

1 IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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3 MICHELLE R. FREEMAN, etc.

Judge Burt Griffin

4

Plaintiff

Case No. 490991

5

vs.

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THE CARDIOVASCULAR CLINIC, et al.

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Defendants

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The deposition of NEIL A. CRANE, M.D., was

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held on Tuesday, February 17, 2004, commencing at

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10:10 a.m., at the offices of Dr. Crane, 5530

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Wisconsin Avenue, Suite 800, Chevy Chase, Maryland

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20815 before Robert A. Shocket, a Notary Public.

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REPORTED BY: Robert A. Shocket

1 APPEARANCES:

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

3
PAUL A. DZENITIS, ESQUIRE

4 On behalf of Defendants
The Cardiovascular Clinic,
5 Christine M. Zirafi, M.D.
James L. Sechler, M.D.
6 Raju Modi, M.D.

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

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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

1 front of you?

2 A Yes.

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

6 A Yes.

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

9 A Yes.

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

12 A Yes.

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

16 A Yes.

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

21 A Yes.

1 Q Doctor, you are an internal medicine
2 physician?

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

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

7 A No.

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

10 A No. I do general infectious disease.

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

15 A Yes.

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

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

20 Q Doctor, you are certified in internal
21 medicine?

1 A Yes.

2 Q And that certification was received in
3 1972?

4 A Yes.

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

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

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

12 A Yes.

13 Q Were there written and orals for that
14 examination?

15 A No, just written.

16 Q And you passed on the first time?

17 A Yes.

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

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

21 MR. TOGERSON: Hello?

1 MR. DZENITIS: Yes.

2 MR. TOGERSON: Oh, okay.

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

5 MR. TOGERSON: Okay.

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

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

10 BY MR. DZENITIS:

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

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

17 Q Are you a member of the American Medical
18 Association?

19 A No.

20 Q Have you ever been a member of that
21 association?

1 A No.

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

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

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

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

20 Q What hospitals do you practice at?

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

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

11 Q Do you teach residents or medical
12 students?

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

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

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

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

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

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

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

15 A Yes.

16 Q What kind of residents were these?

17 A Medicine.

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

20 A Yes.

21 Q Were they doing a rotation in infectious

1 disease?

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

4 Q Where did you do your infectious disease
5 fellowship?

6 A Massachusetts General Hospital in Boston.

7 Q And how long was that?

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

9 Q So you completed your infectious disease
10 fellowship in 1972?

11 A Yes, and all of my training in 1972.

12 Q And then you became certified in '78?

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

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

3 Q Have you written any medical literature?

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

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

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

13 Q What were these published in, do you
14 recall?

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

18 Q What textbook?

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

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

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

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

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

10 A Yes.

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

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

15 Q How long have you been in this office?

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

18 Q Have you ever practiced with partners?

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

1 '77.

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

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

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

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

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

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

1 month now.

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

4 A About four. Four or five times a year.

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

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

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

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

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

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

7 A No. Numerous.

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

15 A If your math is correct, yes.

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

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

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

3 A Yeah.

4 Q -- of cases that you have testified in?

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

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

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

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

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

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

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

7 A '77.

8 Q '77?

9 A I started reviewing cases in '78.

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

12 A No.

13 Q What was this case involving in 1977?

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

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

5 Q Was he a diabetic?

6 A No, I don't think so.

7 Q The case did not go to trial?

8 A No.

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

11 A Three hundred thousand, I think.

12 Q Have you testified in a federal court
13 case?

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

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

18 A No. I don't keep lists.

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

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

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

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

6 A I think about three years ago.

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

10 A No.

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

14 A No.

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

18 A No.

19 Q You have an active practice --

20 A Yes.

21 Q Excuse me, active license to practice in

1 Maryland, correct?

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

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

5 A No.

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

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

10 Q That would be 10 percent of your
11 professional time?

12 A Yes.

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

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

18 Q Do you see patients in this office?

19 A Yes.

20 Q How many days out of the week?

21 A Five.

1 Q Do you regularly do rounds?

2 A Yes.

3 Q Would that be daily?

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

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

10 A Yes.

11 Q Do you advertise your services as an
12 expert?

13 A No.

14 Q Have you ever advertised your services as
15 an expert?

16 A No.

17 Q Are you a member of any expert referral
18 services?

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

1 past which I don't anymore.

2 Q What were those?

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

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

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

16 Q For TASA?

17 A Yes.

18 Q How many cases for Sapanaro?

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

1 altogether. I'm guessing.

