TATE OF OHIO)
) SS IN THE COURT OF COMMON PLEAS
JMMIT COUNTY)

CASE NO. CV-2000-05-1969

OHN PAVLOV,)
Plaintiff) DEPOSITION
)
VS) OF
)
IOPLEY HEALTH CENTER, INC.,) EMIL S. DICKSTEIN, M.D.
Defendant)

Court of Common Pleas within and for the County of Summit, in the State of Ohio.

APPEARANCES

MS. DEBRA J. DIXON,
On Behalf of the Plaintiff

MR. THOMAS A. PRISLIPSKY,
On Behalf of the Defendant

I N D E X

- - -

WITNESS	EXAMINATION	ATTORNEY	PAGE
Dr. Dickstein	Cross	Ms. Dixon	4

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E X H I B I T S

LAINTIFF'S

- Color photocopies

- Report of Dr. Dickstein

- - -

Reported and Transcribed by:
Grace D'Andrea, Certified Stenotype Reporter

STIPULATIONS

It is stipulated and agre d that the deposition may k written in stenotype by Grace D'Andrea, a Notary Public ithin and for the State of Ohio, and a Certified Stenotype Reporter and by her transcribed; and that the deposition may thereupc be used on behalf of the Parties in the aforesaid cause of action, as fully and to the same extent as if written in the presence of the witness and subscribed by the witness i the presence of the Notary Public.

* * *

HEREUPON,

EMIL S. DICKSTEIN, M.D.,

f lawful age, having been first duly sworn by me to testify he truth, the whole truth and nothing but the truth as ereinafter certified, deposes and says as follows:

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:ROSS EXAMINATION

y Ms. Dixon

Good evening, Dr. Dickstein, as you know, my name is)ebra Dixon; I'm one of the attorneys representing the estate)f Ethel Louise Pavlov. I'm here today to ask you some uestions regarding opinions you've expressed in connection vith Mrs. Pavlov's care and treatment and ultimate demise.

Finally, if at any point in time you don't understand a question that I've asked, by all means, ask me to clarify or rephrase it. If you answer the question, I'll assume that you understood that question, and that your answer is truthful and accurate. Fair enough?

Fair enough.

By way of housekeeping, I was handed, when we came in today, an up-dated curriculum vitae --

Yes, ma'am.

-- of yours. Are there any -- not to trivialize the entire contents, but -- meaningful additions or deletions, amendments that would relate specifically to the events of this case from the one that I was given, which was updated last 11/2000?

You may. I am now the medical director of Briarfield Manor Nursing Home, which is in the CV, the new one. So, that, actually would have some import to the case; subject to the questions you might ask, I mean, I believe that would be the only significant change.

No additional writings or lectures that would be specifically applicable to the fact pattern in this case?

Not specifically applicable to the case.

Fair enough.

A little bit out of the order, but since you brought up the medical directorship at Briarfield Manor, as I recall, the last time we met, you had given up a medical directorship of some 17 years at a local nursing home, correct?

That's correct, Heritage Manor Nursing Home, the Jewish Home for the Aged, where I was medical director for 17

years; left that one and, then, subsequently became medical director for this other nursing home.

Q There was a period of time where you were not serving as a medical director at any particular nursing home facility?

A Correct, for some period a little under a year.

Q And prior to being appointed medical director of Briarfield, did you serve as an attending physician for any of its residents?

A Oh, yes, and I do have about 180 nursing home residents in six nursing homes that I currently care for.

Q Specifically as it relates to Briarfield Manor, what events, either within your own practice or at the nursing home proper, presented this opportunity to serve as medical director?

Well, their previous medical director resigned for personal reasons, and I was approached and asked if I was interested in taking the job and, presumably, because of my expertise, and I agreed.

Q Okay. Doctor, is your personal medical practice here at this -- at this particular facility, has it remained fairly constant that approximately two-thirds of your patients are geriatric?

A Yes, ma'am.

Q Geriatric being defined as 65 and older?

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A Right.
Q Jewish Home for the Aged?
A Heritage Manor.
Q Okay. Where else?
A Omni Manor, O-m-n-i; Windsor Hc
Park Vista and Beeghly Oaks. Beeghly is B-e-e-g-h-l-y. And
these are all in Mahoning County.
Q Doctor, prior to the time we got started, I flipped
through your correspondence, and it appears as though P. J.
Malnar initially contacted you by way of letter January 17th of
2001?
A That's probably correct.
Q Was there previous telephone contact with either Ms.

Maln and/or members of her staff in your office regarding potent services and expert in this case?

A I do not remember.

Q Prior to the Pavlov matter, had you ever worked with Ms. Malr or members of her staff in the past?

A No, I have not -- well, not -- well, one of her paralegals is Dale Walker.

Q Okay.

A And I have worked with him, but this is the first /casethat I've worked with Ms. Malnar, and also with Mr. [redacted]islipsky.

And Mr. Walker, as you've mentioned, is Ms. Malnar's [redacted]ralegal. On how many separate occasions did you work with r. Walker in either in consultation or actually preparing expert opinions?

Well, his -- he would not be preparing expert pinion, but I've worked with Attorney Stephan Kremer; Stephan s S-t-e-p-h-a-n; Kremer, K-r-e-m-e-r, at the Akron office. A d I believe with Greg Rossi, who's -- R-o-s-s-i, who's an ttorney there. That was the same case, but -- and Dale Walke: as assisting.

Q Do you recall the name of the plaintiff or the estat of the plaintiff in the matter that you worked with Kremer and Rossi?

A Well, this was a trial in Canton, just concluded two weeks ago, and it was -- now, I'm blocking the name of the plaintiff. The defendants were two physicians. That went to court, and, indeed, the physicians were found non-negligent.

Q Do you recall the name of the plaintiff's lawyer in that case?

A Yes, it was -- the last name was Casey.

Q I'm sorry?

A Casey.

Q Was it a male or a female?

A Male.

Q Was it Casey with a "C" or a "K"?

A C-a-s-e-y, and maybe it was William Casey; I'm not sure.

Q Other than the matter that you recently testified in the Canton area, had you worked with members of the firm of Reminger and Reminger in the past?

A Well, I believe I had had two other cases with Attorney Kremer; one was a nursing home case I was asked to defend. And the other was a case that I was given in which I felt that the defendant physician was guilty of negligence, and I refused to give an opinion on the basis that it would not be helpful for him.

I have worked with some Reminger attorneys in other

offices too.

Q Let's stay for a moment on the Akron office. These two cases with Stephan Kremer, the case that you declined, what type of a fact pattern was that?

A How -- how --

Q Meaning, what type of an injury was it? Was it a claim of medical malpractice versus a nursing home case?

A To the best of my recollection, it was a medical malpractice in which I felt that the patient had been injured.

Q What type of injury did the patient sustain?

A Now, this, I don't remember the details.

Q And that was one of Mr. Kremer's cases?

A Yes, it was.

Q And was the other case that you testified or rendered opinions at Mr. Kremer's request a case where plaintiff's counsel was Mary Jane Trapp?

A You know, I don't remember the specific name.

Q It had to do with tumors on a patient's head?

A That does not ring a bell; I'm sorry. Which is not to say -- I would think I would have remembered that, and that certainly does not ring a bell.

Q Other than the Akron office of Reminger and Reminger, have you served as an expert witness either in terms of providing expert opinions or in consultation with other member:

of Reminger and Reminger at any of their offices?

A Yes, ma'am.

Q On how many separate occasions?

A I would say all totaled, something between 10 and 15 cases I've reviewed or, you know' and I may have had one or two depositions, but my memory of those kind of details is not good.

Q These 10 or 15 cases with the various offices of Reminger and Reminger, over what period of time has that been?

A Well, I believe -- I'd have to -- well, I don't have anything really to check it by, but at least five years, and maybe longer than that.

Q Have each of those 10 to 15 cases been geriatric cases?

A Majority, I have an occasional case which is not.

Q Would the other type of case you would be rendering opinions in on behalf of Reminger and Reminger be internal medicine?

A Correct, or primary care medicine; I'd say that. It would be within the purview of my expertise.

Q We would hope so. Just teasing you.

A I have had cases I've been asked to review which were so totally outside of my expertise, and I've had to decline accordingly; then, one wonders why in the world they were

even -- I was considered as an expert.

Q Has Reminger and Reminger ever contacted you with such a case?

A No, they have not. Or at least to the best of my recollection.

Q Since becoming involved in the Pavlov matter, have you received any new files to review or opine on from the firm of Reminger and Reminger?

Other cases?

Q Uh-huh.

A Actually, I believe I did receive some records last week in another case, but I haven't looked at them yet.

From what attorney at Reminger and Reminger?

And I don't -- I can't even tell you that.

Do you know which office?

A Maybe the Akron office.

Q In terms of your expert services, obviously, you're compensated for your time, correct?

A Yes, ma'am.

Q Can you identify, for the record, what your current fee structure is for these types of cases, both review, deposition and trial testimony?

A $350 an hour, including the deposition here.

Q Uh-huh.

And that covers review of records, discussion, reparation of reports, deposition time, trial time.

It terms of trial time, is there any minimum hourly equirement, for example, a half-day block?

Not as such. I will charge if I have to cancel office hours, which is why I try to do depositions at night, or y time off is Wednesday afternoon. I try to see if trial time annot be arranged for that time because it's less disruptive or the office, and it's less, you know, a problem for the

In terms of this case, separate and apart from the time we're spending together today, including your initial contact, review of the rather voluminous records, perhaps, consultation with counsel, preparation of your report, your meeting with Mr. Prislipsky earlier today, what -- how much time have you spent on the Pavlov matter?

A I don't think I can give you an exact number.

Q Can you give me your best estimate?

A I've spent a number of hours on it. However, it

So, probably when all is said and done, 10 hours,

perhaps, maybe seven hours, something of that ballpark because the records are complex,

Q Certainly. Whether by way of telephone or your -- or correspondence, what specifically did Ms. Malnar or her staff request that you do on behalf of their client?

A Well, they asked me to review the records and give an opinion.

Q And did -- was there any specific area you were asked to give an opinion on or any particular issues you were asked to address?

I'm looking for the sheet that you alluded to.

The January 17th correspondence?

Right. And I just don't see it amongst my immediate things I have here, so it's --

As I recall, there was another page paper clipped to the top.

