IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

MICHELLE R. FREEMAN, etc. Judge Burt Griffin

Plaintiff Case No. 490991

vs.

THE CARDIOVASCULAR CLINIC, et al.

Defendants

_____/

The deposition of NEIL A. CRANE, M.D., was held on Tuesday, February 17, 2004, commencing at 10:10 a.m., at the offices of Dr. Crane, 5530 Wisconsin Avenue, Suite 800, Chevy Chase, Maryland 20815 before Robert A. Shocket, a Notary Public.

REPORTED BY: Robert A. Shocket

APPEARANCES:

JOHN BURNETT, ESQUIRE (by phone)
On behalf of Plaintiff

PAUL A. DZENITIS, ESQUIRE
On behalf of Defendants
The Cardiovascular Clinic,
Christine M. Zirafi, M.D.
James L. Sechler, M.D.
Raju Modi, M.D.

KENNETH A. TOGERSON, ESQUIRE (by phone)
On behalf of Defendants
Parma Community General Hospital,
Parma Hospital Home Health Care

P-R-O-C-E-E-D-I-N-G-S

Whereupon,

NEIL A. CRANE, M.D.

called for examination, having been first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:

EXAMINATION BY MR. DZENITIS:

Q Dr. Crane, my name is Paul Dzenitis. I represent Cardiovascular Clinic, Dr. Zirafi, Dr. Modi, and Dr. Sechler in a lawsuit that's been filed by Michelle Freeman, for the estate of Ms. Huerster. You have been identified as an expert witness in that case and some opinions have been attributed to you. Is that correct, sir?

A Yes.

Q And you have in fact drafted a two-page report that I have dated August 7, 2001, is that correct?

A Yes.

Q And you have a copy of that report in

front of you?

A Yes.

Q Doctor, I'm going to be asking you some questions today. I would imagine you have had your deposition taken before, is that correct?

A Yes.

Q If you do not understand a question that I ask, please tell me and I will try to fix it. Okay?

A Yes.

Q If you answer the question, I'm going to assume that you understood it, is that fair?

A Yes.

Q If you need to take a break, let me know at any time and we will try to accommodate you. All right?

A Yes.

Q And, you're doing a good job of it. Now, let's try to remember not to speak over one another and answer audibly so the record reads clear later. Fair enough?

A Yes.

Q Doctor, you are an internal medicine physician?

A Yes. I specialize in internal medicine with a subspecialty of infectious disease.

Q Do you have any other subspecialty other than infectious disease?

A No.

Q Do you have a particular area of interest in infectious disease?

A No. I do general infectious disease.

Q You have been kind enough to provide me a copy of your curriculum vitae, which I will hand to you. It's a one-page document. And I will ask you, sir, if that's your current and updated C.V.

A Yes.

MR. DZENITIS: We'll mark that as Exhibit Number 1 and have that attached to the deposition.

(Crane Deposition Exhibit Number 1 was marked for purposes of identification.)

Q Doctor, you are certified in internal medicine?

A Yes.

Q And that certification was received in 1972?

A Yes.

Q Did you pass the written and orals the first time?

A Yeah. Well, they didn't have orals. They had recently done away with the oral exams and, so, it was only written and I did pass it on the first time.

Q And, you were certified in infectious disease in 1978?

A Yes.

Q Were there written and orals for that examination?

A No, just written.

Q And you passed on the first time?

A Yes.

Q You are a member of the American Board of Internal Medicine, is that correct?

A Well, that's the, the board certification.

MR. TOGERSON: Hello?

MR. DZENITIS: Yes.

MR. TOGERSON: Oh, okay.

MR. DZENITIS: I'm just looking at the C.V. Here.

MR. TOGERSON: Okay.

COURT REPORTER: Now, who was that on the phone?

MR. DZENITIS: That's Mr. Burnett -- or, excuse me, that was Mr. Togerson.

BY MR. DZENITIS:

Q Are you a member of any medical associations or societies?

A Yes. I belong to the Infectious Disease Society of America, the Montgomery County and State of Maryland Medical Societies, the Greater Washington Infectious Disease Society.

Q Are you a member of the American Medical Association?

A No.

Q Have you ever been a member of that association?

A No.

Q Is there a, or an internal medicine group or association similar to the Infectious Disease Society of America?

A Yes, I think so. Those are the only groups I have ever belonged to that I just told you.

Q What percent of your time is spent practicing infectious disease as opposed to internal medicine?

A Well, time-wise it's about half and half but there's overlap. For example, my internal medicine is primary care. I have my own patients and I'm their primary care doctor but if they should get pneumonia or some other serious infection, I do the infectious disease on them. And conversely in my infectious disease practice when I do consults for surgeons or podiatrists, I often do the internal medicine. So, time-wise it's about half and half but in both directions there's overlap.

Q What hospitals do you practice at?

A They're on my C.V. The one I go to

primarily is called Suburban Hospital in Bethesda, Maryland. Some, sometime I go to Sibley Hospital in D.C., Holy Cross Hospital in Maryland, and Shady Grove Adventist in Maryland. I am also on the staff of George Washington University Hospital but I don't really go there to see patients. I haven't done that for years. But I go there for conferences. And I'm an assistant professor of medicine there as a private doctor. I'm not on the full-time faculty. It's just a title.

Q Do you teach residents or medical students?

A I have in the past but I haven't in the recent past.

Q When was the last time you taught a resident or medical student?

A Ten, fifteen years ago. Maybe, well, if you include medical students, that's the most recent. That's probably five or six years ago, where, you know, what we do as private doctors is just fill in gaps that the full-time faculty asks us to. And the

last thing I did was teach sophomore students how to take histories and physicals but that's been five or six years since I have done that.

Q The last you would have taught a resident would have been ten to fifteen years ago, approximately?

A Yes. I used to go to the Washington Hospital Center, which is another hospital that I had admitting privileges to which I just dropped recently. And there I went on rounds with interns and residents and discussed their patients. There's no classroom teaching for the private doctors.

Q Has all of your teaching experience been as a private physician?

A Yes.

Q What kind of residents were these?

A Medicine.

Q Were they, when you say medicine, they were internal medicine residents?

A Yes.

Q Were they doing a rotation in infectious

disease?

A No. It was general medicine. Infectious disease is a fellowship, not a residency.

Q Where did you do your infectious disease fellowship?

A Massachusetts General Hospital in Boston.

Q And how long was that?

A It was two years, from 1970 to '72.

Q So you completed your infectious disease fellowship in 1972?

A Yes, and all of my training in 1972.

Q And then you became certified in '78?

A Yes. What I did was I first you got, first you have to get certified in internal medicine. That's a requirement. You can't get certified in a subspecialty unless you are already certified in the specialty of internal medicine. And, I worked for an HMO for five years where I was the only infectious disease person in the HMO. So, I didn't feel the need to be board certified. But, when I left the HMO is when I decided to take the board exam in infectious

disease. That's why there's a gap between my internal medicine and my infectious disease boards.

Q Have you written any medical literature?

A Yes. But I took them off my C.V. because they're out of date and they're basic science articles. They're not clinical. The latest one is like 1970, when I was at the NIH.

Q What did you -- do you know how many articles you authored?

A There are about five, and they're molecular biology articles on viruses. They don't deal with clinical diseases, so.

Q What were these published in, do you recall?

A Proceedings in the National Academy of Science and there was an article in Lancet and there was an article in a textbook.

Q What textbook?

A I don't remember. They're really not relevant because, as I said, they're molecular biology articles. I can dig them out if you're, I mean, those

references if you have to have them but none of them deal with any clinical diseases.

Q So that you have not authored an article on clinical diseases or clinical care?

A Right. So, therefore, nothing relevant to this case.

Q Right. We are in an office off Wisconsin Avenue in Chevy Chase, Maryland today. Is this your only office?

A Yes.

Q And, I believe the name on the door of the pulmonology group here is Putnam, Lerner and Simon?

A Yes. I just share the space with them. I don't, I'm not associated with them professionally.

Q How long have you been in this office?

A This particular location since around 1990 but about a block south of here since 1978.

Q Have you ever practiced with partners?

A No, except when I was at the HMO. It's called Group Health Association, which is now part of the Kaiser Permanente system, and that was 1972 to

'77.

Q When did you begin participating in medical-legal review?

A It's about the same time that I left the HMO, around 1978. I was sued myself and the agent for the insurance company liked the way I analyzed my case and asked me if I would like to review cases for them and that's how I started reviewing cases. And, of course, it was initially just defense cases for about five years and then I started reviewing plaintiffs cases around 1982.

Q How many cases would you estimate you have reviewed, medical-legal cases?

A Well, it's, I have reviewed hundreds of cases. I would say in the last ten, fifteen years I review maybe three cases a month from both defense and plaintiffs. Of course, the majority of those don't go any further than the initial review.

Q How often do you give deposition testimony in a medical-legal action?

A I think I'm averaging around one or two a

month now.

Q Do you know how many times you testified live at trial?

A About four. Four or five times a year.

Q Has that pace of testifying live at trial approximately four or five times a year been the same since approximately 1982?

A No. It's been for maybe ten years. You know, initially there were a few cases and it gradually built up and then it stabilized because I sort of cut it off. I can't do, can't do any more than, than I'm doing. In fact, I'm actually cutting down now.

Q Do you know what states you've testified in?

A I hope so. My defense cases are mostly local, D.C. and Maryland. My plaintiffs cases are mostly out of town although I have done plaintiffs cases in D.C. and Maryland. I just don't do them against doctors I work with. But, other states, I would say the majority of the states east of the

Mississippi but the most frequent are Pennsylvania -- these are plaintiffs cases now -- Pennsylvania, Ohio and Michigan.

Q Do you know how many times you have testified in Ohio cases, whether by deposition or live at trial?

A No. Numerous.