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

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

6 Q And from TASA?

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

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

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

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

17 A Yes, I do.

18 Q Are all of your plaintiffs cases from that
19 organization?

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

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

4 Q Do you know if that service advertises
5 your name?

6 A I don't think they advertise my name.

7 Q Do they advertise?

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

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

13 A Yes.

14 Q When was that initial contact?

15 A Well, I wrote down the date that I
16 reviewed the records and that was December 30th of
17 1999. So, the initial, I usually don't keep records
18 sitting around for long so the initial contact had to
19 be no more than two weeks before that.

20 Q What was the form of that contact?

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

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

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

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

21 Q Have you reviewed cases for Mr. Burnett

1 before?

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

4 Q You have reviewed cases for Becker and
5 Mishkind?

6 A Yes.

7 Q How many?

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

11 Q Have you testified live in Cleveland?

12 A Yes.

13 Q Do you recall the last time?

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

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

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

1 Toledo.

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

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

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

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

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

18 A Yes.

19 Q Are all the notes with you here today?

20 A Yes.

21 Q Did you, do you recall what information

1 you first received in the case?

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

4 Q Sure. Take your time.

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

21 Q Did you receive an enclosure letter with

1 those materials?

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

5 Q That's been discarded?

6 A Yes.

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

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

13 Q Why do you do that?

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

1 enough to just keep so I just photostat it.

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

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

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

12 A The discharge summary from the June 13th,
13 '99 admission, the discharge summary from the July
14 2nd, '99 admission and the autopsy report.

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

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

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

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

4 A That's the date I started my review.

5 Q Started the review?

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

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

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

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

17 A Yes.

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

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

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

3 Q What depositions did you receive?

4 A Okay. And what dates did I review them?

5 Q Did you begin your review, correct.

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

15 Q Have you reviewed anything else?

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

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

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

21 Q Have you seen a diary, a computerized

1 written diary in the case?

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

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

9 A Right.

10 Q When did you form your opinions about this
11 case?

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

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

1 depositions.

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

4 A You're right.

5 Q Have you spoken --

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

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

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

21 Q Nevertheless, you formed the opinions that

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

3 A Yes.

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

6 A Yes.

7 Q Were there any drafts of this report?

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

12 Q Do you have any of these other --

13 A No.

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

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

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

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

15 A Yes.

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

18 A No.

19 Q Do you recall any discussion with Mr.
20 Burnett?

21 A Well, I just talked to him yesterday about

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

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

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

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

13 A Correct.

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

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

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

21 A No.

1 Q What do you charge for review?

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

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

10 A Oh, just the records.

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

14 A Yes, the rate of --

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

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

20 Q What do you charge for live testimony?

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

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

3 Q Have you discussed this case with any
4 other physicians?

5 A No.

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

8 A No.

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

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

1 so.

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

5 A Right.

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

10 A Yes.

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

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

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

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

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

5 Q What is C.difficile?

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

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

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

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

4 Q What are the symptoms of C.diff?

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

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

18 A Yes.

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

21 A Yeah. Actually, due to the toxin that the

1 bacteria is producing.

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

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

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

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

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

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

13 Q Do you know the --

14 A Excuse me.

15 Q All right.

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

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

21 A Not precisely. I think what it, the

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

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

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

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

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

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

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

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

19 A Right.

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

1 colitis on pathology?

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

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

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

18 Q What's the appearance on gross?

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

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

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

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

12 Q Right.

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

18 Q Do you know the different layers of the
19 colon?

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

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

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

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

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

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

21 Q And the muscularis propria is the last

1 layer?

2 A No, it's the middle layer.

3 Q What's the last layer?

4 A The outer layer is the serosa.

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

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

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

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

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

12 Q Did Ms. Huerster develop a toxic
13 megacolon?

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

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

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

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

6 Q Do these patients develop impaction?

7 A Impaction?

8 Q Fecal impaction?

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

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

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

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

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

12 A Yes.

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

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

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

7 Q What are the stool tests for C.difficile?

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

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

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

9 Q Ordinarily non-bloody?

10 A Non-bloody, usually.

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

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

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

1 A Yes.

2 Q -- just by the nature of your answer?

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

12 Q And this incubation period is variable?

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

16 Q During the incubation period are there
17 symptoms?

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

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

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

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

8 Q In your report you indicate that on the
9 second full paragraph of the second page, which is a
10 one-sentence paragraph, that it is your opinion Ms.
11 Huerster developed the symptoms of C.difficile colitis
12 around 6/29. And I think, well, let me, I think you
13 indicated to me before the symptoms of C.difficile
14 colitis or C.difficile disease would be diarrhea,
15 fever, possibly cramping, weakness. What symptoms in
16 the records do we have of C.difficile colitis around
17 6/29?