A There it is; there it is. So, this is -- I have consented to review the matter on behalf of Attorney Malnar's client. She requests my frank and candid opinions with regard to the appropriateness of the -- of the care rendered by the nursing home. She mentions a small summary of the case, and that's it.

Q Can you identify for the record what summary of the case Ms. Malnar provided you?

Well, okay. Quote, "As you will recall, this is a case wherein Mrs. Pavlov suffered a fall from a wheelchair and injured her face. She apparently suffered a fractured nose and subsequently a CVA, which resulted in her death." That was the entire substance.

With the January letter, do you recall what documents you were provided to facilitate your -- the opinions you would be providing in this case?

A These documents, with the exception that I received three depositions last week, which are the deposition transcripts of Gloria Jane Davis, Holly Warstler and -- W-a-r-s-t-1-e-r, and Jay Waliga, W-a-1-i-g-a, and someplace in there after initial records, I did receive a copy of the complaint filed against -- or the response to the complaints filed against the home by the Ohio Department of Health and Human Services Health Care Financing Administration.

Q Okay. Let's stick for a moment with the documents that would have accompanied the January 17th, 2001 correspondence.

A Sure, which is this stuff.

Q And just for purposes of the record, that would have been the Copley records from '95 through the date of death?

A Correct.

Q Various Akron City Hospital visits?

A That is correct. I can enumerate if you like, or --

Q Please do.

A The Summa Health System emergency department records of -- there's five of them; comprehensive geriatric assessment, Summa Health System records, Hospice visiting nurse records. I believe that's it.

Q As part of that initial package, if you're comfortable with me alluding to it like that, --

A Oh, sure, no problem.

Q -- did you receive a copy of Mrs. Pavlov's death certificate?

A No, I did not.

Q As you sit here today, have you seen a copy of her death certificate?

A No, I have not. It's been described to me, but I've not actually seen it.

Q When was it described to you?

A Earlier today --

Q That would have been --

A -- by Attorney Prislipsky --

Q As part of your initial --

A -- Prislipsky.

MR. PRISLIPSKY: There you go.

A Prislipsky, P-r-i-s-l-i-p-s-k-y, right? I'm sorry.

Q As part of that initial package, did you receive any photographs of Mrs. Pavlov's injuries?

A No, I did not.

Q Since receiving that package, have you been provided copies of any photographs of Mrs. Pavlov's injuries?

A No, I have not.

Q Did Mr. Prislipsky, likewise, provide you with a verbal description of the injuries that Mrs. Pavlov sustained?

A Only in a very general sense.

Q What did he tell you?

A Basically, that she had some injuries that were in the photos.

Q And as it relates to Mrs. Pavlov's death c rtificate, what did Mr. Prislipsky tell you?

A Well, that, for whatever reason, on the death certificate, Dr. Kontak had included as a -- as a, not a cause of death, but a contributing factor, facial contusions and the like, and that that might be a subject that we would be discussing here.

Q Did Mr. Prislipsky tell you anything else about what import he assigned or believed would be of relevance in this deposition as it relates to Mrs. Pavlov's death certificate?

A Well, he just stated what it said and left the opinion of it to me. I do have an opinion, but if you

eventually care to ask, but that's not the point of it.

Q When you received this packet, the initial packet, did you ever contact anyone from Reminger and Reminger and request a copy of the death certificate?

A In a general sense, I believe that I requested any additional records which would have been -- the attorneys would have thought would have been appropriate for me to see.

MR. PRISLIPSKY: And just for the record, we faxed Dr. Dickstein a copy of the death certificate, and, for whatever reason, it did not arrive, or it was misplaced by secretarial staff or something.

Q At the time that you prepared your expert report in this matter, Doctor, had you ever requested a copy of the death certificate from any of the attorneys or staff at Reminger and Reminger?

A Only in the general sense of requesting any other additional records that they felt might be helpful.

Q When you realized you did not, in fact, have the death certificate, you didn't believe that precluded you from opining on the issues that you had been requested to, correct?

A My personal opinion is that the death certificate is irrelevant to the case because the evidence by which my opinion is based is in the records, primarily in the nursing home as well as in the hospital, and there's nothing that I felt, then

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relate to Mrs. Pavlov's care and treatment?
A No, ma'am, I have not. I created my own.
Q And that would be the document that you graciously photocopied for us, correct?
A That is correct.
Q Has there been anything removed from your file that you brought down this morning -- or this afternoon?
A Nothing of any consequence. No, basically, nothing. I mean, occasionally I'll just throw out loose correspondence, which has no bearing on anything, but in this case, I didn't even do that. I just -- this is my works; this is everything I have.
Q Doctor, in terms of your writings, have you ever writte on the topic of nursing home standard of care?
A Yes, I have, in the sense of my publication number 1, which is called "Admitting Patients to a Nursing Home." And it was the principle that standard of care included getting as much records as possible when a patient enters a nursing home to be able to help care and so on.

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But also article 3 which is "Federal Regulation of Medical Practice in Nursing Homes," and article 4, which is my article in the New England Journal of Medicine on "Medicare Coverage in Nursing Homes, a Broken Promise," they indirectly at least relate to standard of care.

None of those are specific to the issues in this case, but, in general, that does apply.

Q Have you ever written on the subject of brain trauma in the geriatric population?

A Not as such, no, I have not.

Q Have you ever written on the subject of brain trauma it relates to falls in the geriatric population?

A No, I have not.

Q Have you ever lectured on any of those topics, standard of care in the nursing home setting, brain trauma in general or brain trauma secondary to falls in the geriatric population

A Okay. By "lecture," you mean formal or informal?

Q I appreciate the fact, and, maybe, I'm making some assumptions based on our last meeting. I understand that you do -- you have had occasions to do formal lecturing, and you also do bedside teaching, correct?

A That is correct. So, I have not formally lectured on the subjects, but bedside teaching, which would be to medical

students of various levels and residents, yes, I have discussed such issues. Most of that is sort of at the blackboard and talking about such issues that are important.

Q As part of this bedside teaching, have you ever explained to -- or espoused to these medical students or even, perhaps, geriatric fellows, of a causal link between head and facial trauma secondary to fall and brain injury?

A Well, in the sense -- and we do not have any geriatric fellows down here; this would be residents -- interns and residents -- that one would be worried, perhaps, after a fall that a resident might develop a subdural hematoma as distinct from other sorts of brain injuries such as a stroke from a multi-infarct dementia, which would be unrelated to a fall.

Q As part of your bedside teaching that relates to concerns post-fall and signs of subdural hematoma, what do you teach medical students to be attuned to or concerned about as a potential sign or symptom of a subdural hematoma in a geriatric patient?

A Many things, include utilizing the nursing staff in the nursing home, which is what we're talking about here, I believe, who would know an individual the best and because of that and seeing them on a regular basis would be able, more often than not, to tell if there was some symptom or sign that

represented something that they considered seriously wrong from the person's status quo ante. So that they will, then, be able to alert the physician that there was a major problem, in their opinion.

And, in fact, I find that very valuable as how the nurses feel greater than other sorts of things, such as neuro signs or necessarily -- although these are certainly appropriate to do, and I recommend them to be done and the like.

So that I think that many times the standard of care does revolve around the best clinical judgment of those in attendance and that does weigh into seeing differences which could be of, you know, a list of possible differences is long, long, long.

Q Let me back up and ask you a few follow-up questions.

You indicated that, in your opinion, it would be important to know the impressions of the nursing staff as to the condition of the patient after a trauma in determining at least a subdural hematoma should be considered, correct?

A Well, the standard of care for an attending physician in a nursing home is only to see a resident once every month.

Q Uh-huh.

A *And* it's totally unlike a hospital setting where you see somebody every day. So an attending physician in a nursing

home really is very dependent upon the nursing home staff, so that in discussing a patient with a nursing home staff person, a nurse presumably, but it could be a nursing assistant; it could be somebody else you trust, you rely upon, you know, what they are telling you.

Q Would it be fair to say that the nursing staff serves as, basically, your eyes and ears as an attending physician in a nursing home?

A I think that's very well phrased.

Q And would it, likewise, be fair to say that as an attending physician in a nursing home, you are dependent on an accurate representation orally or in writing by way of the chart as to that patient's condition at any given time?

A In essence, I would agree with that; I would not disagree.

Q And would you agree that as an attending physician for a geriatric patient who is a resident in a nursing home, you have to make your best, in many occasions, when you are not on site, you have to make your best clinical decisions based on the information that's being conveyed to you by the nursing staff?

A Right. And your best judgment, in this case, is, of course, the standard of care.

Q Now, we were talking a little bit earlier about the

bedside teaching and some concerns that you may have regarding a subdural hematoma after a fall. Would you agree that it's appropriate and, in fact, the standard of care when a patient has suffered a head injury that regular neurological checks be done for at least 24 hours post-injury?

A I think it depends on the character and the nature of the injury and on the individual and the like. In general, I think it would certainly not be inappropriate to do neurological checks.

Q In patients that you are an attending physician for, if that patient had suffered a moderately severe head and facial trauma, would you expect that patient to be checked neurologically over the next 24 hours?

I think it would be a reasonable anticipation, yes.

And would that neurological check include things like checking pupillary responses?

A Perhaps, --

Q Grip strength?

A -- movement of arms and legs, grip strength, mental status, vital signs, that sort of thing.

Q And if there had been any deviation or abnormalities as part of those neurological checks, would you expect to be recontacted by nursing staff?

A Significant abnormalities, yes, I certainly would.

Q For example, if a patient went from being oriented times three to oriented times one within that 24-hour period, you would expect a call?

A Well, it would depend upon what the patient was like beforehand. So, if they waxed and waned and this was known to the staff and that other features intervened such as depression, I mean, it becomes the staff's decision as to whether or not that is truly significant.

If somebody, in 24 hours, went from being oriented times three to oriented times two to oriented times one to unconscious, I think that would be a very obvious example when you are correct.

But if it waxed and waned going to oriented times one and or times two and then back to times three again, I think many people -- I have my days that, perhaps, I can't remember what day it is.

Q You're in good company.

I noticed as part of your CV that you gave a presentation in October of 1994 on elder abuse.

A Yes.

Q Where did you give that presentation?

A At the YWCA in Youngstown.

Q And were there any written materials that accompanie that lecture?