Q Do you know, well, you, just by doing the simple math if you are testifying live at trial you believe approximately four or five times a year and you have been going at that pace for approximately ten years, in the last ten years you would have testified live at trial approximately forty to fifty times, is that accurate?

A If your math is correct, yes.

Q How many times did you testify last year, was it the four or five pace?

A You know, I really sort of put it out of my mind after I'm finished but probably four times last year, was, but I'm just guessing now because I don't remember every case once it's over.

Q Do you know the percentage breakdown of plaintiff to defendant --

A Yeah.

Q -- of cases that you have testified in?

A I think it's roughly half and half. It was initially all defense cases the first, the first five years and then the plaintiffs cases gradually built up. So, after the first five years it was still mostly defense cases. But, now I think it's half and half. I'm sure there are years where there's more plaintiffs than defense and other years vice versa.

Q In the past ten years would you estimate that of the forty or fifty trials that you have testified in they've been half for the defense and half for the plaintiff?

A I think so but, you know, I don't really keep records. As I said, that's, you know, I try to forget the case after it's over.

Q What about breakdown of review, that is, cases that come in?

A You know, that, I think it's roughly half

and half also but again it may not be, I may not be really precise in that.

Q You indicated to me that you have been a defendant in a case on one occasion when your interest in participation in medical-legal review began. I think you told me that case was in 1978?

A '77.

Q '77?

A I started reviewing cases in '78.

Q Have you been a defendant other than in this one case?

A No.

Q What was this case involving in 1977?

A That's when I was at the HMO and I saw a patient with a man in his sixties with chest discomfort. And it was made worse with lying down and better with sitting up. And I thought he had a hiatal hernia, what we now call gastroesophageal reflux. And he got, he did have that on x-ray and he got better with antacids but about six months later he had a massive heart attack and died. And the issue was a

misdiagnosis. Probably what happened I think is that he had both, you know, he had a silent coronary disease, then he did have gastroesophageal reflux. The case settled.

Q Was he a diabetic?

A No, I don't think so.

Q The case did not go to trial?

A No.

Q It settled, you indicated; do you believe for how much?

A Three hundred thousand, I think.

Q Have you testified in a federal court case?

A I may have sometime in the past. I don't remember.

Q Do you have a list of the cases that you have testified in?

A No. I don't keep lists.

Q Have you ever had to prepare a list of cases that you have testified in?

A You know, I have been asked to in past and

I just tell them I don't keep lists so I sometimes just go by, try to go by memory for recent, like in the past year.

Q When did you join the infectious Disease Society of America?

A I think about three years ago.

Q Are you familiar with any guidelines that body has for experts who participate in medical-legal review?

A No.

Q Has your membership in the Infectious Disease Society of America ever been suspended, revoked or limited in any way?

A No.

Q Has there ever been any inquiry or question regarding your participation in medical-legal review to your knowledge?

A No.

Q You have an active practice --

A Yes.

Q Excuse me, active license to practice in

Maryland, correct?

A Maryland, D.C., Virginia and Missouri.

Q Has your license ever been suspended, revoked or investigated in any way to your knowledge?

A No.

Q What percent of time do you spend reviewing cases for lawyers testifying in depositions, testifying live at trial?

A I think it's about 10 percent of my time.

Q That would be 10 percent of your professional time?

A Yes.

Q And then what do you spend the remainder of your professional time doing?

A Clinical practice. As I said, I do primary care and I do infectious disease consults and roughly half and half.

Q Do you see patients in this office?

A Yes.

Q How many days out of the week?

A Five.

Q Do you regularly do rounds?

A Yes.

Q Would that be daily?

A Yes, seven days week, if there are people in the hospital. I used to be on a, there's a group of infectious disease doctors, we took turns, but we just found easier to see our own patients.

Q And you do, most of your patients would be at the Suburban Hospital in Bethesda?

A Yes.

Q Do you advertise your services as an expert?

A No.

Q Have you ever advertised your services as an expert?

A No.

Q Are you a member of any expert referral services?

A Well, I'm not a member but I get cases from one, Forensic Medical Advisory Service. There were two other services I've gotten cases from in the

past which I don't anymore.

Q What were those?

A The first, the one who gave, sent me my first plaintiffs case was Sapanaro in Cleveland. And, I stopped reviewing cases for Sapanaro about, I think four or five years ago. There's another service, I just got a very small number of cases, that I stopped a long time ago and that's Technical Advisory Service for Attorneys.

Q When did you stop working with Technical Advisory Service for Attorneys?

A Must be ten years ago. But, there was never, there was never many, I think maybe there was a total of ten cases altogether from them or five, five to ten.

Q For TASA?

A Yes.

Q How many cases for Sapanaro?

A Sapanaro, there were a lot of cases, almost too many. That's one of the reasons I stopped. And I can't -- a couple, two, three hundred, I guess,

altogether. I'm guessing.

Q I would assume all the cases from Sapanaro were plaintiffs cases?

A With some, with very few exceptions. I guess maybe 95 to 99 percent were plaintiff cases.

Q And from TASA?

A I think they were all plaintiff cases. I don't, you know, again there was a small number. From Forensic probably 95 percent are plaintiffs.

Q Why did you stop reviewing cases for Sapanaro four or five years ago?

A Well, there were too many of them and they were poorly organized and just took too long to go through.

Q Do you still review cases for Forensic Medical Advisory Service?

A Yes, I do.

Q Are all of your plaintiffs cases from that organization?

A No. I get plaintiffs cases directly from plaintiffs attorneys, including this one. This is,

maybe a third of my, or a fifth, I don't know, a fourth to a fifth of my plaintiff cases come from Forensic.

Q Do you know if that service advertises your name?

A I don't think they advertise my name.

Q Do they advertise?

A But I think they advertise, yes. I assume they do. I've never seen an advertisement but I assume they do.

Q You indicated you received this case directly from plaintiff's counsel?

A Yes.

Q When was that initial contact?

A Well, I wrote down the date that I reviewed the records and that was December 30th of 1999. So, the initial, I usually don't keep records sitting around for long so the initial contact had to be no more than two weeks before that.

Q What was the form of that contact?

A You know, I don't know. I could just tell

you in general. I'm called. I'm given a brief idea of what the case is about, with the question would you be willing to review it. And I only have two criteria. One is that it's in my field and two that I have the time. Other than that, I don't, I don't base any decision on what the attorney tells me, just, just to make sure it's something in my field, in, you know, my field of infectious disease or internal medicine. But, I would say about 80 percent of my reviews are, have to do with infectious disease and the other 20 percent or maybe less have to do with general medicine. Not that the defendant, the defendant as far as I'm concerned can be any specialty. It's just the issue involved has to be infectious disease or internal medicine.

Q Do you recall the form of the first contact in this case?

A No, I don't recall but I'm, it was probably a phone call. I have reviewed other cases for this firm before so they know me.

Q Have you reviewed cases for Mr. Burnett

before?

A That, I don't think so but, I can't be a hundred percent sure. I don't think so.

Q You have reviewed cases for Becker and Mishkind?

A Yes.

Q How many?

A You're taxing my memory. Probably five to ten. I know it's not a large number and it's not one or two.

Q Have you testified live in Cleveland?

A Yes.

Q Do you recall the last time?

A I think the last time was for this firm. There's a case with Mr. Peskin and it's sometime in the past year.

Q Do you recall the last time you testified in Cleveland -- well, strike that. Have you ever testified for the defense in Cleveland?

A No. Never been asked to but I have had defense cases in Ohio, just three or four, I think in

Toledo.

Q Did you review any summary or rendition of the facts in this case, written rendition of the facts in this case before your review of the medical records?

A I don't think so, no. And even when I'm sent a summary, I don't really use it because I don't base my opinions on that.

Q Do you remember who you spoke with, with this initial contact from Mr. Burnett's office?

A You know, I don't even know if it was Mr. Burnett or I know they have a nurse that works there that often is the initial contact on these cases, so, it was either Mr. Burnett or the nurse.

Q You have some handwritten notes in front of you. As you reviewed the materials in this matter, did you make notes?

A Yes.

Q Are all the notes with you here today?

A Yes.

Q Did you, do you recall what information

you first received in the case?

A Well, I would refer to my notes to answer you.

Q Sure. Take your time.

A Right. I can tell you how I organize the my notes. Pages one through four are notes from records. Page five is my, what I call my comment sheet. That's the, sort of a summary of facts, what happened and opinions. And then I also reviewed depositions and I lettered those pages to keep them separate, A through D, are notes from deposition. But, only page five is anything from me. Everything else is what I gleaned from the records of the depositions. So, to answer your question, the first thing I reviewed was the Parma Community Hospital admission of June 13th to June 25th, 1999, Home Health records, June 25th to June 30th, 1999, Parma Community Hospital admission, July 2nd to July 5th of 1999 and then the autopsy. And I can tell you what depositions I reviewed if you like.

Q Did you receive an enclosure letter with

those materials?

A There's probably a letter that said this is the records we discussed or something but I didn't keep that.

Q That's been discarded?

A Yes.

Q Did you review anything else with that initial packet of information other than what you have told me?

A No. I might tell you, I also photostat certain things, like discharge summaries and autopsy so in my notes it will say see copy.

Q Why do you do that?

A It's just, I've just learned this over the years, that I always photostat discharge summaries and autopsies and then that's really all I have here but sometimes I'll photostat like an infectious disease consult or something I think it's better not to just take notes on because I don't, when I take notes, I don't copy the whole thing. I just take notes on the highlights. And some things I think it's important

enough to just keep so I just photostat it.

Q Would the material that you photostat, copy and have with you be particularly significant information in the case?

A Well, in this case, it's just discharge summaries and autopsy which I always do, so there's nothing unusual about that.

Q You've made a pile there with your notes of the information that is photostat copied. Could you please read into the record what you have copied there?

A The discharge summary from the June 13th, '99 admission, the discharge summary from the July 2nd, '99 admission and the autopsy report.