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

1 29th. And the history and physical by Dr. Modi, which
2 was dated July 3rd, says five days ago developed
3 diarrhea, so, and cramping, abdominal pain so that
4 would put it at June 28th if these histories are
5 accurate.

6 Q Exactly.

7 A Right.

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

10 A No.

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

12 A That's correct.

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

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

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

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

4 A Yeah. And I should make it clear.

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

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

15 A Yes. I'm just basing it on those
16 histories and I am agreeing that June 28th and June
17 30th notes don't mention diarrhea.

18 Q And, you aren't telling us about the
19 degree of disease process that was discovered on July
20 2nd, 1999 that there must have been symptoms two,
21 three, however many days earlier, correct?

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

8 Q What does Amodium do with C.diff?

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

11 Q How does that make it worse?

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

1 dysentery not to take Amodium or Lomodil.

2 Q What is infectious diarrhea?

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

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

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

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

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

1 Q What is that for?

2 A You mean in her case?

3 Q Yes.

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

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

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

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

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

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

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

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

19 A Yes.

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

1 A I don't think it has any effect.

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

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

13 A 25th.

14 Q -- 25th of June?

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

18 Q What was causing her thrush?

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

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

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

6 A I don't think so.

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

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

12 Q Why?

13 A Because I don't have storage space.

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

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

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

1 A Yes.

2 Q Was it appropriate to get a
3 gastroenterology consult?

4 A Yes.

5 Q How does Flagyl treat C.difficile disease?

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

14 Q Is Flagyl an oral medication?

15 A It can be given orally and IV.

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

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

20 Q Please, feel free.

21 A It was given orally.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 A Yes.

19 Q To your knowledge?

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

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

3 A I have 1800 hours on July 3rd.

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

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

10 Q Why didn't that happen?

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

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

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

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

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

14 A I don't know. That's why I'm saying, I
15 mean, there's got to be a gray area where you can't be
16 certain. At 1800 it was too late, on July 3rd. At
17 1700 it was probably too late. I mean, it doesn't
18 work that fast. So, you just keep going back. You've
19 got to have some time for the drug to work. And
20 that's why I said six to eight hours but it's just an
21 estimate.

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

11 So, you know, it looks like these
12 different physical exams and then Dr. Modi said on
13 July 4th, worse abdominal distension. So you can see
14 the progression. Also you can see the progression in
15 the laboratory tests. Her potassium was gradually
16 rising, her CO2, which is really bicarbonate was
17 gradually dropping. Her renal function was gradually
18 deteriorating. So you can see the progression on the
19 laboratory test, too. So, given the fact that it
20 takes time for antibiotics to have some effect, that's
21 why I say eight hours or so before 1800 on July 3rd,

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

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

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

8 Q Can a fecalith cause infection?

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

14 Q When did Dr. Zirafi order the Cleocin?

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

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

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

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

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

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

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

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

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

21 A Yes. She did the opposite of what should

1 have been done.

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

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

6 Q Well, she ordered that test?

7 A Yes.

8 Q Do you know why she ordered the Cleocin?

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

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

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

21 Q Did she have any wheezing or any

1 respiratory complaints?

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

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

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

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

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

1 reviewed her deposition after I wrote the report.

2 But, Dr. Modi on July 3rd said continue Clindamycin
3 for C.difficile colitis. So the record seems to
4 think, seems that they thought they were treating the
5 C.difficile with Cleocin and that's clearly wrong.

6 Q Well --

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

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

16 A Right.

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

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

1 Q Did this patient receive a dose of
2 Cleocin?

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

6 Q Why doesn't it matter to you?

7 MR. BURNETT: Can I interrupt for a
8 minute?

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

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

13 MR. DZENITIS: Sure.

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

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

18 MR. BURNETT: Doctor, how do you look?

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

20 MR. DZENITIS: He wants to take ten
21 minutes.

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

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

6 THE WITNESS: Yes.

7 MR. DZENITIS: That's fine with me.

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

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

13 MR. DZENITIS: That's fine.

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

16 MR. TOGERSON: Good. Good.

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

19 MR. TOGERSON: That's fine.

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

1 MR. TOGERSON: Yeah.

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

4 MR. TOGERSON: That's fine.

5 MR. DZENITIS: That's fine.

6 MR. BURNETT: Thank you very much.

7 (There was a break in the proceedings.)

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

14 THE WITNESS: Sure.

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

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

1 made Ms. Huerster's condition worse?

2 A Well, there's first of all the issue of
3 one or two. I have in my notes that she got a dose at
4 2200 on July 2nd and I wrote here apparently also at
5 1000 on July 3rd. I wrote "apparently" because I guess
6 I wasn't sure whether she got that morning dose or
7 not. But, I think she probably did because it was
8 ordered every twelve hours. Well, the Clindamycin, I
9 told you all antibiotics can incite C.difficile
10 disease but Clindamycin is, was the first one
11 described and it's still probably the leading cause of
12 C.difficile disease.