A I believe there were, not prepared by me, but I was sponsored by -- oh, boy, it's been a little too long now. I don't remember the details, but there were other sponsors who prepared and had literature present for the audience and passed it out. But I did not keep any, or I do not have any such with me.

Q Can you tell me a little bit about your portion of that presentation?

A Sorts of things that might be tip offs that someone was abused. Make sure that you don't confuse somebody who just has falls and is fragile and gets bruises with somebody who has been abused. Right sorts of things to do when you think somebody might be, you know, types of abuse.

Q Did any portion of that lecture address concerns about or tip offs, as you indicated, of abuse that happens in a nursing home setting?

A To my recollection, this had nothing to do with nursing homes. This was abuse within people's homes by care takers, and in understanding even near that, trying to understand why elderly are abused in that context.

Q Doctor, do you recognize any geriatric journals as reliable sources of information?

MR. PRISLIPSKY: Objection.

A Well, there are lots of journals out there, and one,

as a physician, has to read any articles or textbooks or monographs or things that come off the computer with that certain sense of, you know, doubt that one should always accompany with reading the sorts of things that come out, so that I don't necessarily differentiate a potential value of an article from what's considered a major journal, like the Journal of American Geriatric Society, in which I've been published or other journals like that, and some of what they call the throw-away journals because any of them might have some potentially valuable information.

Q Are there any specific geriatric journals that you would consider as a reliable source for information related to the effects of head trauma on cognitive function in the elderly?

MR. PRISLIPSKY: Objection.

A Well, in the same way, I would not dispute the possible value of articles from any, you know, journal probably anybody could mention; as long as when one reads the journal, those articles, one recognizes that they may or may not be valid.

I mean, certainly our New England Journal of Medicine is probably the most prestigious journal in the entire world, and there are articles in there that have had to be -- that have been repudiated and have found not to be of value. But,

you know, other things being equal, I would certainly say there are many superb articles that have helped us as physicians.

Q Are there any articles or sources of articles that you recall -- specifically recall reading that relate to the effects of head trauma on cognitive function in the elderly?

A No, ma'am.

Q In the last five years, do you recall reading any articl on brain trauma or head injury in the elderly?

Well, I don't doubt, because I do receive a number o journal that the subject has come up, and I've read the article to a greater or lesser degree or maybe just scanned them or looke at a title, but I can't quote chapter and verse

Q Can you describe for me what preparation you [undertook for today's deposition?

A Sure. I went through all my records here and the depositions and meditated on the case.

Q You also met with Mr. Prislipsky?

A For about 15 minutes, 20 minutes.

MR. PRISLIPSKY: Ten.

A Ten minutes? I was giving you the benefit of the doubt, prior to our meeting here.

Q And while it's still fresh in your mind, what did you and Mr. Prislipsky discuss?

The records I had, the curriculum vitae, I had extra

copies; I have extra copies of the -- my notes for you guys. The death certificate we did discuss.

The -- whether or not you all came to the right address or the wrong address, and whether or not you were able to get into the building, and I think where the rest room was.

Q Did you perform any literature searches or have anyone on your behalf perform my literature searches in conjunction with formulating your opinions in this ease?

A No, ma'am, I did not.

Q You indicated a series of deposition transcripts that you've been provided. Have you, in fact, had an opportunity tc review those in their entirety?

A Yes, I have.

Q And you've, likewise, been provided a copy of Dr. Leonard Williams' report?

A Yes, I did. I -- sorry, I forgot to mention that earlier when we were discussing things, although where that report just went to -- that's here.

Q Were you given that as part of your initial packet?

Q Were you also provided a copy of Dr. Shapiro's report?

A No.

Q Are you aware of the fact Dr. Shapiro has been retained on behalf of the defense as well?

A No, I have not.

Q I'm assuming, then, you haven't been provided a copy or a summary of Dr. Shapiro's deposition?

A I was totally unaware until you mentioned it this moment. I have no idea who a Dr. Shapiro is.

Q Okay.

A Probably I should.

Q Did Mr. Prislipsky give you a summary or a synopsis of John Pavlov's testimony by way of deposition, Mrs. Pavlov's son?

A No, he did not.

Q Let me represent to you that Dr. Shapiro is a neurologist who's been retained on behalf of the defense in this case, and it's my understanding that Dr. Shapiro will be testifying as to causation in this case.

A Causation of death or causation --

Q That's my understanding at this point.

A Okay.

Q Are you planning to defer or to accept Dr. Shapiro's opinions as a neurologist regarding the effects of blunt trauma and its effect on the brain?

A If they --

MR. PRISLIPSKY: Objection. I don't know if he can answer without knowing --

A Well, my answer is if they coincide with my own opinions, I will agree, and if they do not coincide with my opinions, I will disagree.

Q In your day-to-day practice, Doctor, do you have opportunities to consult neurologists?

A Yes, ma'am.

Q And would it be fair to say that in consulting a neurologist, you don't just, as a knee-jerk reaction, defer to their medical judgment, correct?

A I use their judgment as a consultant, but it certainly does not mean that I necessarily have to agree with them or implement their suggestions. I'm looking for assistance.

Q And would it be fair to characterize a neurological consult as providing you a tool to assist you in formulating the most appropriate plan of care for your particular patient?

A I would agree with that completely.

Q And would I be correct in my assumption that during the course of your long and healthy practice in the area of geriatrics that you have had many occasions where you have disagreed with the conclusions of a neurologist that's

consulted -- you've consulted?

A I would disagree. I think in the main, by far, I am in total agreement with neurologists and, in general, with other consultants. That's why I use them, and certainly the vast majority of cases, I take their lead and maybe feel like I've been taught by them. So I feel it's very beneficial, but I leave myself the opening to disagree if there are situations, which are rare, but will occur, that come up.

Q You leave the door open to exercising your own best independent medical judgment armed with the information the neurologist has provided you?

A Correct. And I would not consult the neurologist unless I wanted his opinion, unless I valued it, unless I anticipated that I would be using it.

Q Okay.

A And that's true of all consultants.

Q In the course of your practice, I guess it's almost a given by way of dealing with the geriatric population, I'm certain there are multiple occasions each year where you are the physician that signs the death certificate, correct?

A Unfortunately, that is quite correct.

Q And many of those occasions, I'm assuming, are deaths where a death certificate is prepared in the absence of an autopsy?

A Almost invariably. Autopsies in geriatric patients are rare

Q And do you consider it your duty as the physician signing a death certificate to ensure, to the best of your ability, the accuracy of that document?

A I do.

Q And you understand when you execute that document that it is a legal document, correct?

A That is correct.

Q And that you have -- when you sign that, you represent that you are --

MS. DIXON: Let me rephrase the question.

Q Do the death certificates you sign as a person's attending or treating physician represent a reliable document regarding both the immediate cause of death and contributing cause of death of that individual?

A That is what the death certificate is supposed to state.

Q And you understand that is your duty to accurately identify both immediate and contributing cause of death as the physician signing that document?

A Yes, ma'am.

Q Because, as you indicated earlier, invariably with the older population, these are death certificates that are

prepared and executed absent an autopsy?

A Not invariably, but the vast majority of the time.

Q Most of these people die in the natural progression as opposed to some acute event, correct?

A Well, everyone dies acutely. Maybe rephrase that one.

Q The lion's share of nursing home patients that you serve as attending for and ultimately prepare a death certificate, that is done -- that's prepared where there is no autopsy, correct?

A Correct.

Q And isn't it true that the reason you, as the attending physician, execute that death certificate is because you're in the best position to state or conclude both the immediate and contributing causes of that individual's death?

A I don't know legally what the requirement is for who signs the death certificate, but, certainly, the primary care physician is typically the one who does fill out the death certificate.

Q Let me ask the question a little bit differently, then, Doctor. In your experience in patients that are -- individuals who are residents in a nursing home setting where you serve as the attending physician, are you in the best position to state or conclude both the immediate and the

contributing causes of that individual's death?

A More often than not, I am, indeed.

Q As part of your conversation with Mr. Prislipsky, did he tell you that Mrs. Pavlov's attending physician identified both dementia, cerebrovascular accident as the immediate causes of Mrs. Pavlov's death?

A He so did.

Q And you don't have any reason to disagree with that, correct?

A I have reason to disagree with that, yes.

Q What about the immediate causes of death as CVA and dementia do you disagree with?

A Now, recognizing I am disagreeing with causation on a patient who I've never seen, and -- and, but based upon my review of the medical records, I have to say that I think that the way that I think that the death certificate, causation contributing issues are in the main inaccurate and incorrect.

Q Let's --

A If I was going to fill out the death certificate from the best of my abilities from what I know and, again, I've never seen the patient; I don't know the patient; I would agree that stroke was the major issue causing death, and they always ask the time. And the stroke, I think, was on September 15th, which was the cause of the death and was unrelated to events

prior to that such as the fall.

So, I think the cause of death was stroke, and it was of six days nature. Contributing causes were hypertension, non-insulin dependent diabetes and atherosclerosis. And that's the sum and substance of what I would have put on that death certificate, unless there is other information that I'm not privy to.

Q And you haven't had an opportunity to speak with Mrs. Pavlov's attending physician, correct?

A No, I have not.

Q And what you've just identified as to what you would have completed on the death certificate, that's based on your review of the record as opposed to any direct knowledge of the patient, obviously?

A That's correct. As a second -- and, then, they do have that blank were it says, you know, not direct cause of death but contributing causes, I would have included this multi-infarct dementia.

So, I do think if, when Dr. Kontak -- well, the strokes that cause multi-infarct dementia, so -- and what I'm saying is that if he used the word "dementia" in the sense of strokes causing multiple infarcts, and this is a specific disease or syndrome, state multi-infarct dementia, that that - that that's perfectly acceptable to put on there.

But dementia itself is not a cause of death, and the facial trauma is not a cause of death, and, you know, cause of death is very specific.

Q Doctor, have you ever included on an elderly -- in an elderly person's death certificate, either as an immediate or a contributing cause of death, failure to thrive?

A I may not have used that specific term, but, yes, I certainly have used something of that nature.

Q And in your experience with the geriatric population, has profound depression ever led to what is commonly known as a failure to thrive?

A I don't think I have ever used depression as a cause of death or contributing cause of death. I don't think that is particularly accurate.

Q My question was a little bit different than that.

A Well, the answer to your question is no.

Q So, that I'm clear, profound depression in a geriatric patient cannot lead to a failure to thrive?