Q And, then at some point, excuse me, did you receive additional material?

A Yes. And I always write dates in the left, on the left-hand column. So, it was depositions I reviewed after the initial record review.

Q The initial record review, backtracking a little bit, would have been conducted on or by --

well, you tell me. There's a date up on the upper left-hand column, corner of your first page of notes, which is 12/30/99. What does that mean?

A That's the date I started my review.

Q Started the review?

A Started. I can't say I ended it that day but I might have taken a couple of days to review the records.

Q Do you know when you would have received the material before you started the review?

A Well, as I said, I already answered that. No more than two weeks before but I didn't write the date down when I received the material.

Q With the depositions do you similarly have a date when you would have started the review of those?

A Yes.

Q Would you have received the depositions within two weeks of your review?

A Yes. I just, when I get something I take it home and when I get a chance I open it up and

review it but I never let it sit more than a couple weeks.

Q What depositions did you receive?

A Okay. And what dates did I review them?

Q Did you begin your review, correct.

A Right. On June 20th of '01, I reviewed the depositions of Dr. Quallich, Dr. Gopal -- I'll shorten his name -- Dr. Lazo, L-A-Z-O. And on July 27th of '01 I reviewed Dr. Sechler and Dr. Modi and on July 9th of '03, I reviewed Dr. Zirafi, period. And on October 30th of '03 I reviewed Mary Ann Ambrose, Carol Stern -- Carol Stem, S-T-E-M, Denise L-A-U-X, and both depositions, deposition number one and number two of Christine Huerster.

Q Have you reviewed anything else?

A No. If I did, they would be in my notes.

Q Did you receive the exhibits from Ms. Christine Huerster's deposition?

A If they were attached to it, I would have seen them but I don't keep them.

Q Have you seen a diary, a computerized

written diary in the case?

A Again I don't, either I did or I didn't, and if I did, I didn't pay attention to it because it's not in my notes. I don't think I saw it, no. I don't have an, as lawyers say, independent memory of anything. I just go by my notes.

Q When did your -- the report is dated August of 2001, I believe, the written report?

A Right.

Q When did you form your opinions about this case?

A Well, I think I formed my opinions after reviewing the records. And I don't think the depositions really changed my opinions any but I can tell you that my comments sheet is more recent than the report.

So, if we ever get to it, I can just read you my comments sheet and that's my opinions based on everything I reviewed. Because, as you can see, the report was written before I read Dr. Zirafi's deposition and the nurses and Christine Huerster's

depositions.

Q And in the report it's indicated in the first sentence that you had Dr. Zirafi's deposition?

A You're right.

Q Have you spoken --

A I don't know if -- this must be a misdate. No, I couldn't have. I must have added that because I couldn't have because her deposition was done May 30th of '03 and I reviewed it July 9th of '03 so that must be a mistake. I don't know why it says that. I'm sorry.

Q Do you believe you added that to your report or do you believe that was part of the initial report that was generated?

A It must have been part of the initial report that was generated. It's dated August of '01 and her deposition was done in '03 so that must be just a mistake. I never noticed that. I don't think there's anything in the report that quotes anything from her deposition.

Q Nevertheless, you formed the opinions that

you hold in this case before Dr. Zirafi's deposition was taken?

A Yes.

Q This report dated August 7, 2001, is this the only report that you have generated?

A Yes.

Q Were there any drafts of this report?

A There must have been some typographical errors but I'm not sure what you mean. I mean, this is, I'm sure there were corrections in spellings and so on.

Q Do you have any of these other --

A No.

Q Did you discuss your report with Mr. Burnett or anyone else after its initial -- did you discuss any drafts or changes to this report with anyone?

A I may, I may have asked him if it's clear, you know, if it's written with a clear language but he didn't suggest any opinions if that's what you're, you're asking. Yeah, because, for example, where I

added if the home care nurses knew of the severe diarrhea, doctors should have been informed, that, that had to be from a conversation. It must have been a question from Dr. -- Mr. Burnett. Because, I hadn't read the nurses' depositions yet. And there's nothing in the record that shows that they knew of it. And it is in Christine Huerster's deposition, which I read after this report. So, I probably was asking, answering questions from Mr. Burnett when I wrote some of these things.

Q You kept notes from your review of records, depositions and you've got some notes which contain your opinions as you describe them, or the comments page, right?

A Yes.

Q Did you keep any notes from discussion with Mr. Burnett?

A No.

Q Do you recall any discussion with Mr. Burnett?

A Well, I just talked to him yesterday about

the deposition and each time that I would review something I would give him a call and discuss how it affects my opinions.

Q I think you indicated that the opinions that you formed were based on the medical record review which had been completed by or on or about December 30, 1999, correct?

A Yes, starting that day and ending either that day or the next day.

Q And the depositions didn't give you important information or significant information which changed your opinions in the case?

A Correct.

Q Did you suggest Mr. Burnett put any questions to any of the defendants in deposition?

A Well, I think not directly but in an indirect way. You know, if I give them my opinions it sort of tells them what questions to ask.

Q Do you recall any questions you asked Mr. Burnett to put to any of the witnesses in this case?

A No.

Q What do you charge for review?

A I charge 250 an hour but I have a maximum of a thousand for the initial review. And, I have a minimum of a thousand for a deposition because, you know, it's office hours. Other than that one maximum, one minimum, it's two-fifty an hour for my time.

Q In this case, what does the initial review consist of, just the records or the records and the deposition?

A Oh, just the records.

Q So that the time spent for reviewing additional material would be at the clip of 250 an hour?

A Yes, the rate of --

Q The rate of, and what is your charge for testifying in deposition?

A It's two-fifty an hour but it's a minimum of a thousand because I have to schedule off the morning.

Q What do you charge for live testimony?

A It's still two-fifty an hour but it's for

an eight-hour day because I have to schedule off the whole day. So it would be 2,000.

Q Have you discussed this case with any other physicians?

A No.

Q Have you done any medical searches to form your opinions in this case?

A No.

Q Are your opinions based upon any medical literature or textbooks?

A I'm not basing my opinions on them but I'm familiar with the Clostridium difficile colitis and the treatment, diagnosis and treatment. I didn't look it up just for this case but, you know, we see it all the time. So, I do refer to textbooks in general. The one I tend to generally use is Mandel, Douglas and Bennett, Principles and Practice of Infectious Disease. And I also use Sanford's Handbook of Antimicrobial Therapy. And, I mean there are many other reference materials that I can go to if I need to but this is something I deal with almost every day,

so.

Q But, specifically in reference to this case, you are not basing your opinions upon any medical literature or text, correct?

A Right.

Q And, I would assume the opinions you've formed are based upon your education, experience and background as an infectious disease physician as well as an internal medicine physician?

A Yes.

Q Do you consider the Mandel and Sanford texts that you mentioned to be reliable?

A Yes. Thank you for not using the word authoritative. They're reliable. They're useful. They're well recognized. It's just the word authoritative tends to be used differently by an attorney than by doctors.

Q I would assume, well, why do you not consider these texts to be authoritative?

A Well, just, I think my understanding of the legal definition of that word means that

everything in it is accurate and true and, you know, that's not true of any textbook. There are always some things that are out of date or some things are opinions rather than facts.

Q What is C.difficile?

A Well, the C stands for Clostridium, and it's a bacteria that generally resides in the intestinal tract, not in everybody, I mean, but there are people who are carriers of it. And, it's capable of producing a toxin that causes inflammation of the colon.

And, usually it can be spread from person to person through hand contact. It's really a fecal-oral spread or from inanimate objects in the environment that can get on somebody's hands and then find its way to their mouth and then spread that way.

And it somehow seems to seems to be activated by antibiotics as far as proliferating and producing toxins. I don't know the mechanism of that. It's just a well-known phenomenon. There are cases in which antibiotics are not involved in the pathogenesis

but the great majority of them seem to be related to antibiotics except for the antibiotics used to treat it like Flagyl and Vancomycin.

Q What are the symptoms of C.diff?

A Well, if you have C.difficile disease, the symptoms, the most common symptom is diarrhea but they can also have abdominal pain, cramping, fever, weakness. I mean, there's symptoms related to loss of fluids and electrolytes and then there's the complications of what's called toxic megacolon where the colon just dilates and they get abdominal distension, become, have the syndrome of sepsis or the colon can perforate and they get peritonitis. But I think the commonest symptoms would be fever and diarrhea.

Q And, C.diff is the bacteria itself, correct?

A Yes.

Q C.diff colitis would be the condition of inflammation of the colon due to the C.diff bacteria?

A Yeah. Actually, due to the toxin that the

bacteria is producing.

Q How often do you treat patients with C.diff colitis?

A Could I -- first of all, generally we call it C.difficile disease because you can't, you don't really know if there's active colitis unless you do a scope and most patients aren't scoped. They all, I guess they all have a certain degree of colitis. So, C.diff disease and C.diff colitis are essentially synonymous. But I see it all the time. I mean, I see several cases a month. It's a very common problem in the hospitals.

Q In your report on page two, on the second full paragraph down, it's a one-sentence paragraph. You describe symptoms of C.difficile colitis. That's why I was using that terminology.

A Yes. I think -- let me see. Yeah. I'm just quoting Dr. Modi when I said that but as I said before, I think they're roughly synonymous, C.difficile disease and C.difficile colitis but I'm just quoting Dr. Modi in that paragraph.

Q Is C.difficile disease and C.difficile colitis synonymous with pseudo membranous colitis?

A No. I mean, I guess it depends on who you ask but my impression is pseudo membranous colitis is a more advanced stage. It's a subset of C.difficile disease where you actually see pseudo membranes on the colon. But again that requires a colonoscope or a sigmoidoscope and in most cases we don't do the scope. So, we just diagnose somebody with fever, diarrhea and a positive C.diff test as having C.diff disease. You can't call it pseudo membranous colitis unless you do a scope and see the pseudo membranes.