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

19 Q Do you have - I'm sorry.

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

1 Zirafi ordered.

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

5 A I think most likely it did.

6 Q Why?

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

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

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

1 hours being in her system.

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

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

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

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

16 Q How much Lomodil did she get?

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

1 records again.

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

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

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

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

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

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

1 Q Two pages; what two pages do you have?

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

4 Q Which is a two-page document?

5 A Yes.

6 Q Is a 600-gram heart a large heart?

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

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

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

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

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

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

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

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

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

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

7 Q Were there blood cultures taken?

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

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

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

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

8 Q What was the cause of the acidosis?

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

12 Q What was causing the renal insufficiency?

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

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

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

1 Q Did it?

2 A What?

3 Q Did it in her case?

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

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

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

17 Q Can it cause someone to die?

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

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

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

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

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

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

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

5 Q Is that consistent with the mucus plug?

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

14 Q What would the high potassium cause?

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

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

1 before dying?

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

10 Q Without an arrhythmia?

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

1 bronchus. And I can't rule that out.

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

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

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

16 A And the failure to treat the C.diff.

17 Q The C.diff should have been treated how?

18 A Flagyl.

19 Q Without cultures?

20 A Well, you order the -- it's a toxin assay.

21 It's not a culture.

1 Q Sorry, without the stool samples?

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

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

14 A Right. And ordering Lomodil, those two
15 things.

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

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

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

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

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

10 Q And your criticism of Dr. Sechler --

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

21 Q And you don't have any medical records or

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

3 A Right.

4 Q Or the office?

5 A Right.

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

8 A Yes.

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

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

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

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

1 The average person, the average 64-year-old white
2 woman is expected to live 20 years. Now, I think
3 she's below average. She had mitral valve
4 replacement. She had congestive heart failure. She
5 has COPD. Keeping in mind average isn't healthy,
6 doesn't mean healthy, it just means the average
7 64-year-old, that combines all healthy and unhealthy
8 people together, I think, I would say given good
9 medical care maybe ten years, half the expected life
10 expectancy. But that's really a rough estimate.

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

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

16 Q Understanding that she was on oxygen?

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

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

5 Q Did she have any regurgitation in the
6 valves?

7 A Could you repeat that?

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

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

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

20 A Which discharge summary is that?

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

1 A Oh, okay.

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

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

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

15 A Yes.

16 Q -- in this case?

17 A Yes.

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

21 A Yes.

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

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

5 MR. DZENITIS: Gentlemen, Mr. Togerson?

6 EXAMINATION BY MR. TOGERSON:

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

10 A Yes. Yes.

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

21 A Maybe you need a hearing aid.

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

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

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

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

19 Q You made notes of the depositions?

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

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

3 A We will.

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

6 A Yes. They're very brief.

7 Q Would you read them into the record for
8 me.

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

1 That's, for the other two nurses I just
2 have very brief. For Carol Stem I wrote, "I would
3 report diarrhea to the doctor. I saw the patient June
4 26th of '99." And I put in parentheses, I think she
5 meant June 28th, with a question mark. For Denise
6 L-A-U-X, I just said, "Saw patient June 26th of '99."
7 That's all I wrote.

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

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

12 Q Her deposition referred to the 26th?

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

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

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

1 judgment as I'm reading it.

2 Q All right.

3 A But they didn't tell me anything new.

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

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

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

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

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

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

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

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

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

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

20 A Correct.

21 Q Now, and, did you also review Christine

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

4 A Yes.

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

11 MR. DZENITIS: Object to the form.

12 Q Do you follow me with that?

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

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

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

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

4 MR. DZENITIS: Object to the form.

5 A Yes.

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

12 A Yes.

13 MR. DZENITIS: Object to the form.

14 A Yes.

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

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

3 MR. DZENITIS: No questions.

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

7 MR. DZENITIS: Yes. Yeah, they're exhibit
8 --

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

12 MR. DZENITIS: Can we make a copy here?

13 THE WITNESS: We can make two copies.

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

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

19 MR. DZENITIS: Okay.

20 MR. TOGERSON: Thanks very much, Doctor.

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

1 okay?

2 MR. TOGERSON: That's fine.

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

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

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CERTIFICATE OF DEPONENT

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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.

1 State of Maryland ~

2 Baltimore County, to wit:

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

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

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

15 As witness my hand and notarial seal this
16 1st day of March, 2004.

17

18 Robert A. Shocket,

19 Notary Public

20 My Commission Expires:

21 November 1, 2006

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