A Oh, I'm sorry. I misconstrued your question.

Yes, failure to thrive can be as a result of profound depression.

Q Also, so I can just clarify your previous answer: You would disagree with Mrs. Pavlov's attending physician that her facial contusions were a contributing factor to her death?

A Yes, ma'am.

Q And you would, likewise, disagree with Dr. Kontak, Mrs. Pavlov's treating physician, that depression was a significant condition that contributed to her death?

A Yes, ma'am.

Q Do you agree with the neurologist, Dr. Shapiro, whose deposition I took, I believe on April 16th, that external trauma to the head and face indicates the amount of trauma to that individual's brain?

MR. PRISLIPSKY: Objection. I don't know that he can answer that question without seeing the entire deposition or the context of that one phrase. But if you have an answer, go ahead.

A I do not have an answer. I don't think I can respond to that --

Let me ask the question --

-- without the entire context.

Q Let me ask the question, Doctor: Do you believe that external trauma to the face and head indicates the amount of trauma to the brain internally?

A Well, I think the question is extremely vague. I mean, if somebody gets hit on the head with a sledgehammer, I mean, you can assume that there's considerable internal damage.

However, I think in the context of this case and what

we're talking about are residents of nursing homes, as well as people in general, are hitting their heads or falling on themselves and having facial trauma all the time, and I have had patients who have, essentially, no blemish externally who had bled to death. And I have had patients with massive trauma externally who have not had any brain damage at all.

So, in general, I'm sure there's a correlation between the amount of damage done and what you might anticipate is happening internally, but it is certainly on an individual, one-by-one case, I don't think you can do that kind of /correlationvery well.

Q Doctor, would you agree that there are serious and, in fact, profound brain injuries that can incur that are not detectable by way of CT scan?

A Yes, I would agree.

Q And can we also agree that some of those injuries include axonal shear injuries?

A Well, could you be a little more specific when you say that? I mean, shearing of blood vessels --

Q Yes.

A -- that are so insignificant as not to cause enough bleeding that would be found on a CAT scan?

Q Correct.

A Sure.

And can we agree, in a patient who has already compromised brain tissue, that axonal brain -- axonal sheer injuries to the blood vessels that are not able to be appreciated by way of CT scan can, nonetheless, have a residual effect?

A I think, while it is obvious that CAT scans may not pick up injuries and that injuries may be subtle, in the context of this case where we're talking about the fall on July 12th, we're talking about the significant change in the individual on September 15th that that would therefore -- that would not apply to this case.

Although, theoretically or hypothetically, one could say, sure, that axonal -- that minor injuries may not be apparent and may become more severe at a later time.

I think, again, the patient here had this multi-infarct situation, which is different from what you're talking about.

Q Doctor, in your opinion, are the elderly likely to be more affected by head trauma than younger people?

A In general, yes.

Q Would you agree that research suggests that the progressive loss of brain tissue with age makes the elderly -- leaves the elderly with less reserve to cope with insult or trauma to the brain?

A I would agree.

Q Would you agree with Dr. Shapiro that a stroke can be a sequelae of blunt-force trauma to the head and face?

MR. PRISLIPSKY: Objection. Same objection I lodged earlier. I don't think you can answer that. Maybe it would be better if you just go ahead and talk to Dr. Shapiro.

A I would agree. I mean, I can give an opinion in general, but not knowing what Dr. Shapiro specifically said, I can't speak to what he said.

Q Let me represent this to you that Dr. Shapiro indicated that stoke can be a sequelae of blunt-force trauma to the head and face. Would you agree or disagree with that statement?

MR. PRISLIPSKY: Same objection.

A In a loose sense -- in a loose sense, depending upon how one defines the word "stroke," which can be defined in several different ways, the answer is yes.

Q Doctor, let me represent to you that at the time of his deposition, Dr. Shapiro indicated that from the time of Mrs. Pavlov's admit to Copley in 1995 through early July of 1999, she was relatively stable. Would you agree with that statement?

A It depends on what you mean by the word "relatively." I mean, she certainly had a four-year period where she had

no -- where there were no events such as she had at the end of September of '99. So, in that respect, it was certainly more stable.

Q How would you describe Mrs. Pavlov's course from admit in 1995 through early July of 1999?

A In general, I would agree that it was pretty stable. She had ups and downs; she had periods where she was depressed. She had periods where she had problems eating and swallowing and coughing and that sort of thing. She had periods where she was the president of the residents council apparently, which is, you know, a significant position to be able to hold for a nursing home resident.

Q Based on your review of the record, during that four-year period of time where you indicated she had ups and downs, and you enumerated for the record some examples of those, --

A Yes.

Q -- would it be fair -- or is it consistent with your review of the record that Mrs. Pavlov, during that four-year period, as a general proposition, rebounded from those downs and at least got to some midline?

A Oh, I would agree. She had times when she was up and down. I mean, it could be characterized, for example, her eating patterns where the periods through those years where she

didn't eat as well and other periods that she ate everything.

Q Doctor' I'm going to hand you what's been marked Dickstein No. 1.

A Sure.

Q It's a set of laser copies of the injuries Mrs. Pavlov sustained --

A It's good quality picture.

Q -- on July 12th of 1998. And this is the first time you're seeing these photos, correct?

A That is correct.

Q Did you ever request photographs of Mrs. Pavlov's injuries prior to the time you prepared your report in this case?

A Only in the general sense of asking for any records that the attorneys felt would be appropriate for me to review.

Q And based on your history with the attorneys of Reminger and Reminger, have they, as a general rule, provided you with information -- all the information you needed to prepare your report?

A I believe so, yes.

Q Can we agree that those -- the photographs that are marked on Exhibit 1 represent someone who has sustained a serious head and facial trauma?

MR. PRISLIPSKY: Objection.

A I would --

MR. PRISLIPSKY: I just want to enter an objection. There's no date on the pictures, so if that makes it difficult to presume what date they were taken as to the progression of any injury.

Doctor, let me represent to you, as I'm sure you know by way of the depositions you're reviewed, the nursing staff at Copley indicated by way of deposition testimony that these photographs represented Mrs. Pavlov's condition shortly after the incident on July 12th of 1999. Is that consistent with your read of those deposition transcripts?

MR. PRISLIPSKY: If I may, Deb, I'm not trying to argue with you, but it may be significant to say if they were taken on July 13th versus July 17th. And in saying "shortly," I don't know if that actually gives an adequate time frame.

DR. DICKSTEIN: Could you ask the question again?

Q You did read the nurses' depositions, correct?

A That's correct.

Q Do you recall the portions of the deposition where the nurses were -- obviously, you didn't have them as an exhibit to the transcript or you would have seen them before today -- but they did explain to you that, by way of the deposition transcript, that they had cared for Mrs. Pavlov, and those -- and those photographs fairly and accurately

represented the injuries she sustained by way of the July 12th, 1999 fall?

A That is correct.

Q Okay. with that as a background, Doctor, can we agree that those photographs marked as Exhibit 1 represent somebody who has sustained a serious head-and-facial trauma?

MR. PRISLIPSKY: Objection.

A I would disagree with the word "serious." Certainly, this is someone who has suffered a facial trauma. The word "serious" is a difficult word to use because it -- because some people with fragile blood vessels and fragile skin, as many geriatric people have, can have some pretty significant bleeding and bruising and swelling, but not have internal injuries.

So, in that sense, if you mean by the word "serious," for example, a stroke, I'd have to disagree. If you mean by "serious," you know, the pain and discomfort that goes along with having a pretty good wallop and bruising and swelling and obvious pain that would accompany that, then, I would agree with you, yes.

Q Based on the photographs alone, --

A Yes.

Q -- how would you describe the injuries that are depicted?

I would say that the person --

MR. PRISLIPSKY: Objection. Can I have a continuing line --

MS. DIXON: Absolutely.

MR. PRISLIPSKY: -- on anything related to the picture.

I would say that it shows a woman -- an elderly woman with extensive bruising in the periorbital, left cheek and area around her nose and, perhaps, a little on her forehead and with significant swelling around her nose. I would be as descriptive as possible.

Let me ask you to assume, just for the purposes of this question, that you were serving as Mrs. Pavlov's attending physician the day of this incident.

Sure.

You would expect to be called by the nursing staff regarding this incident, correct?

A Yes, I would.

Q And if you were Mrs. Pavlov's attending physician, you would be relying on the nursing staff, once again, to act as your eyes and ears as to what was transpiring with this patient and what the nature and extent of her injuries were, correct?

A Yes, ma'am, I would.

Q And you, in turn, would give orders according -- or, I guess, you would give orders for Mrs. Pavlov's care responsive to the information that you were provided?

A Right. An attending physician is the one responsible, but, again, relying upon the information given.

Q Let's take this July 12th date, specifically. Are you at all critical of Dr. Kontak in the care that he provided by way of telephone orders for Mrs. Pavlov?

A No, ma'am.

Q Are you at all critical of Dr. Kontak's care and treatment of Mrs. Pavlov from July 12th through the date of her death?

A No, ma'am. I may be critical of what he put on hi death certificate, but with that one exception, no.

Q Literary exceptions aside?

A Literary exceptions aside, yes, thank you.

Q Medically speaking, you don't have any criticisms of Mrs. Pavlov's attending, correct?

A No, I do not.

Q Do you know Dr. Kontak?

A No, I do not.

Q Based on the injuries that are depicted on Exhibit 1 would you expect neurologic -- regular neurological assessment to be performed on Mrs. Pavlov for the 24 hours post-injury?

A I think it would be very appropriate.

Q And that would consist of the types of things we discussed earlier, level of orientation, pupillary responses, grip strength, ability to follow simple commands?

A Yes, ma'am.

Q If, immediately following the incident which led to the injuries depicted on Exhibit 1, Mrs. Pavlov was not making any sounds to indicate that she was even aware of the trauma she had just sustained, would that cause you concern as her attending physician?

MR. PRISLIPSKY: Objection.

A I think it would have to be in the context of what was going on because we do know, of course, that -- if I can --

Q Absolutely.

A -- quote where it basically said that -- that she made no complaints of pain or discomfort about any other area of her body; any other area, meaning, she apparently may have complained about the nose; it's kind of unclear exactly, and range of motion appears normal and so forth.