Q Do you know the --

A Excuse me.

Q All right.

A Now, some doctors do use it a synonymously so I don't want to be confusing about this.

Q Do you know the mechanism by which this toxin created by C.diff leads to pseudo membranes on the colon?

A Not precisely. I think what it, the

reason they're called pseudo membranes is because they're not really membranes. I think it's just exudate and inflammatory debris that the endoscopist is seeing. So, it's just part of the inflammatory condition, which is what colitis is. It's an inflamed colon, literally. And the pseudo membranes I think is just inflammatory debris that is sort of sticking to the lining and looking like membranes. But, I'm sure somebody can be more precise than that, but, as far as the mechanism.

Q How long does it take for the toxin created by C.diff to lead to the formation of pseudo membranes which are apparent on visual examination?

A I think there's a wide range, to answer you, but it's probably on the average of two or three days.

Q Are patients who develop pseudo membranous colitis as opposed to just patients who have C.diff colitis, are patients who develop the pseudo membranous colitis further along in the disease process?

A I think in general, yes. But, again, you know, we talked earlier, some people use the terms synonymously, pseudo membranous colitis and colitis. The difference is you have to do a scope to diagnose pseudo membranous colitis. There are --

Q Pseudo membranous colitis -- I didn't mean to interrupt you. I'm sorry.

A Yeah. There are a lot of people with C.diff disease that don't have a scope done so you wouldn't know if they have pseudo membranes or not. But, I guess a general answer to your question is, yes, if you see pseudo membranes, it's further advanced. But, there's a tremendous amount of overlap because, as I said, a lot of people with C.diff colitis are never scoped so you never know if they have pseudo membranes. This patient wasn't scoped.

Q This patient had an autopsy, an examination of her colon?

A Right.

Q Did she have pseudo membranous colitis on pathology, or, excuse me, yeah, pseudo membranous

colitis on pathology?

A Yeah. You know, I just have two pages. I don't have a description of the gross and microscopic exam but the pathologist said pseudo membranous colitis as one of his conclusions so I have to assume she had pseudo membranes.

Q What would one expect to find on microscopic examination pathologically if a patient has pseudo membranous colitis?

A Well, okay, I'm not a pathologist so I have to answer you from an internal medicine, infectious disease perspective. I think they would find a lot of inflammatory cells on the surface and sheets of inflammatory cells and debris, which I think is what forms the so-called pseudo membranes. So, you would see that on microscopic but you also see it on gross exam.

Q What's the appearance on gross?

A Well, you know, again I'm not a pathologist so, be similar to what the endoscope shows, which is things that look like membranes and

really aren't. They're just sheets of white blood cells and mucus and other debris that cause membrane appearing, appearance, patches. You see it's in patches and it looks like membranes but it isn't really membranes so that's why it's called pseudo membranes.

Q Would you place any significance to the degree to which the pseudo membrane would penetrate the layers of the colon?

A In other words, how deep does the inflammation go?

Q Right.

A Yeah. These are really getting into pathology, but, pathology questions but I know that the colon can perforate so it must go deep in severe cases. So, yes, probably the deeper it goes, the more severe the disease, if that's what you're asking.

Q Do you know the different layers of the colon?

A There's generally three, talk about three layers, the mucosa, which is the inner surface, the

serosa, which is the outer surface and the, I think it's called the muscularis, which is the middle layer, where the smooth muscle is. But I think a pathologist can be more precise than that.

Q Would edema of the submucosa extending into the muscularis propria mean to you extensive disease?

A No. Edema is just part of the inflammatory response.

Q What about acute inflammatory infiltration by polymorphonuclear leukocytes which extend well into the muscularis propria?

A Well, that's where we talked about, if it extends into the muscularis layer, it's probably more a more severe case than if it doesn't extend into that layer. Because, it starts in the mucosa and probably the deeper it goes the more severe the case is, because I know one of the bad complications is perforation so that means it would have to go all the way through.

Q And the muscularis propria is the last

layer?

A No, it's the middle layer.

Q What's the last layer?

A The outer layer is the serosa.

Q Do you know how long it would take for someone to have pseudo membranous colitis to develop inflammatory infiltration by polymorphonuclear leukocytes extending well into the muscularis propria?

A Probably a few days but I think it's so variable. It depends on the severity of the disease. You know, some people have mild disease that can go on for a week or two and never get that severe and other people can have severe disease that progresses more rapidly. So, I think you can only answer questions like that with generalizations, like a few days.

Q Would the few days be after the development of pseudo membranous colitis?

A No. The development of it, the first up is the activation of the bacteria, the release of toxin and then the inflammation of the mucosa. And then later it would progress to forming pseudo

membranes and penetrating into the deeper layers. But, that's the sequence. And then what causes toxic megacolon, which is another complication, I'm not sure the mechanism of that. It's probably the entire colon is involved and goes into the muscularis and involves the and paralyzes the colon because the muscularis layer is what gives the colon the constricting, the peristalsis and if that's paralyzed, then you get the toxic megacolon. But, this is sort of a general description, not a scientific description that I'm giving.

Q Did Ms. Huerster develop a toxic megacolon?

A According to the pathologist at the end she, he described changes consistent with toxic megacolon.

Q After the first step, which you said was the activation of bacteria, what symptoms arise?

A The early, probably the earliest symptom is diarrhea and then fever and then others. But, fever and diarrhea may be every, may be all the

symptoms a person has. But, of course, cramping can be associated with diarrhea. And in uncomplicated cases usually that's it, fever, cramps and diarrhea, and then an elevated white count if you go into the laboratory testing.

Q Do these patients develop impaction?

A Impaction?

Q Fecal impaction?

A Usually not. I mean, that's a complication of constipation, not diarrhea. But if they develop toxic megacolon, if it's almost like an ileus, then it can resemble fecal impaction but it really isn't. I'm not aware of fecal impaction being a hallmark of C.difficile disease.

Q Would impaction be consistent with development of a toxic megacolon and the halt of normal colon function?

A Yeah. I mean, there are other causes for toxic megacolon and fecal impaction actually can cause diarrhea, ironically, because what's happening is fluid is building up proximal to the impaction and

then goes around it. And, fecal impaction can cause dilation of the colon. I don't think of that as toxic megacolon. But, I think probably they can develop signs and symptoms that are similar to toxic megacolon because they get a dilated colon and they can become septic. I don't think that's what happened here but that would resemble this, yes.

Q How does one -- I would assume fecal impaction can lead to cramping, can lead to diarrhea, and can lead to fever and increased white blood count as well, correct?

A Yes.

Q How does one differentiate or distinguish fecal impaction from C.difficile disease or pseudo membranous colitis?

A Well, usually they're not as sick with fecal impaction but there are some overlapping features. You do a rectal exam; you can feel the impaction in most cases. You can do a plain x-ray of the abdomen and see the impaction in most cases. And, so, I mean usually fecal impaction is not that

difficult to diagnose and you relieve the impaction and the person gets well. That's a very different presentation from C.difficile disease. And the other, beyond that, the stool test for C.difficile you can do but usually with a fecal impaction you can feel it with your rectal exam or see it on x-ray.

Q What are the stool tests for C.difficile?

A You're actually testing for the toxin. And there's various tests. There's a toxin assay. And I'm not an expert on this either. I just, because that's, that also is a clinical pathologist would be the expert. But I think they do a toxin assay on living cells or they do a test for the toxin using antibody antigen reaction, I think are the two commonest ways of detecting it. We usually don't do a stool culture for C.difficile because even if you culture it, it doesn't prove C.difficile disease. You have to show the presence of a toxin.

Q What kind of diarrhea does one exhibit after the activation of bacteria due to C.difficile disease?

A Well, I think what you're asking is both the quantity and the quality. The quality is, it's usually a non-bloody, watery diarrhea. The quantity is usually profuse but it can be just a normal, you know, like a viral diarrhea, anywhere from just a diarrhea that resembles an ordinary gastrointestinal virus to a profuse diarrhea that just won't stop. So there's a wide range in that also.

Q Ordinarily non-bloody?

A Non-bloody, usually.

Q Does the quantity of diarrhea depend upon the severity of the disease or inflammation?

A I think, I mean, as a general rule that's probably, that's true. It's just common sense that the worse the disease, the worse the diarrhea. And by the way, usually there's a history of being on antibiotics or recently being on antibiotics. Sometimes C.diff disease starts after the antibiotic has been stopped but most of the time the person is, it starts while they're on antibiotics.

Q I would assume that's variable as well --

A Yes.

Q -- just by the nature of your answer?

A I think my experience is most of the time they're on antibiotics but there are many cases, that's not rare, that they just, they've been recently stopped because everybody infectious disease has an incubation period between the time of the onset of the disease and the time of symptoms and signs. So, the people who develop C.difficile disease after the antibiotic has been stopped are probably already in the incubation period while they're on antibiotics.

Q And this incubation period is variable?

A Yes. But, I mean, it's no more, I don't think it's any more than a few days in general, again in general.

Q During the incubation period are there symptoms?

A By definition, no. That's the definition of incubation period.

Q Do you believe Ms. Huerster based on your view of the records in this case was exhibiting

symptoms of C.difficile disease during her first hospitalization at Parma?

A Based on the records, no. Based on Christine Huerster's deposition, yes. And I'm not here to decide that. But the records seem to indicate she was not having symptoms during the June 13th to June 25th admission.

Q In your report you indicate that on the second full paragraph of the second page, which is a one-sentence paragraph, that it is your opinion Ms. Huerster developed the symptoms of C.difficile colitis around 6/29. And I think, well, let me, I think you indicated to me before the symptoms of C.difficile colitis or C.difficile disease would be diarrhea, fever, possibly cramping, weakness. What symptoms in the records do we have of C.difficile colitis around 6/29?

