ YES ☐ NO ☐ MAYBE			

TIME	T	P	R	BP	VISUAL ACUITY O.D.	O.S.	POLICE NOTIFIED
1213	98.5	139	36	134/84			☐ YES ☐ NO

INITIAL NURSING NOTES: Diaphoretic total c SOB since Sunday. 9 appts at Dr. Davids Naeem-taking Med (pain pill) x 2 wk. Pt arrives SOB - diaphoretic Denies Chest pain Cold/sweat. Cephalgia. Hx syphilis delayed. Tempered test from Dr Naeem office. Breath sounds decreased bilateral P wheeze ® base.

1V 500 NS (L) ante.

☒ EMERGENT ☐ URGENT ☐ NON URGENT

INJURY: DATE/TIME/PLACE

AMBULANCE EQUIPMENT ON ARRIVAL:
☐ C-COLLAR ☐ BACKBOARD ☐ MAST
☐ AIRWAY-SPECIFY: ☐ SPLINTS ☐ IVS
☐ OTHER:

HISTORY (TIME:) ☐ DICTATE

PMH / SOCIAL:

OLD CHART REVIEWED:

PHYSICAL EXAM:

TIME	X	DOCTOR'S ORDERS	X	DOCTOR'S ORDERS
1215	X	MONITOR ☒ B/P ☐ CARDIAC		ABG ☐ RA ☐ ___ L/M
		VS: REPEAT		
		VS: ORTHO		CARDIAC ORD SET
		IV BOLUS		CARDIAC 27
1213		IV NS KVO		TRAUMA PROFILE
		GLUCOSE STRIP		UA ☐ DIP ☐ MICRO ☐ C&S
		FOLEY		PREG. ☐ URINE ☐ B-HCG ☐ QUANT
		NG		CBC DIFF
1214		O2 via C 81%		7 or 27
1213		SpO2 ☒ RA ☐ ___ L/M 96%		
		BLOOD CULT. X ___		AMYLASE / T&C
		CHLAMYDIA		LIPASE / T&S UNITS
		G.C. CULTURE		ETOH / DILANTIN
		STREP SCREEN		THEO / DIGOXIN
		MONO SPOT		CALCIUM / MAGNESIUM
		RESP. THERAPY		MYOGLOBIN / TROPONIN I
				PT /PTT
		OLD CHART		TOX SCREEN ☐ URINE ☐ BLOOD

ORDERS

Start Morphine

Prepare 5000 units Heparin premix in

ASA + po now

- Cardiac Sx IV now, repeat + 2 doses @ 5 hr

MS 30 4 prn IV q 2 hrs

NTG drip 10 mcg

12:50 Streptokinase per protocol

CT / X-RAY: Pt left 325 ☐ RAD ☐ ED

EKG 1203 TIME DONE 1231 TIME TO MD 1235

DISPOSITION

☒ ADMISSION ☐ TRANSFER ☐ DISCHARGE ☐ OR ☐ DOA/DAA ☐ AMA ☐ LWBS

Admit - CCU

ADMISSION REQUEST TIME: ROOM NUMBER: CCU #1

CONDITION ON D/C ☐ STABLE ☐ IMPROVED ☐ AMBULATORY ☐ NOT IMPROVED

DX: Acute myocardial infarction

DX: left pulmonary embolism

PHYSICIAN SIGNATURE: Akbar Naeem

PHYSICIANS ASSISTANT

☐ CASE REVIEWED AND DISCUSSED

☐		☐ DR.	☐ DR.
C	D:		
ANSWERED:			

ER-1 (REV 6/95)

Reg D/T: 11/23/96 12:13
JOHNSON, MOSE T
PT#: 101442952
MR#: 092199
FAMILY DR: 000445 NAEEM, M. AKBAR
ER DR: 000284 CARROLL, MARION
DOB: 09/08/52 AGE: 44Y

EMH_ER_FS1 11/23/96 12:14

PENGAD-Bayonne, N.J. PLAINTIFF'S DEPOSITION EXHIBIT 5 6-13-00