I would be impressed by her pain tolerance, although, again, I mean, sometimes injuries that look dramatic, you know, are -- at least, initially too, people may or may not have significant pain. We all know somebody who's been in an accident and feels fine initially, and then an hour later, you

now, sort of realizes that they're hurt.

MR. PRISLIPSKY: Those are Debra's whiplash clients.

DR. DICKSTEIN: Well, they're about six weeks later after . no. You can strike that; I'm sorry. I apologize.

(Whereupon, a discussion was had off the record.)

Doctor, separate from what you -- the notation you ust read into the record as to complaints of other areas of her body, --

Yes.

-- if just as a general proposition, Mrs. Pavlov ost-injury was not making any sounds or speaking in a manner o even suggest that she was aware of the trauma she had just ustained, would that be a significant finding to you as her reating physician?

MR. PRISLIPSKY: Objection.

I would find that far less insignificant than what he appraisal of the nursing staff was. I mean, this is omebody I don't know, and I don't know if this is someone -- ow vocal she was in general, and, so, I'm dependent, again, upon the nursing staff to tell me what they think might be significant in that case.

So, of and by itself, the answer to that is no; I don't think that's necessarily significant.

Q You did pick up by way of the records that Mrs.

Pavlov's swelling and bruising was rather immediately apparent, correct?

A Yes.

Q Based on that type of bruising, swelling, and I will represent to you that it's the testimony of the nursing staff that she was not making any sounds to indicate pain or otherwise responsive to the situation.

A Sure.

Q Would you have, had you been her attending physician, recommended emergency room assessment?

MR. PRISLIPSKY: Objection.

A No, I think I would have interpreted it the other way, that I was very pleased that she was not in that significant amount of pain, and that if the patient had complained of a great deal of pain and, you know, we know -- you know, and that she was having great problem, that would make me more likely to send the patient to the emergency room, not that she was not complaining about pain.

Q Is inappropriate response to painful stimuli a sign or symptom of shock?

A Well, I mean, everybody's different; everyone's an /individual. It is true that, depending on how you define the word "shock" that that may be the case. But, typically, if someone is in shock, they're unconscious, and we know that she

was conscious the whole time. Or I believe from reading the records that she was.

Q It's not your testimony that a person cannot be in shock while conscious, correct?

A Depends on how you define the word "shock."

Q How do you define shock?

A Shock is typically where the blood pressure has dropped out the bottom and where somebody is in extreme condition, life threatening, and a condition which was apparent that Mrs. Pavlov was not in. So, there may be levels of consciousness present, but I could see nothing in the record that suggests that she was in shock.

Q Doctor, I'm going to hand you a copy of your report marked as Exhibit 2.

A Sure, I have a copy of it here too, so I can use that as well.

Q The document I've marked as Exhibit 2, is that the only report you've generated in this case?

A Yes, ma'am.

Q Were there any rough drafts of it?

A I believe this was the only -- this was the draft and the report.

Q As you sit here today, do you stand by all the opinions that you've expressed in your correspondence to P. J.

alnar dated March 24th, or have you changed, altered or mended any of your opinions since the time that was written?

MR. PRISLIPSKY: Do you want to read the whole thing?

MS. DIXON: Feel free.

Well, let me run through it.

Well, I certainly do not disagree with anything that I've previously written. Off the top of my head, I can't think of anything else I would add to it; although, perhaps, your questioning would stimulate me to come up with something else that I should have put in the report that I didn't, but off the top, I stand by it.

Q Doctor, now that you've seen the photographs that are marked as Exhibit 1, do you think those photographs would have assisted you in formulating your opinions?

A Well, I mean, any records are an assist in formulating a theory -- my opinions. I don't think that the photos would have changed my opinion in the least.

Q Would they have helped you realize the extent of Mrs Pavlov's injuries?

A Well, it correlates with how I had a mind's-eye view of what her injuries were like from the -- from the records as such. I mean, obviously, she sustained facial trauma, and it's reported that she had bruising and swelling, and that's what the pictures show. She had facial trauma and bruising and

;welling, as well as some skin tears and other assorted .njuries that we can see in the picture; for example, she has ıer left arm wrapped and so forth.

Q Based on the documentation in Mrs. Pavlov's chart, did you expect the trauma to be as shown in Exhibit 1 to be of the magnitude that it was?

A Well, I mean, there's a two-part answer to that. I mean, the one part is, "What did I expect to see?" And the answer is, I mean, I've seen a lot of patient trauma in my day, and this is within the range of what one anticipates seeing, I mean, to a greater or lesser extent.

And the other side of the question is: How significant this is in relation to the records and the problem that, you know, Mrs. Pavlov suffered from and, as such, seeing the pictures are not -- really does not make me change my opinion one way or the other.

Q Did reviewing any of the depositions that you were subsequently provided cause you to modify or change any of your opinions?

A No, ma'am.

Q Doctor, directing your attention to paragraph 3 of your report, you state that, quote, "On July 12th, 1999, her foot apparently caught while she was being pushed in her wheelchair, and she fell on the floor face first," period, end

quote.

The nurse who wrote the note of the event did not use the word, quote, "apparently," end quote. Why did you choose that word?

A Because -- well, why did I use the word? Well, because I think that reading any report and reading any situation, one has to take it a little bit -- well, subjective and objective. Subjective is where someone reports something, and I think it's not inappropriate to wonder about the validity of the statement. Objective is a number, you know, it's a blood pressure recorded.

I think one could say that, you know, initial report is probably accurate, and, apparently, it was, but I'm ermitted to have a little doubt, perhaps, and not knowing som of the details and maybe seeing other records later. And, on the other hand, for example, we know that when Mr. Pavlov reported to the consultant geriatrician about the course of events, 1 mean, what he said did not jibe with what the record said.

So, you know, I don't think there's anything wrong with having a little grain of salt in reading things.

Q Based on your review of the photographs, would you agree that the injuries depicted in those photographs are equally consistent with a physical assault?

A Yes, I would.

Q And can you -- would you agree that, by way of the injuries alone, there is no way, other than eyewitness testimony, to determine the etiology of those injuries?

A Well, I mean, everyone is relying, as am I, upon the history that's given by the people involved. And we know that the nurse's aide was the only person with Mrs. Pavlov at the time. And, so, as I've said, apparently, she caught her foot and fell on the floor face first.

I don't know of anybody, and I've gathered nothing from the records I have anybody is disputing that this is what happened. I could come up with multiple other scenarios as well; I mean, some of the ceiling may have fallen down and hit her on the head. I mean, you know, but I'm discounting that; I'm taking at face value what is in the chart.

Q Did you consider that it was unlikely for the event to occur in the manner described?

A No. It sounded totally realistic, and, you know, you're wheeling; you're doing your job, and the foot accidentally catches, and before you can do anything else, you fall down and hit yourself. And it happened so quickly, I'm sure that Mrs. Pavlov was unable to do anything, and the nurse's aide was unable to do anything. And accidents like this can and do happen despite everyone's best efforts.

Doctor, by way of the record, I'm certain you've gleaned Mrs. Pavlov was a fairly tall woman?

Well, --

She was almost my height.

I don't want to disparage you, but I don't know if I ould define you as tall.

I'm five, 10; it doesn't get a lot taller than that.

Okay. She was, obviously, a substantial woman, yes.

Q At the time of the incident, she weighed approximately 140 pounds?

Sure.

And she had right-sided paralysis?

That's correct. And she used her left foot to help get around, and we know that she was, you know, using -- helping to feed herself and so forth.

Q Based on the fact she was somewhere between five, 10 and six foot tall, 140 pounds with right-sided paralysis and placed in a wheelchair, do you know what that, seated in a wheelchair with those dimensions what her center of gravity would be?

A Well, it depends on, you know, how you're seated in there, and it depends on your position in there, and it's going to vary. It depends on your body habitus, you know, as to whether you're a little more top heavy or bottom heavy, that

kind of stuff.

Q Based on your review of the record, can we agree at the time Mrs. Pavlov's body left the wheelchair, she was not wearing a Lap Buddy?

A That is correct.

Q Is it your read of the medical record that there was, in fact, an order by Dr. Kontak for her to wear a Lap Buddy?

A Well, and with the understanding that periodically you have to remove it, but that is absolutely correct.

Q This came up, actually, in the deposition of Dr. Williams, and since you practice in the Greater Ohio area, --

A Yes.

Q -- is a Lap Buddy considered a restraint by Ohio statute?

A In a way it is, yes. Well, restraint, you mean, people define the word "restraint" in different manners, and I'm not completely sure what the precise legal definition is. But, basically, a physician's definition of a restraint is something that keeps a resident from doing things; you're restraining a certain action. So, certainly, that would be a restraint.

Q And there are certain standards and protocols within the nursing home if a device like a Lap Buddy was considered a restraint that they would need to be released periodically,

correct?

A That's correct.

Q Usually, two hours, released 10 minutes?

A Yes, ma'am.

Q In the facilities that you are familiar with as an attending physician, I am certain over time you have had opportunities to give orders for a restraint, correct?

A Yes, ma'am.

Q And in those facilities, can we agree that the scheduled use of those restraints, the amount of time it's left on and the periodic reprieves from that or releases from those restraints are charted?

A Not necessarily. I mean, some routine kinds of things don't make it into the chart. My emphasis in the homes is patient care, and I feel strongly that I've seen in some homes where the charting was fantastic, but the patient care was very poor, which means all the energy was spent in charting and not in taking care of the residents.

Q In most of the homes that you serve either as an attending or a medical director, is there at least a chart that is to be used to indicate when a restraint is in place and when it is released?

A I honestly don't know if all of the homes have such things. I mean, that's the sort of thing that I don't find

think it matters if a patient -- you know, if it's recorded every two hours, whether they were turned or not. I think the important thing is, you know, look at their condition, look at the resident and how they're being taken care of.

Q Do you know as it relates to Mrs. Pavlov whether or not the Lap Buddy was a restraint?

A Yeah, I think it was.

Q Do you know what the Copley protocol or procedure was in July of 1999 regarding charting of restraints and the release of restraints?

A I do not know what the policy was.

Q Do you know the purpose of utilizing the Lap Buddy on Mrs Pavlov was?

A Well, it was something of a restraint.

Was it to keep her in the wheelchair as opposed to sliding or falling out of it?

A Well, I mean, the two words are interchangeable.

Q I guess as a practical matter, I'm asking you: Is

:hat consistent with your understanding of the purpose of utilizing the Lap Buddy as part of Mrs. Pavlov's plan of care?