A Well, that's, based on the July 2nd and July 3rd notes, that July 2nd in the ER it states beginning three days ago began to have abdominal pain and diarrhea so three days ago would have been June

29th. And the history and physical by Dr. Modi, which was dated July 3rd, says five days ago developed diarrhea, so, and cramping, abdominal pain so that would put it at June 28th if these histories are accurate.

Q Exactly.

A Right.

Q The point is, there's nothing, there are no contemporaneous records --

A No.

Q -- medical records that you're aware of --

A That's correct.

Q -- that there were symptoms of C.difficile disease around 6/29?

A That's correct. I don't even have a record on June 29th. I do have a record on June 28th and June 30th, which don't mention diarrhea.

Q Is there any other information you are basing your opinion upon other than the emergency room note indicating the diarrhea began three days ago, and Dr. Modi's record indicating the diarrhea started five

days ago, both reported by history that you are using to base your opinion upon that she developed symptoms of C.difficile colitis around June 29?

A Yeah. And I should make it clear. There's Dr. Quallich also on July 3rd that says four to five days ago developed diarrhea and abdominal pain. So that fits with the other two histories. But, I guess I should make it clear, this really isn't my opinion. I'm just telling you what the record says. I don't have an opinion on when it started. I don't know.

Q Well, so we're clear, what you are doing is backdating based upon histories in the record, correct?

A Yes. I'm just basing it on those histories and I am agreeing that June 28th and June 30th notes don't mention diarrhea.

Q And, you aren't telling us about the degree of disease process that was discovered on July 2nd, 1999 that there must have been symptoms two, three, however many days earlier, correct?

A Right. And the other thing is the ER doctor's note says it began three days ago uncontrolled with Amodium. So it suggests that it just didn't start that day; otherwise, how could it be uncontrolled with Amodium? But again I'm just telling you what the record says. I don't, I don't know independently when it started.

Q What does Amodium do with C.diff?

A It can make it worse. It's slows down peristalsis.

Q How does that make it worse?

A Well, I can give you the theory how it makes it worse but there's knowledge that it does. The theory is that maybe by slowing down peristalsis it keeps the toxin in the colon longer and allows the colon to being exposed to it for a longer period of time, rather than flushing it out, which is what diarrhea would do. But, it's known that antiperistalsis medication like Amodium and Lomodil aggravate C.difficile colitis as well as other forms of dysentery. We tell people with a bacterial

dysentery not to take Amodium or Lomodil.

Q What is infectious diarrhea?

A Well, literally diarrhea due to infection but that could be viral, it could be bacterial. And, you know, there's many other bacteria besides C.difficile. There's E.coli and Salmonella and Shigella, cholera, et cetera, and with all of those, antiperistalsis agents can make it worse. The only thing that antiperistalsis agents seem to be good for is viral diarrhea and maybe food related, food poisoning.

Q Is C.difficile disease a subsection of infectious diarrhea?

A Well, I think it can be called infectious diarrhea but usually we call it toxic because of the toxins are causing it.

Q What antibiotic, well, do you have an opinion as to whether or not an antibiotic that Ms. Huerster was on led to the C.difficile disease?

A Yeah, Levaquin. That's the only one she was on.

Q What is that for?

A You mean in her case?

Q Yes.

A Because it can be used for a lot of things.

Q Yeah, I'm speaking specifically about Ms. Huerster.

A Yeah. In her case it was used for her presumed lung infection. In the June 13th to 25th admission, she had an exacerbation of her COPD. She did not clearly have pneumonia. But, I think there was a suspicion of pneumonia and/or bronchitis. So, that's what Levaquin was prescribed for. And I have no problem with that, you know.

Q What did the Levaquin do to cause the C.difficile disease?

A Well, any antibiotic can cause C.difficile disease. And how it does it, I'm not, I'm not a hundred percent sure. It may be probably by inhibiting other bacteria in the colon. And, you know, bacteria are competitors with each other and

tend to, there tends to be a balance in the normal flora in the colon as well as other places, in the mouth and the vagina also.

And when you disrupt that normal flora with an antibiotic, you can allow the bacteria that are resistant to that antibiotic to proliferate by suppressing its competitors. How exactly that happens, I don't, you know, there must be scientific explanations for that but it's just an observation. That's why people get yeast infections in their mouth and vagina when they're on antibiotics, other things that, where antibiotics disrupt the normal flora. That's probably the mechanism.

Q I believe you indicate in your report here -- and feel free to review your notes -- Ms. Huerster was on Prednisone as well which was being tapered down after her discharge from the hospital. Is that correct?

A Yes.

Q What effect, if any, would that have on the development of C.difficile disease?

A I don't think it has any effect. Prednisone can suppress the immune system but, you know, it affects the immune system against certain organisms but I don't think against C.diff disease. I've never seen, heard of C.difficile develop as a result of Prednisone by itself. It's usually the result of antibiotics. And I don't think, I don't know of any literature that shows that people, let's say, on antibiotics and Prednisone are at any more risk than antibiotics without Prednisone.

Q Was Ms. Huerster immunocompromised after her discharge from the Parma Hospital on the --

A 25th.

Q -- 25th of June?

A She was to a certain extent with the Prednisone but again not specifically for C.difficile disease.

Q What was causing her thrush?

A Well, the Prednisone and antibiotics can cause thrush. Thrush is a yeast infection that's, if somebody is already carrying yeast, then you give them

antibiotics, you can activate it just like you're activating the C.difficile and, well, Prednisone will activate that, too, by suppressing the immune system.

Q Ms. Huerster was diabetic as well, I believe?

A I don't think so.

Q Do you have a copy of the records from Cardiovascular Clinic?

A No. I told you what records I reviewed. And, by the way, I returned the records. I always do that after I do the initial review.

Q Why?

A Because I don't have storage space.

Q So you have not reviewed the office records of Dr. Sechler, Dr. Zirafi and Dr. Modi?

A That's correct. I told you all the records I reviewed. There's two hospitalizations and the home care records.

Q Was it appropriate for the physicians on Ms. Huerster's readmission to the hospital to obtain an infectious disease consult?

A Yes.

Q Was it appropriate to get a gastroenterology consult?

A Yes.

Q How does Flagyl treat C.difficile disease?

A Well, Flagyl is a, is probably the most effective drug for anaerobes. That means bacteria that can't survive in the presence of oxygen. And, Clostridium difficile is an anaerobe. What its mechanism of action is on the anaerobe I would have to look up. I just, I just know that it's an effective treatment for anaerobes in general and it's the drug of choice for C.difficile disease.

Q Is Flagyl an oral medication?

A It can be given orally and IV.

Q In Ms. Huerster's case, do you recall what, how it was given?

A Well, as I told you, I don't recall anything so I'm going to look at my notes.

Q Please, feel free.

A It was given orally.

Q How long does it take before Flagyl reaches therapeutic levels after its oral administration?

A Thirty minutes, sixty minutes. Now, that's, wait a minute, that's blood level. You know, it's, you actually have two things going on here. You have, in this case you have antibiotic in the blood and also in the intestinal tract. It probably takes longer, if any, it's mostly, must be acting through the blood because most of it gets absorbed in the small intestine and doesn't really get down to the colon. There are other treatments for C.diff like Vancomycin, for example, that strictly is, stays in the colon and then it depends on the transit time, how long it takes to get down to the colon.

Q Well, is it your understanding that oral Flagyl would have to be absorbed in the blood before it acted upon the colon?

A No. No. But it will get absorbed in the blood earlier than it will get to the colon. And either way it acts fairly quickly. That doesn't mean

the disease resolves in 30 or 60 minutes, just the beginning of the action is that quick.

Q Do you know what the action is which occurs within the thirty to sixty minutes after the administration?

A Well, I mean, you can't observe that. You can just, you just know it starts, it would start working on the bacteria that quickly but you wouldn't observe any change in the patients's condition in thirty to sixty minutes but over a matter of six to twelve hours you would.

Q What change would one see within six to twelve hours?

A The first thing would be a decrease in her temperature and then you would start seeing a decrease in the symptoms. But it would take a few days for the patient to, for the diarrhea to stop altogether. I see improvement in 12 to 24 hours in the patient's symptoms but it's acting on the bacteria right away.

Q Is there ever a point of no return, so to speak, with a patient with C.difficile disease?

A Yes. I think when they have toxic megacolon, there's a high mortality to that and often you have to just remove the colon surgically. If they have a perforation, then that's a whole different disease beginning, peritonitis due to the bacteria that are in the colon. I think before that you have a very high cure rate. I don't think I have ever seen a person die from C.difficile disease so that's why I think earlier treatment would have been beneficial in this case. But she wasn't, she didn't have any of the complications on day one that I can see.

Q You have never seen or treated a patient who has died of C.difficile disease?

A I don't think so, no. I think I would remember that.

Q That would include at any of the hospitals that you practice at?

A Yes.

Q To your knowledge?

A Yes. That doesn't mean they don't die. I'm just telling you my own experience.

Q When did Ms. Huerster receive her first dose of Flagyl?

A I have 1800 hours on July 3rd.

Q You would ordinarily expect then certainly by 1800 hours on July 4th that she would see improvement of symptoms?

A Yes. That's what I would have expected prospectively. That's not what happened, obviously, but that's what I would have expected.

Q Why didn't that happen?

A Well, since she was getting appropriate treatment, she must have passed the point of no return. That's a hindsight statement. But, prospectively I wouldn't have expected that and I think that the doctors themselves didn't expect that either.

Q At what point in time did Ms. Huerster reach the point of no return?

A Well, sometime between her presentation on July 2nd, which was 1411 hours, to July 3rd at 1800 hours. And since, as a general rule, infectious

diseases progress exponentially, you would have to be closer to the July 3rd, 1800 hours than the July 2nd, 1411 hours. So, you can't, you know, you can't really be precise in answering that question, you know, to tell you the minute when it was too late. But, somewhere between six and eight hours before the Flagyl was started there was probably a gray area where you can't tell but I think, I think certainly at the evening of July 2nd it wasn't too late to start treatment.

Q Well, how are you able to say that six to eight hours before July 3 at 1800 the administration of Flagyl would have saved her life?

A I don't know. That's why I'm saying, I mean, there's got to be a gray area where you can't be certain. At 1800 it was too late, on July 3rd. At 1700 it was probably too late. I mean, it doesn't work that fast. So, you just keep going back. You've got to have some time for the drug to work. And that's why I said six to eight hours but it's just an estimate.

Also, another way you can look at this is her clinical condition on July 3rd. Dr. Modi noted her abdomen was distended. It was not distended the night of July 2nd, although Dr. Quallich did not describe it as distended when he saw the patient. I think he saw the patient after Dr. Modi. And, Dr. Gopal I think saw the patient after Dr. Modi and didn't say it was distended but it was quite tender to palpation. When Dr. Lazo saw the patient in the ER, it was just some epigastric tenderness.

So, you know, it looks like these different physical exams and then Dr. Modi said on July 4th, worse abdominal distension. So you can see the progression. Also you can see the progression in the laboratory tests. Her potassium was gradually rising, her C02, which is really bicarbonate was gradually dropping. Her renal function was gradually deteriorating. So you can see the progression on the laboratory test, too. So, given the fact that it takes time for antibiotics to have some effect, that's why I say eight hours or so before 1800 on July 3rd,

it may have been too late but I can't be sure.

Q What's the significance of the finding of abdominal distension in a patient with C.difficile disease?

A That is a possibly impending toxic megacolon because normally C.diff doesn't cause abdominal distension.

Q Can a fecalith cause infection?

A Fecal impaction can, yeah, not a fecalith. That's just a little stone that sticks in a diverticulum or the appendix. Dr. Quallich was suspecting that when he saw the patient July 3rd. I don't think she had that as it turned out.

Q When did Dr. Zirafi order the Cleocin?

A I think her, her, I think she just called in orders at 1630 on July 2nd. That's when all of her orders were, because she didn't really see the patient. She just called in those orders at 1630.

Q What do you base your opinion on that she didn't really see the patient?

A Well, there's no note by her own. I think

she said that in her deposition. And, by the way, I didn't mention Lomodil in my report. It's in my comment sheet and she ordered that, too. It's another criticism.

Q Are you critical of Dr. Zirafi for not diagnosing C.difficile disease at the time of Ms. Huerster's admission to Parma Hospital?

A I am critical of not including it in the differential diagnosis and acting on that. I think she did include it in a differential diagnosis based on the orders because she ordered a test for C.difficile toxin. But, she didn't act on that. That's my criticism.

Q So we're clear, your understanding is C.difficile was included on the differential diagnosis, correct?

A Apparently. I mean, she didn't write a note but apparently based on what she ordered, yes.

Q Your criticism is failure to act upon what was on the differential diagnosis?

A Yes. She did the opposite of what should

have been done.

Q She obviously ordered the stool cultures to determine if this was C.diff, correct?

A Yes. I said it's not really a culture. It's a toxin assay.

Q Well, she ordered that test?

A Yes.

Q Do you know why she ordered the Cleocin?

A She stated to continue treatment for the respiratory infection. Remember, the patient had been on Levaquin for that and I think she, she stated in her deposition she was worried about anaerobes and Cleocin has better anaerobic coverage than Levaquin except for the C.diff. It doesn't cover that.

Q Did Ms. Huerster when she presented to the hospital have any respiratory complaints, according to your review of the records?

A No. I think her primary problem was diarrhea and fever. And she had a normal chest x-ray or chest x-ray that didn't show any infection.

Q Did she have any wheezing or any

respiratory complaints?

A You know, I'm looking at my notes but I don't think so. I think her primary problem was the fever and diarrhea and cramps. I'm not critical of starting the Cleocin, just, but I'm just critical of not treating C.difficile.

Q When you say you're not critical of starting the Cleocin, explain for me what you mean.

A Well, if there was some suspicion that she might have continued lung infection, then Cleocin is okay to cover that but she should know that it can aggravate C.difficile and so can Lomodil.

Q And the reason why I ask the question is because you state in the report there was a deviation from the standard of care to prescribe Cleocin rather than Flagyl on 7/2. Now, so that I understand, you are not critical of the decision to prescribe the Cleocin alone, correct?

A Well, it depends on the reason. You know, this is really before I read Dr. Zirafi's deposition, even though that's in my report, but clearly I

reviewed her deposition after I wrote the report. But, Dr. Modi on July 3rd said continue Clindamycin for C.difficile colitis. So the record seems to think, seems that they thought they were treating the C.difficile with Cleocin and that's clearly wrong.

Q Well --

A But if she was treating the lung infection with Cleocin, then that's not, I'm not critical of that.

Q So, if she was acting under the impression that this patient had a lung infection, or, well, had a lung infection or something that could be addressed by the Clindamycin such as the negative anaerobes that you said she mentioned in the deposition, you're not critical of the prescription of that medication?

A Right.

Q What you are critical of is administration of Cleocin for treatment of C.difficile disease?

A If that's, that's what Dr. Modi said and that's clearly wrong. But, in her deposition Dr. Zirafi said that's not the reason she gave it.

Q Did this patient receive a dose of Cleocin?

A Yes. I think she got two doses but I know that's a dispute but it really doesn't matter to me if she got one or two.

Q Why doesn't it matter to you?

MR. BURNETT: Can I interrupt for a minute?

MR. DZENITIS: Yes, sir. Yeah. Is this John?

MR. BURNETT: Yeah. I'm sorry to interrupt. Can I take ten minutes?

MR. DZENITIS: Sure.

MR. BURNETT: Are we going to be okay in taking ten minutes, everybody?

MR. DZENITIS: I'm okay if the doctor's okay.

MR. BURNETT: Doctor, how do you look?

THE WITNESS: I don't know what he said.

MR. DZENITIS: He wants to take ten minutes.

THE WITNESS: We can go without him, can't we?

MR. BURNETT: You probably could actually. I'd kind of appreciate it if you wouldn't. Is that okay with everybody?

THE WITNESS: Yes.

MR. DZENITIS: That's fine with me.

MR. BURNETT: Because we're going almost on two hours and I need to do something real quick and if that's all right, do you want to just keep the conference call going instead of re-calling everybody?

MR. TOGERSON: Yeah, let's do that.

MR. DZENITIS: That's fine.

MR. BURNETT: Because I'm not sure that I could get this going again.

MR. TOGERSON: Good. Good.

MR. BURNETT: So I'm just going to leave it on if it's okay by you.

MR. TOGERSON: That's fine.

MR. BURNETT: What is it, about ten to twelve right now?

MR. TOGERSON: Yeah.

MR. BURNETT: Let's get started back at twelve if that's okay with you guys. All right?

MR. TOGERSON: That's fine.

MR. DZENITIS: That's fine.

MR. BURNETT: Thank you very much.

(There was a break in the proceedings.)

MR. DZENITIS: Doctor, I'm going to -- we'll get back to the deposition. I would like to have a copy of your notes made and both the notes of your review with the factual information as well as the comments sheet that we will attach as number two to the deposition if that's okay.

THE WITNESS: Sure.

(Crane Deposition Exhibit Number 2 was marked for purposes of identification.)

Q Going back to the last question, I believe it was about one or two doses of Clindamycin. We can have the court reporter read it back but I guess what I'm trying to get to is, do you have an opinion as to whether or not the one or two doses of Clindamycin

made Ms. Huerster's condition worse?

A Well, there's first of all the issue of one or two. I have in my notes that she got a dose at 2200 on July 2nd and I wrote here apparently also at 1000 on July 3rd. I wrote "apparently" because I guess I wasn't sure whether she got that morning dose or not. But, I think she probably did because it was ordered every twelve hours. Well, the Clindamycin, I told you all antibiotics can incite C.difficile disease but Clindamycin is, was the first one described and it's still probably the leading cause of C.difficile disease.

So, I would, one would presume that it would aggravate an already existing C.difficile disease. I don't think there's any literature because nobody's going to do that experiment, give somebody C.difficile disease, Clindamycin, and see what happens. So I --

Q Do you have - I'm sorry.

A So I presume it would aggravate C.difficile disease as well as the Lomodil that Dr.

Zirafi ordered.

Q Do you have an opinion as to whether or not those medications in this case did make the disease worse?

A I think most likely it did.

Q Why?

A I mean, you don't have a -- well, because they're known to do that. We don't have a control where Sally Huerster didn't get them and see what happens. I mean, so, all you can say is you more likely than not, since we know Lomodil is known to aggravate it and Cleocin is known to cause it, so, it probably would also aggravate it if it causes it.

Q How did the one or two doses of Clindamycin aggravate the disease?

A The same way it incites the disease -- I can't give you the exact mechanism -- by suppressing the competitors of the organization, probably. And it's not just the one or two doses. It's the fact that it's in her system all this time. It's not the number of doses necessarily. We're talking about 24

hours being in her system.

Q Did the one or two doses of Clindamycin suppress the competitors in Ms. Huerster's colon such that she became worse with the disease?

A Presumably. I think that's just another way of asking the same question.

Q Well, and what I want to know is how we know that this happened. I understand it can be associated in literature or it can be written about in records or in theory we can discuss this. But, how do we know in Ms. Huerster's case this one or two doses made a difference?

A We don't know. We just presume since it can incite the disease that it would also aggravate the disease. That's all I can tell you.

Q How much Lomodil did she get?

A She was ordered one or two tablets every six hours as needed for diarrhea. I think she got two tablets during the night of November, I mean September -- the night of July 2nd, 3rd. She might have gotten more but I'm not sure. I would have to look at the

records again.

Q Where do you get the information that there was a dose of Clindamycin at 2200 and possibly at 1000 on the 3rd?