A Well, to, you know -- all of that, to keep her from falling out of the wheelchair, to keep her from sliding out, to help keep her in place, to -- something for her to lean on, all of those things.

Q Based on your review of Mrs. Pavlov's record, was the Lap Buddy utilized as a safety tool?

A Well, in the same -- I mean, that's part and parcel of everything else. I'm not disagreeing with you.

Q Okay. Doctor, can we agree that the nurses who took care of Mrs. Pavlov on a day-to-day basis, both on and after July 12th 1999, would be in a better position, or better able than you to describe in detail her condition?

A Yes.

Q Can we agree that the family members who frequently visited her in the nursing home would be in a better -- better suited than yourself to detail her condition both before and after the fall?

A I think one would have to give full consideration to their feelings and opinions, sure.

Q If the nurses who regularly cared for Mrs. Pavlov had testified, as I'm sure you gleaned from their depositions, that she was not acting normally and was very depressed as soon as

one week after the 7/12/99 trauma, would you disagree with them?

A As I read some of the depositions, they said she was depression, but that was not significantly different from how she had been at times prior to the trauma.

Q Do you specifically recall the testimony of Jay Waliga?

A He -- well, no, I'd have to see exactly what he said and in the context in which he said it. Do you have a page number on that?

Q No, actually, I don't.

A Okay.

Q Let me -- let me rephrase it, if you don't mind?

A Sure.

Was it your impression, by way of reviewing those depositio transcripts, that Nurse Jay Waliga was the nurse primarily responsible for Mrs. Pavlov's care?

A That's correct. He was the charge nurse.

Q And, as the charge nurse primarily responsible for Mrs. Pavlov's care, would you be willing to accept as true his description of Mrs. Pavlov's condition after the July 12th, 1999 incident?

A Well, I think everyone interprets things, so one would say to accepts as true, you know, you always have to

consider what someone is saying, but I would certainly not disagree with how, you know, he felt or what he said. I mean, maybe if you rephrase the question, it would be better.

Q I guess, fundamentally, what I'm asking you, Doctor: Are you willing to accept as true the perceptions of the nurse who was primarily responsible for Mrs. Pavlov's care as to her condition on and after July 12th, 1999?

A I think one would have to take it as a major consideration as someone who was the charge nurse, but it would have to be in the context of what other nurses and people in the home were saying.

And, also, I think one would have to seriously consider the records themselves and, you know, and the course of events and everything else that happened. I think you have to take the whole picture and the whole context and not just pull out, you know, individual events.

Q Doctor, were there any other significant events, if you will, between 7/12/99 and the time of Mrs. Pavlov's death other than the 9/15/99 CVA --

A Oh, I --

Q -- that would have contributed to changes in her condition?

MR. PRISLIPSKY: Objection. Speculative.

A Well, what do you mean by the word "serious"?

MR. PRISLIPSKY: I believe she said "significant."

A Significant, I'm sorry. I'm sorry, I apologize, significant.

Q I guess, events you would consider as contributing to Mrs. Pavlov's change and condition.

A Well, I mean, we know that the initial X-ray missed the broken nose; we know a subsequent one did show the nasal fracture. I mean, that's -- I think is significant in her condition, sure.

I think there was -- I mean, a potential worry, for example, on July 18th with left eye blurring that something was going on, and we know it wasn't because she saw the eye and it was just a topical problem, but, I mean, this ha [potential significance.

Is this the sort of answer you're looking for? I mean, --

Based on your --

-- on August 18th, I mean, I know from the record that Mr. Pavlov, the son, for example, has said that, you know, when he talked to the geriatric doctor that his mother had progressive and continuous confusion, depressed oral intake and coughing, so I think it's significant, for example, that the only recording of any coughing was on one day, August the 18th. I mean, you can weigh that both ways. I don't know. I mean,

I'm having a difficult time with the question.

I mean, in terms of the ultimate -- her ultimate death, I think knowing what happened after the fact, and this is after the fact, I think the events from September 15th on are highly significant in terms of what happened to her causing her death, but I don't see anything between July 12th and September 15th which makes me feel like there's something that is a direct cause of her death.

Q Doctor, in your opinions, if the injuries depicted in the photographs resulted in brain trauma severe enough to cause changes in Mrs. Pavlov's affect or behavior after July 12th, 1999, would such a trauma be a contributing factor to her death?

MR. PRISLIPSKY: Objection.

A This is all hypothetical. So you're saying if the injuries were significant enough to cause brain damage, would the brain damage have been significant enough to cause death? Then, I suppose in that totally hypothetical context, the answer would be, sure it would.

I mean, if the question is: Did her injuries cause her death, was it a significant cause of her death, the answer is yes. The answer is, if the injuries were not a cause of her death, was that a significant cause of her death, the answer is no.

Q Doctor, in your opinion, if the injuries that are depicted in Exhibit 1 resulted in brain trauma severe enough to cause headaches that were not present before the trauma, would you consider the trauma as a contributing factor to Mrs. Pavlov's death?

MR. PRISLIPSKY: Objection.

A I don't -- no, I would not relate specifically headaches as something that would be necessarily related to someone's death.

Q Doctor, if the injuries depicted in the photographs resulted in brain trauma severe enough to cause difficulty with speech after July 12th, 1999, the July 12th, 1999 trauma, would you consider that trauma severe enough to relate to her death?

MR. PRISLIPSKY: Objection.

A Same reason, no.

Q How about if the injuries depicted in the photograph caused Mrs. Pavlov to have blurry vision after July 12th, 1999, would you consider that trauma to be severe enough to relate tc her death nine weeks later?

MR. PRISLIPSKY: Objection.

A Well, we know she had blurry vision, and we know that it was unrelated. The answer is clearly no.

Q If the injuries you see depicted in the photographs resulted in changes in Mrs. Pavlov's level of orientation,

would you consider that brain trauma severe enough to relate to her death nine weeks later?

MR. PRISLIPSKY: Objection.

A No, ma'am; no, ma'am.

Q If the injuries depicted in the photograph are -- resulted in severe depression, withdrawal and insomnia, would you consider that trauma a contributing factor of her death?

MR. PRISLIPSKY: Objection.

A No, ma'am.

Q You're aware of the fact that Dr. Kontak requested -- actually instructed the staff, based on Mrs. Pavlov's severe depression, withdrawal and insomnia to prepare a depression log; did you see that in the record?

A Well, there's a question if that was through him or through the psychologist, but, yes, indeed.

Q And you indicated by way of your previous answer that Mrs. Pavlov had a history of depression, correct?

A That's correct.

Q Did the fact that they had, the psychologist or Dr. Kontak, whomever actually gave the order, --

A Sure.

Q -- instructed that a log be created indicate to you that there was a worsening of her condition?

A At least to that moment in time, yes.

Did you see anywhere where the depression log was tually created?

No, I did not.

You would expect that to be contained in the atient's chart, correct?

Yes, I would.

Q And as an attending physician, if an order is important enough for you to give, you would expect it would be important enough for the nursing staff to follow, correct?

A I hope all my orders are implemented, certainly.

Q And you understand, as a medical doctor, depression to be a very serious medical condition, correct?

A Well, not necessarily. I mean, if there's six of us in the room, by statistics, half of us are going to be depressed to a certain extent. So, "very serious" can be somebody who is suicidal, and, you know, and that's very serious, but there's levels of depression.

Q Do you know how depressed Mrs. Pavlov was when the depression log as instructed to be created?

A She was clearly depressed; there's no question about it. I mean, it's a little bit subjective as to how depressed is depressed and how different that was from previous bouts of depression, but I'm not disputing that she was depressed.

Q At the time of that order, would you agree that the

depression was significant enough for the physician and/or the psychologist to order it to be logged and monitored on a regular basis?

A Apparently so.

MR. PRISLIPSKY: Three of us are depressed?

DR. DICKSTEIN: Off the record.

(Whereupon, a discussion was had off the record.)

Q Doctor, would you agree that dementia is a decrease in a person's cognitive ability?

A Yes, decreased mentation, that's what the word means.

Q Do you agree that the symptoms that we've been discussing as to Mrs. Pavlov, the increased depression, withdrawal, insomnia, changes in level of orientation, blurry vision, difficulty with speech, headaches and changes in behavior represent a decrease in Mrs. Pavlov's cognitive abilities?

MR. PRISLIPSKY: Objection.

A Well, I mean, there are -- maybe if you could just repeat the question for me. I wasn't anticipating how it was going to come out.

Q Let me rephrase.

Doctor, can we agree that after July 12th, 1999, Mrs. Pavlov was noted by staff to be not acting normally and to be very -- and was very depressed.

A At times.

Q Would you agree that after July 12th, 1999, Mrs. Pavlov was noted to have changes in her affective behavior?

A At times.

Q Would you agree that after July 12th, 1999, she was noted to have headaches that were not present before the trauma?

A At times.

Would you agree that after the July 12th trauma, Mrs Pavlov was noted to have difficulty with her speech?

Well, at times, but this is not necessarily new.

She was noted to have blurry vision?

Yes, which we discussed already.

Changes in her orientation?

At times, which she had had before.

Severe depression, withdrawal and insomnia?

A Yes, ma'am.

Q And prior to July 12th, 1999, had Mrs. Pavlov ever had that constellation of symptoms?

A Not as those specific ones; no, she did not, or at least that I'm aware of.

Q I appreciate the fact you haven't seen Dr. Shapiro's deposition testimony, but let me represent to you he testified that trauma can cause microvascular brain damage severe enough

to disrupt a person's ability to think.

A Okay.

Q Is that consistent with your medical understanding?

A Yes.

Q What is "microvascular brain damage," Doctor?

A Well, "microvascular" by definition means little, teeny blood vessels, and damage to them is damage to them.

Q Are you familiar with the phrase "the punch-drunk fighter syndrome"?

A Yes, dementia pugilistica

Q Do you recognize that as a concept -- let me rephrase that.

Do you recognize that as a medical reality in your practice?

A I think the star example is Muhammad Ali, Parkinson's disease despite the fact that he, you know, from being hit.

Q Doctor, is thinking or the thought process part of a person's cognitive capacity?

A One more time?

Q Is thinking or the general thought process part of a person's cognitive capacity?

A Yes, I would think so.

Q Are you aware of the fact that a CT may not depict or appreciate microvascular brain damage?

appreciate

A Yes, ma'am.

Q Can we agree that a person's behavior along with other clinical signs and symptoms is often the only way microvascular brain damage can be determined or appreciated?

A Well, as such, I would not disagree.

Q Doctor, let me ask you to look at page two of your report, fifth paragraph, where you address the issue of negligence --

A Yes.

Q -- regarding the events of 7/12/99. Can you give me the definition of negligence that you're referring to in that paragraph?

A Well, we're talking about standard-of-care issues. So, various standard-of-care issues in this situation were how many assists was it presumed that Mrs. Pavlov would have, and if you ask me, I would say based on the records one assist. So, that's not a standard-of-care negligence.

Is it negligence that, you know, that in a situation like this that Mrs. Pavlov caught her foot in the wheelchair, and the answer is no. I mean, you know, something like that is an unpreventable sort of a thing. Is it negligence that she did not have the Lap Buddy on? And the answer is no because periodically, you know' you do take it off like being wheeled to bed, and, you know, you're going to take the Lap Buddy off

t the time you're going to transfer somebody to bed. We know he was not being transferred at that time; she was just being ushed in the wheelchair, and no one is, I think, stating that he had to have multiple people pushing her wheelchair.

That's the sort of questions here I think you're sking me and I'm answering.

How were you defining the difference between egligence and an accident?

Well, negligence is fault; accident is -- well, I ean, what I really -- you know, is the nursing home liable? I ean, that's what I'm saying negligence. I mean, did they ommit malpractice because Mrs. Pavlov caught her foot and fell s opposed to accident are, you know, things which a jury -- I ean, this is not for me to find -- this is for a jury to find hat, you know, it just is an occurrence which was unfortunate ut which was not something that was foreseeable and for which he nursing home is liable.

Q Do you know how -- have you been provided any dimensions of the room in which this incident took place?

A Not otherwise than what's in the, you know, the epositions where you're talking about, you know, one bed two eds, but, no, I don't have specific dimensions.

Q So, would it be fair for me to assume you don't know ow far it was that this nurse's aide intended to push Mrs.

Pavlov in the wheelchair without the Lap Buddy, correct?
A Not --
MR. PRISLIPSKY: Objection, speculative.
A No, I do not.
Q You would agree that there was an order for the Lap Buddy, correct?
A Yes, I would.
Q And we talked about the fact earlier that the Lap Buddy was presumably put in place as a safety measure, correct?
A Along with the other reasons that you alluded to, yes; yes, ma'am.
Q Can we agree that residents in a nursing home have a right to a safe environment?
A Yes, ma'am.
Q Can we agree that residents have a right to adequate staffing and supervision to prevent accidents?
A Yes, ma'am.
Q Do you agree that nurses whether LPNs, RNs, nursing assistants who render care in a nursing home setting have a duty to take all precautions necessary to ensure a resident's safety?
A Yes, ma'am.
Q Do you agree that nurses whether LPNs, RNs, nursing assistants who render care in a nursing setting have a duty to

substandard nursing care?

MR. PRISLIPSKY: Objection.

A Well, I mean, in the context of what we have been talking about, now, you can argue at times what is, you know, what is -- I mean, those are very general sorts of things which I'm in complete agreement, and I agree with your last question. One can argue, again, that -- let me stop right there and say, yes, I basically agree with you, yes.

Q Regarding your statement that the standard of care was for one assist for transfers with Mrs. Pavlov, --

A Yes, ma'am.

Q -- are you aware that prior to July 12th, 1999 there were numerous nurses' notes which indicated her care givers felt that she was, quote, "extensive assist with transfers," end quote?

A Well, I'm aware of what it says, but the official documentation, which is the NDS and which is the legal document, and similar I'll refer to one assist; the nursing summaries refer to one assist.

Q Prior to July 12th, 1999, when was the last NDS that

A Well, it's here.
Q This document that was faxed to you?
A Well, it's -- that was -- it's there, but, I mean, it's right here in the chart. And this was where it says one assist; this was 6/26/99. There's no page numbering, but that's what it is.
Q And is that the document that was faxed to you on March 23rd of 2001?
A Yeah, I think that's the same page.
Q And whose handwriting was it on the bottom that says "as of 7/12/99"?
A Well, that was my handwriting. That was just a note to me, although that's -- well, that's what I wrote.
Q Doctor, would you agree that in the course of providing nursing care in a nursing home facility it's incumbent upon the nursing staff to use their best professional judgment?
A I would agree with that, yes, ma'am.
Q And if in the best professional judgment of the nursing staff, Mrs. Pavlov required two -- excuse me, assistance with transfers times two, that would be the requisite standard of care as it relates to Mrs. Pavlov?
MR. PRISLIPSKY: Objection.

A Well, understanding that in several locations, and I can pull them out for you, it says one, if they thought, you know, and the people who were responsible for the situation and recorded it as two; then, two would have been the right number. If they recorded it as one, then, one is the right number.

Q Are you aware of the quarterly interdisciplinary meeting of, I believe, it was 6/21/99?

A Let me see if that's --

Q It may have been the 22nd.

A Let me see if I can remember which section of the chart that's in. It's back here I think. No, that's another one; that's -- that's not it. How about over here?

Q Would you agree with me that that says extensive assists --

MR. PRISLIPSKY: Objection, vague.

A Well, I disagree actually. In looking at that one, I hear "extensive assists," I don't think in terms of numbers; I think in the amount of assistance that the individual needs. I mean, how capable are they doing it on their own; to what extent they need somebody or some bodies to help them? That's what I think of.

Q When we were talking about the nursing staff making judgments based on that particular resident's needs, --

A Sure.

Q -- would you be looking to the time frame -- let me rephrase the question.

In a evaluating how many -- how much assistance Mrs. Pavlov required with transfers on **7/12/99**, would you look to the previous few weeks to determine how many individuals assisted her with transfers prior to that date?

A It would be one of the things one could look at; I'll certainly give you that. I don't think that's all of them.

Q Do you as a medical director and as attending physician participate in quarterly interdisciplinary meetings at your various facilities?

A Well, I may -- well, where I'm medical director, yes. At others, I make the reports up and don't actually attend.

Q Are the conclusions of those interdisciplinary meetings important to you as an attending physician?

A Sure.

Q Do you rely on the information presented by way of those quarterly meetings to assist you in determining what are appropriate orders for that patient moving forward?

A Well, it's all in the context of discussing with the nurses what they think is appropriate and important, and that's one vehicle for doing that; yes, I agree.

Q Doctor, do you agree that nursing staff has a duty to ensure that a resident's feet are properly positioned in a

wheelchair prior to pushing that patient?

A Yes, I do.

Q And the reason that that's important is so that the patient's feet don't catch under the wheelchair?

A Well, I mean, that would be a consideration.

Q Or otherwise cause injury, correct?

A Sure, sure. I mean, although, as we know, someone could be wheeled in a wheelchair literally thousands of times, and one time the foot catches despite all best efforts.

Q But, nonetheless, you would agree that the nursing staff or whomever is assigned to that duty has an obligation to ensure that the feet are properly positioned prior to engaging the wheelchair?

A And that the person is basically positioned in general, and that their arms are positioned and that all the other sorts of things that one does on an everyday basis.

Q Would ensuring that the -- if, in fact, Mrs. Pavlov's feet had been properly positioned prior to the wheelchair being engaged on July 12th, 1999, do you believe the injury to Mrs. Pavlov would have occurred?

MR. PRISLIPSKY: Objection.

A In general, it may not be the specific injury, the one we are talking about. I know how many times I stumble over my own feet and accidently bump into objects and knock myself,

even though I think I am cognitively intact and should be able to know where I'm putting my feet so that I think that even if feet are placed in the right position, it is certainly possible for an accident to occur.

So, I think that answers your question.

Q Actually my question is more direct than that, Doctor. If Mrs. Pavlov's feet had been properly positioned, i.e., placed on the foot pedals prior to that wheelchair being engaged on July 12th, would this incident have occurred?

MR. PRISLIPSKY: Objection.

A I think it certainly could have, yes.

Q And if Mrs. Pavlov had been wearing a Lap Buddy on July 12th, 1999 prior to the wheelchair being engaged, would this injury have occurred?

A No, that would not have occurred.

Q Doctor, in paragraph five on page two of your report you also make the statement, quote, "after the fall, all appropriate measures were done," period, end quote. What do you mean by that?

A Well, Dr. Kontak was notified; X-rays were done; the patient was assessed, that sort of thing. The son was contacted.

Q Anywhere in the record, within 24 hours after the incident, do you see where neurological checks were performed

on Mrs. Pavlov?

A Well, only indirectly. There's no direct record of that that I could find, no.

Q What's the indirect record you're relying upon?

A Well, it does state that -- actually, not 24 hours, but 72 hours, which may have been their standard of care, a little better than some other homes, perhaps. But it says on July 15, 1999, "continues with 72 observation -- 72-hour observation for a fall on 7/12/99," and then it goes into the details of bruises and tender and swollen and the skin tears and so forth, and -- but the resident was up in the wheelchair and will continue to monitor.

Doctor, let me ask you to confine your answer to the 24-hours post-trauma. Is there --

Oh, I'm sorry. I'm sorry. No, I did not see any indication of the immediate 24 hours afterwards. I mean, some vital signs, for example, are recorded, which would be part of, you know, something like that, so, I mean, to that extent.

But there's nothing about the specific neurological exam that we discussed earlier, nothing to check level of orientation, grip strength, pupillary response, things of that nature, correct?

A Yes. Yes, I agree.

Q So that I'm clear on your opinions: Is it your

testimony that it is within the standard of care for Mrs. Pavl to have sustained the magnitude of injuries depicted on Exhit 1 while in the presence of a certified nursing assista who is pushing her wheelchair?

MR. PRISLIPSKY: Objection.

A Repeat the question.

Is it your opinion that it is within the standard care for Mrs. Pavlov to have sustained the magnitude of injuries depicted in Exhibit 1 while in the presence of certified nursing assistant who was pushing Mrs. Pavlov wheelchair?

MR. PRISLIPSKY: Objection as to form.

A Yes, ma'am.

Q Was it a violation of Mrs. Pavlov's dignity to be unclothed a the time that this took place?

A No, ma'am.