A Well, right now I'm getting it from my notes so how I got it originally, it must be from the medication sheets.

Q And then similarly the one or two tablets or, excuse me, the two tablets of Lomodil that you said she got throughout the night for diarrhea?

A Again I can't, I think I saw it either in the nurses' notes or the medication sheets. I would have to look at that again. I haven't looked at the records for, for, you know, for four years. So I would have to look at them again. I'm just testifying from my notes.

Q From the autopsy report, the pages that you have, am I correct that you have three pages from that report which consist of the --

A Well, already I'm going to say no because I've got two pages.

Q Two pages; what two pages do you have?

A The final diagnosis, which he lists one through twenty.

Q Which is a two-page document?

A Yes.

Q Is a 600-gram heart a large heart?

A I think so but I can't, I don't, I don't remember right now what the normal weight is. He did, he did in his diagnosis number four, said biventricular hypertrophy so that means it was enlarged.

Q Is a left ventricular myocardium hypertrophy measuring approximately two centimeters in thickness significant to you?

A It sounds like it's enlarged but it's really out of my field. It's really a pathologic question.

Q Ms. Huerster when admitted to the hospital on June 13, 1999, weighed at or around 200 pounds and was complaining of swelling. Do you have an opinion as to the cause of that swelling?

A Well, they thought she was mild to moderate congestive heart failure, initially. But, you know, I haven't, what I have in front of me is I have the discharge summary which shows at physical exam, no edema. So I don't know, when you said complaints of swelling, maybe she had a history of edema but if she did have edema, I would ascribe it to congestive heart failure. Could be peripheral venous insufficiency also.

Q Assume for purposes of the question that she lost 13 pounds during this hospitalization and at the time of her discharge she had no residual leg edema, is that edema consistent with heart failure?

A Yes, and/or venous insufficiency in the legs. But, you know, under the final diagnosis, diagnosis number two is congestive heart failure. And also in the discharge summary it says she was diuresed by Dr. Sechler's group. I know she was treated with Lasix.

Q In your report you indicate that the autopsy was consistent with sepsis secondary to

C.difficile colitis. What are you basing that opinion upon?

A Well, the autopsy, you don't really see sepsis on an autopsy but the pseudo membranous colitis with evidence of toxic megacolon was in the autopsy and the clinical course was consistent with sepsis.

Q Were there blood cultures taken?

A Um, yes. The only cultures I have in my notes are July 5th and they were negative. But, if you are implying that blood cultures have anything to do with the definition of sepsis, they don't. Sepsis is a syndrome that's not dependent on the blood cultures in the definition.

Q When did this sepsis syndrome begin with Ms. Huerster?

A She had some evidence of early sepsis, actually, on July 2nd when she came to the emergency room. Sepsis syndrome is a spectrum from early to middle to late. And, she had, when she presented to the emergency room, she had actually high -- low, a low temperature, although a history, let's see, low

temperature, history of chills, no documented fever, elevated white count, left shift, a low platelet count. These are, these add up to evidence of early, early sepsis. It's difficult to define early sepsis because a lot of things can do these things but as she progressed, she definitely was septic. She became acidotic.

Q What was the cause of the acidosis?

A I think the sepsis syndrome plus maybe a loss of bicarbonate in the diarrhea, renal insufficiency. It's multifactorial.

Q What was causing the renal insufficiency?

A The sepsis, the loss of fluids but they replaced the fluids. So, I think it was mostly sepsis that caused renal insufficiency.

Q What was the cause of the elevated potassium that she experienced and that was --

A Well, they were giving her potassium and they stopped it as the potassium was going up. Acidosis is related to elevated potassium and sepsis can cause elevated potassium.

Q Did it?

A What?

Q Did it in her case?

A Again I think it's multifactorial. She was getting acidotic, she was going into renal insufficiency and she was being given potassium and all those things add up to causing elevated potassium levels.

Q What was the cause of the mucus plug in the left upper lobe bronchus?

A You know, first of all, what evidence did she have a mucus plug in her left upper lobe bronchus? I didn't see that. But that can be caused by dehydration, just lying in bed and not mobilizing secretions. And that's a common finding in debilitated patients in the hospital.

Q Can it cause someone to die?

A Usually not unless an entire lung is plugged up in somebody with COPD who doesn't have a lot of reserve capacity.

Q I'm going to read from the nurses' notes

on 7/5/99, at 6:15 in the morning. I'll just ask you to assume that this is the note from this day. If you would like, you can read along with me. Lab in to draw BC times two, patient audibly gurgling and spit up with encouragement. Small amount, brown/red fluid, shut off IV and suctioned patient for same. 6:20, patient's eyes rolled up and express was called. See express sheets for details. Doctors informed. Daughter and family aware of patient expired 6:55, paperwork filled out, Life Bank notified. Is that set of facts consistent with patient developing a mucus plug?

A Now, for this to be consistent with a mucus plug, the trachea would have to be plugged up. I mean, this has to be an aspiration episode where there's, air is just not getting into the lungs at all, for somebody to die like this. And --

Q Do you have -- I'm sorry. Go ahead.

A If she spit up with encouragement, I thought, I had the impression that she had a primary cardiac arrest. There's another note by the house

officer that says, well, the house officer note just says -- never mind. That doesn't help. There's a note by Dr. Modi which says she suddenly coughed up mucous with blood and immediately coded.

Q Is that consistent with the mucus plug?

A I don't think so. I mean, it has to be a major aspiration, where there's not just a plug in a bronchus but the trachea has to be plugged so that air is not getting in. And it says she coughed it up. They suctioned her. I think, my impression is that she had a primary cardiac arrest causing this, due to the metabolic abnormalities, the high potassium, the acidosis.

Q What would the high potassium cause?

A Well, high potassium causes arrhythmia and acidosis causes arrhythmia and sepsis causes arrhythmia so I think it's all those factors can cause her to have a cardiac arrest.

Q Was there -- sorry, I didn't mean to interrupt you. Was there any evidence in the records that you saw that Ms. Huerster had an arrhythmia

before dying?

A No. This was a sudden cardiac arrest, it looks like. Dr. Modi's last note states there was no arrhythmia before the event. Now, I don't know if she was on a monitor or not so I don't know how he knows that but assuming it was true, then this was just a sudden arrest, an asystole or a ventricular fibrillation. That potassium and bicarbonate levels are certainly sufficient to do that.

Q Without an arrhythmia?

A Well, this was the arrhythmia. No preceding arrhythmia. And it's three factors. It's the potassium, it's the bicarbonate and it's the general toxins produced by the sepsis syndrome that can all cause cardiac arrest. That's what I think happened because, you know, if you read Dr. Modi's note, it looks like she had a massive pulmonary embolus but she didn't have that at autopsy. It could have been a major aspiration episode but it just seems less likely to me but that's what the mucus plug would be, would be the trachea being plugged, not a

bronchus. And I can't rule that out.

Q Now, have you covered all the reasons why you believe this to be inconsistent with a mucus plug?

A I just, I just got finished saying I can't rule that out. I just, I just think that if it's a mucous plug, it would have to be the trachea because this has to be a total asphyxiation in order for her to die like that. And, that would be a major blockage of the trachea. Just doesn't look like that's what happened but I guess it's possible.

Q You talked about earlier the note that Dr. Modi wrote where he says continue Clindamycin for C.diff. And, I believe we've talked about Dr. Zirafi and her actions when she admitted Ms. Huerster to the hospital and the Lomodil and the Cleocin?

A And the failure to treat the C.diff.

Q The C.diff should have been treated how?

A Flagyl.

Q Without cultures?

A Well, you order the -- it's a toxin assay. It's not a culture.

Q Sorry, without the stool samples?

A Right. Well, you order the stool sample but you don't wait for the result. That's, a general principle in infectious disease is if the patient is sick enough, you never wait for the result before you start empiric treatment. That's why we call it empiric treatment. We don't know for sure that they have that condition. We just think that they probably have it and so you cover that therapeutically while you are waiting for the result.

Q So, your primary criticism of Dr. Zirafi is failure to treat the suspected C.diff with empiric Flagyl, correct?

A Right. And ordering Lomodil, those two things.

Q And ordering the Lomodil, and we have discussed the Cleocin issue. Your criticism of Dr. Modi is the note which was the next day?

A I'm not critical of Dr. Modi because there's no causation there. They got an ID consult who countermanded that right away. I mean, I don't

have the times of these but it looks like Dr. Gopal came if fairly soon after Dr. Modi wrote that note and countermanded it so there's no harm done by Dr. Modi.

Q You're not critical of Dr. Modi's management of Ms. Huerster aside from this note which you think --

A Right. I mean, if Dr. Gopal didn't come in and save the day, then I would be critical but Dr. Gopal countermanded that fairly quickly.

Q And your criticism of Dr. Sechler --

A Well, that's contingent on whether the nurses, that's contingent on whether the daughters and daughter-in-law called Dr. Sechler's office and reported severe diarrhea. And I can't, I don't know if it's true or not so if it's true, then I would be critical of Dr. Sechler for not, on June 27, June 28, July 1st if he didn't respond appropriately to those phone calls. But I don't, I can't, it's not up to me to decide if those phone calls were made and what was said.

Q And you don't have any medical records or

contemporaneous records that that information was conveyed to Dr. Sechler?

A Right.

Q Or the office?

A Right.

Q Have we covered all of your criticisms of the case --

A Yes.

Q -- with respect to the doctors and the doctor group?

A Yes. My criticism of Dr. Sechler is contingent on what was said and my criticism Dr. Zirafi is firm and that's it. I'm not critical of Dr. Modi. I mean, I'm critical of him but it doesn't, there's no harm done.

Q Do you have an opinion as to Ms. Huerster's life expectancy?

A Yeah. I just, I just do an estimate. The way I go about that is to look up what is the average person at her age expected to live and then say is she average and if not, how much below average is she.

The average person, the average 64-year-old white woman is expected to live 20 years. Now, I think she's below average. She had mitral valve replacement. She had congestive heart failure. She has COPD. Keeping in mind average isn't healthy, doesn't mean healthy, it just means the average 64-year-old, that combines all healthy and unhealthy people together, I think, I would say given good medical care maybe ten years, half the expected life expectancy. But that's really a rough estimate.

Q Does your rough estimate take into account the degree to which she was experiencing congestive heart failure and the degree of her COPD?

A Yes. She's, that's why I'm giving half the average life expectancy.

Q Understanding that she was on oxygen?

A Yeah. All I know is she had an exacerbation June 13th of her COPD. We see that quite often. She had mild to moderate congestive heart failure, which was treated and she responded to treatment. And she can continue to go on like that.

We see patients like that all the time. You know, my associates here are pulmonary specialists and they see people like this all the time and I discuss cases with them.

Q Did she have any regurgitation in the valves?

A Could you repeat that?

Q Did she have any regurgitation in the heart valves or in the heart?

A No. Well, not, I mean, they didn't hear any murmurs when she was -- I'm just looking at the discharge summary from the June 13th admission. No, I think her valve was functioning well.

Q The discharge summary I'm reading from Dr. Sechler, the impression was under number two, mitral stenosis, status post mitral valve replacement with mild to moderate paraprosthetic leak and moderate to severe global left ventricular systolic dysfunction on echocardiogram.

A Which discharge summary is that?

Q I'm sorry. That's a consultation report.

A Oh, okay.

Q Does that -- and I was reading from the second part of that report. Does that affect your opinion as to her life expectancy?

A No. That's why I'm saying half the, you know, because she had significant comorbid conditions. But she was stable. I mean, he also says in what you just read, no significant prosthetic valvular dysfunction. So, I think she was stable, as far as I know. And I haven't looked at the old records. But, the, her primary problem June 13th of '99 was pulmonary, not cardiac.

Q Have we covered all the opinions you have regarding the doctors and the physicians group --

A Yes.

Q -- in this case?

A Yes.

Q If you review additional information and form additional opinions, could you please notify Mr. Burnett so that I can speak with you again?

A Yes.

MR. DZENITIS: Thank you. Those are all my questions.

THE WITNESS: I don't think I will, though, by the way.

MR. DZENITIS: Gentlemen, Mr. Togerson?

EXAMINATION BY MR. TOGERSON:

Q Right. Doctor, this is Ken Togerson. I represent Parma Community General Hospital and Parma Home Health Care. You understand that, correct?

A Yes. Yes.

Q Now, I had a little trouble listening to you because either my phone or your system causes fades so often I wouldn't hear the entire question or entire answer. And, I tried to intuit from what was said, what was asked or vice versa. I probably don't need to go into any of that but I simply say it and hope, you know, if you have been moving back and forth away from your speaker phone that you will kind of speak straight into it, at least until I get through my small part of this deposition.

A Maybe you need a hearing aid.

Q I might well need a hearing aid and various other aids but I don't think I will be able to get them by the time this deposition is over. You've made additional notes since reading the depositions of those witnesses that you have been provided with after you did your initial report, is that correct?

A Yes. You want, if I can be precise, the depositions I read after my report was Dr. Zirafi, and I'm sorry my report says I read that but I didn't, and the three nurses, Mary Ann Ambrose, Carol Stem and Denise "Low" or Laux and then the two depositions of Christine Huerster.

Q Have you made any notes other than in those depositions and the exhibit you referred to as the notes you made?

A No. They're on pages, remember I told you I letter the pages for depositions, so they're on pages C and D, are the notes from the depositions.

Q You made notes of the depositions?

A Yes. I take notes when I read a deposition.

Q And, has Mr. Dzenitis made your notes an exhibit to this deposition?

A We will.

Q Okay. Have you made any notes referring to the depositions of nurses Ambrose, Stem or Laux?

A Yes. They're very brief.

Q Would you read them into the record for me.

A Yes. For Mary Ann Ambrose, and I have little page numbers so you will see on the notes, but, it says, "If patient reported severe diarrhea, I would report it to the physician immediately. Same for elevated white count. I consider severe diarrhea as ten to thirteen loose bowel movements a day and inability to take fluids. Five to ten per day is moderate. I would report mild, moderate or severe to the doctor. I don't remember this patient. Record shows I saw her June 30th of '99. I called Dr. Sechler regarding the CBC. The white count was elevated. If I knew patient had diarrhea, I would have told Dr. Sechler."

That's, for the other two nurses I just have very brief. For Carol Stem I wrote, "I would report diarrhea to the doctor. I saw the patient June 26th of '99." And I put in parentheses, I think she meant June 28th, with a question mark. For Denise L-A-U-X, I just said, "Saw patient June 26th of '99." That's all I wrote.

Q All right. Well, you understand that Stem, Nurse Stem saw Mrs. Huerster on the 28th?

A That's what I put in parentheses. I thought she saw her on the 28th.

Q Her deposition referred to the 26th?

A Yes, page six. It might have corrected that later in the deposition but I didn't write that in my notes.

Q All right. Well, what was the purpose of making those notes from those depositions as you have read?

A Well, when I'm sent a deposition, I take notes from it and I just, as I read it, I write down what looks important to me. I just sort of use my

judgment as I'm reading it.

Q All right.

A But they didn't tell me anything new.

Q All right. And, they didn't cause you to change any opinions that you otherwise had or expressed in your report of August 7th, 2001?

A That's correct. My opinions on the nurses is simply contingent on what was said, and, but that the records showed no deviation as far as I'm concerned and nor did the depositions of the nurses.

Q So you were satisfied after reviewing the home health care records and reading the depositions that from what the nurses said they did, that they could remember and what their contemporaneous records reflected that those passed the standard of care, is that so?

A Yes. The only, the only thing that makes one question it is, of course, Christine Huerster's deposition where she says we told them about severe diarrhea and the records of July 2nd and July 5th stating that she had diarrhea, suggested that she had

diarrhea as of June 28th or 29th. So, it, really the only, then the question becomes were they told and so on. But it's not really up to me to decide. I'm just saying if they were told, they should have done something and they're saying the same thing, if we were told, we would do something.

Q So, any opinion you have with regard to the nurses is contingent on facts that you can't make any determination on, is that so?

A Right. Right. My only opinion is that if they were told, they should have told the doctor and they're saying the same thing, so.

Q Now, you have never expressed any criticism of the hospital itself, is that so?

A That's correct. I don't have any.

Q So, that goes for both admissions, that is, the original admission of 6/13/25 and the follow-up admission of 7/2/1999 through 7/5, you have no criticisms?

A Correct.

Q Now, and, did you also review Christine

Huerster's deposition? I know you did because you just told me you did but she says in her deposition that she also called and told Dr. Sechler, is that so?

A Yes.

Q Now, if she, if that is, if you contingently accept that in the same way you contingently accept that she said she told the nurses, if she told Dr. Sechler, there would be an interruption in any kind of cause and effect from the nurses not reporting to Dr. Sechler?

MR. DZENITIS: Object to the form.

Q Do you follow me with that?

MR. DZENITIS: Object to the form. Go ahead. I'm sorry.

A Yes, I do follow you with that. In other words, it's really, it becomes a double thing. If she told the home care nurses, they should have told Dr. Sechler but at the same time Christine Huerster says she called Dr. Sechler.

Q Yeah. So, if she did both of those things hypothetically, as she says she did, once Dr. Sechler

knew, that would relieve the nurses from any causative element of anything that subsequently happened, is that so?

MR. DZENITIS: Object to the form.

A Yes.

Q Because it is also your testimony that had any physician known by at least July 1st and also by July 2nd of this condition, therapeutic medication could have been given that in your opinion would relieve the patient of the problems which subsequently developed?

A Yes.

MR. DZENITIS: Object to the form.

A Yes.

MR. TOGERSON: All right. Now, you really, the only -- well, strike that. Let me just take a look at my notes. No sense in repeating what you already said. All right. I believe that's, that that does it, Doctor. I think I have satisfied myself, so, I appreciate the additional time you provided in this instance. This may give rise to

further questions by Mr. Dzenitis but I am content for the moment.

MR. DZENITIS: No questions.

MR. TOGERSON: Well, if there are no questions, can Paul, will you see that Dr. Crane's notes are marked as an exhibit?

MR. DZENITIS: Yes. Yeah, they're exhibit --

MR. TOGERSON: Are you going to keep control of those exhibits, Paul, or are you going to give them to the court reporter?

MR. DZENITIS: Can we make a copy here?

THE WITNESS: We can make two copies.

MR. DZENITIS: What we'll do is make two copies here and handle it that way so that he doesn't have to have stickers on his notes.

MR. TOGERSON: Okay. All right. Then I guess, we're concluded.

MR. DZENITIS: Okay.

MR. TOGERSON: Thanks very much, Doctor.

MR. BURNETT: He'll read and sign, Ken,

okay?

MR. TOGERSON: That's fine.

MR. DZENITIS: We're signing off. Thanks.

(Deposition concluded at 12:35 p.m.)

CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary, I will attach on a separate sheet of paper to the original transcript.

_____

Neil A. Crane, M.D.

State of Maryland

Baltimore County, to wit:

I, ROBERT A. SHOCKET, a Notary Public of the State of Maryland, County of Baltimore, do hereby certify that the within-named witness personally appeared before me at the time and place herein set out, and after having been duly sworn by me, according to law, was examined by counsel.

I further certify that the examination was recorded stenographically by me and this transcript is a true record of the proceedings.

I further certify that I am not of counsel to any of the parties, nor in any way interested in the outcome of this action.

As witness my hand and notarial seal this 1st day of March, 2004.

_____

Robert A. Shocket,

Notary Public

My Commission Expires:

November 1, 2006

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Deposition of Neil A. Crane, M.D.

February 17, 2004