Q In your opinion, was it also within the standard of care for a certified nursing assistant to leave Mrs. Pavlov lying on the floor injured in a pool of blood while she left the room to get help?

MR. PRISLIPSKY: Objection as to form.

A Well, yes, ma'am, in, you know, it may need elaboration, but as stated, yes, ma'am.

Q In your opinion, was it the standard of care for Mrs.

Pavlov not to have received emergency room treatment until almost a week after her injuries and only at the insistence of her son?

MR. PRISLIPSKY: Objection as to form.

A Yes, ma'am, and I would, if asked, state that I don't necessarily believe that emergency room visit was necessary.

Q What about medical evaluation, period?

A What about it? That's not a question.

Q Are you aware of the fact that Mrs. Pavlov did not receive any medical, meaning by a physician, evaluation until she was seen at the emergency department almost a week after the incident, and only at the insistence of her son?

A That is correct.

Q Do you believe that that's within the standard of care for her not to have been seen by a medical doctor until

MR. PRISLIPSKY: Objection as to form.

A Absolutely, yes, ma'am.

Q Are you aware of the fact that Mrs. Pavlov's nose was not broken in one place, but two?

A Actually, I don't remember the contents of the X-ray report, but I'm not -- would not dispute it. I'd have to see what the actual report said.

Q In your -- regarding your conclusion that Mrs. Pavlo

did not exhibit any significant changes until August 18th, 19 when she exhibited difficult -- difficulty, excuse me, swallowing, do you disagree with the nurses who have already testified that Mrs. Pavlov exhibited a progressive decline in the two months after the 7/12/99 incident through her date of death?

Well, the key word is the word "significant." And I stand by my report.

Doctor' in your opinion, would it be within the standard of care to use the same nursing assistant pushing th wheelchair for Mrs. Pavlov on 7/12/99 to provide her continue care after that date?

MR. PRISLIPSKY: Objection to the form.

Do I think it's within the standard of care that she continued caring for the resident?

Q Yes.

Of course I do.

Q Doctor, you indicated very early on that you've been provided the Ohio Department of Health Annual Surveys --

A Yes, ma'am.

Q -- for Copley, and those are documents you're familiar with?

A Yes, ma'am.

Q As a general proposition?

As a general proposition, yes, ma'am.

And as someone who serves as both an attending hysician and a medical director of nursing homes, you're amiliar with the state survey process?

Yes, ma'am.

You understand that nursing homes have to -- that there are regulations that they need to comply with, correct?

Yes, ma'am.

And a nursing home's failure to comply with those series of regulations can result in deficiency notices --

(Witness nods head affirmatively.)

-- and potential licensure violations, correct?

That is correct.

And in your experience within a nursing home setting, s ate surveys are serious business, correct?

Absolutely.

And homes prepare all year long for their annual surveys, correct?

Yes, ma'am.

And they are unannounced?

Yes, ma'am.

And as a medical director at a nursing home, you consider both deficiencies and licensure violations serious, correct?

amount -- well, it would certainly cause me general concern about what is going on but that the findings can be quite variable at times.

Q Generally speaking, do these state surveys serve as a report card as to the quality of care and the nursing home's compliance with state regulations?

A I think that's the general feeling; although, for an insider, I've found that I have to disagree many times, that I do not -- I do not personally agree with that statement, although I understand that that is the conventional wisdom, yes.

Q And whether you disagree on a personal or professional level with the conclusions of state surveyors, as somebody intimately familiar with the nursing home setting, you understand that those deficiencies need to be corrected?

A Absolutely.

Q And, likewise, licensure violations need to be?

A Positively, ma'am.

Q And for a home to have licensure violations, that risks Medicare and Medicaid funding, correct?

A Loss of, yes, ma'am.

MR. PRISLIPSKY: Objection. I don't think that's accurate.

Q Doctor, have you seen state survey results for Copley Nursing Home?

A I may -- let me -- upon opinion of Counsel, --

Q Actually, Doctor, it's not appropriate for him to give you an answer at the deposition, so --

Okay.

-- he can note his objection, and we'll deal with it later.

A Sure. And maybe -- I know that certainly homes can lose thei Medicare and Medicaid functions under certain situations and I may be inaccurate as to, you know, specificall which violation actually produces that or what's appealable. I don't know; I'm not a lawyer, obviously.

Q You have seen the state survey results for Copley, year 1998, when Mrs. Pavlov was a resident, correct?

A Well, I've been provided with these records here.

Q Have you, likewise, seen the results of the state investigation into Mr. Pavlov's complaints about the events of 7/12/99?

A I do not believe those are in here, no, ma'am. Let me say -- well, it's hard, you know, it does not specify in here whose complaints resulted in what. So, the answer to that is I'm not able to answer that one.

Q Let me ask the question slightly differently, Doctor. Are you aware of the fact that John Pavlov, Louise Pavlov's son, specifically complained to the Ohio Department of Health regarding the event of 7/12/99?

A I garnered that from the depositions.

Q Doctor, if I told you that the state investigation determined that Copley merited citations and licensure violations regarding failure to provide supervision to prevent accidents in regarding a resident's right to a safe environment, would any aspect -- I'm sorry, would that affect any portion of the opinions you've previously expressed in this case?

A No, ma'am.

Q How about the fact that Mr. Pavlov's complaint to the state regarding the events of 7/12/99 were substantiated; would that change any of the opinions that you've expressed in this case?

MR. PRISLIPSKY: Objection, speculative.

A I think one has to, you know, weigh that in consideration. I don't want to take anything like that

.ightly, but the answer to the question is no, ma'am.

Q You're familiar with the State of Ohio Residents Bill of Rights, correct?

A Yes, ma'am.

Q And you understand -- let me rephrase that. Doctor, what is your understanding of what the Nursing Home Residents

residents?

A Their rights.

Q And would you agree with me that that bill of rights is extended to each and every nursing home resident in the State of Ohio?

A Well, yes, certainly, ma'am.

Q And that nursing homes have an affirmative obligation to ensure that those rights are protected -- those residents' rights are protected?

A Yes, ma'am.

Q Just by way of reference, I have provided you a copy for your reference.

A Uh-huh, thank you.

MS. DIXON: Actually, let's take a break and let him change tapes, so he doesn't run out.

(Whereupon, a recess was taken.)

Q Doctor, based on your understanding of the Ohio's

Nursing Home Bill of Rights, would it be a violation of any o the rights enumerated to leave a patient or a resident withou their teeth for several weeks at a time prohibiting ordinary meal intake?

MR. PRISLIPSKY: Objection.

A I mean, if one -- I'm sorry; what was the verb you used about --

Q Prohibiting or --

A No, initially, you said that not giving the resident their teeth and --

Q Leaving a resident without their teeth.

A It would depend on the context. I mean, if you purposely didn't --

Q Are there any circumstances --

A Sure. If you purposely withheld an individual's teeth you know, maliciously, that would certainly violate the bill of rights.

Q Would there be any period of time which you would find replacement of that resident's teeth unacceptable?

MR. PRISLIPSKY: Objection.

A It depends on the circumstances.

Q What circumstances would it be appropriate to leave resident without replacement teeth for 10 to 12 weeks?

A Well, I mean, different --

MR. PRISLIPSKY: Objection.

A I'm not a dentist, but I know that different people have different problems with, you know, getting dentures made and fitted, and so -- because you don't want to damage the linings of the mouth where the dentures are, so, you know, I'm sure there's a period of time within which it's appropriate to have things done, but I'm not qualified to be able to say what the right time is.

Q Doctor, would the following scenario constitute a violation of any of -- the resident's bill of rights: Removing a patient or a resident from a main dining room with their regular tablemates at the request of the dining room manager?

MR. PRISLIPSKY: Objection.

A Not -- you're asking is that a violation of rights, and I would answer no, ma'am.

Q Would you consider it a violation of any of the Nursing Home Bill of Rights for a patient or resident to leave a call light on for in excess of 30 minutes unresponded to?

MR. PRISLIPSKY objection.

A Well, I think it is -- it certainly should be responded to within that time.

Q Would that constitute a violation of any of the Nursing Home Bill of Rights?

MR. PRISLIPSKY: Objection.

A In a sense; I mean, we're talking about an individual who's been in this home for four years, and we're talking one moment in time. But, you know, if you want to view that as a violation of rights, I would have to agree with you, yes.

Q Doctor, would you consider it a violation of the Nursing Home Bill of Rights for a patient to be left covered in feces?

MR. PRISLIPSKY: Objection.

A It would depend -- I mean, obviously, the resident needs to be changed, so it's a context of how long and what else was going on and all that sort of stuff. It could be.

Would you consider it a violation of the Nursing Home Bill of Rights for a nurse's aide to willfully leave a soiled washrag on a resident's bible?

MR. PRISLIPSKY: Objection. You mean willfully -- you mean, intentionally?

MS. DIXON: Yes.

A I think if they intentionally left it, the answer would be yes.

MR. PRISLIPSKY: Can I have a continuing objection --

MS. DIXON: You sure can.

MR. PRISLIPSKY: -- as to resident's rights?

Q Would you consider it a violation of the Nursing Home Bill of Rights for a nursing home to knowingly employ an

ndividual convicted of an assault as a nurse's aide?

A It's circumstantial, I mean, people go to prison and are -- serve their sentences and, then, presumed that they could be -- you know' I mean, and what circumstances are we talking?

Q Do you think it's ever appropriate for a nursing home to employ an individual who has a conviction for assault?

A Yes.

Do you believe it is ever appropriate for a nursing home to employ a nursing assistant who has been discharged from her employment with another home for abusing or otherwise not properly caring for residents?

When one says "ever," the answer is yes. Obviously, I'm not suggesting that, you know, -- I'm only suggesting that one has to look at circumstances.

MS. DIXON: Let's go off the record for just a second.

(Whereupon, a recess was taken.)

Q I have a few more questions, Doctor, before we conclude for the night.

Getting back to the Nursing Home Bill of Rights, --

A Yes, ma'am.

Q -- would you consider it a violation of any of the enumerated rights for a nurse's aide to repeatedly place a call

light on the paralyzed side of a patient such as Mrs. Pavlov?
A And done purposely?
Q Well, let me put it this way: Who had been corrected about it repeatedly and continued to place it on her paralyzed side.
A Yeah, I would tend to agree with that, yes.
Q At the beginning, you indicated when I asked you about if your report contained all your opinions you said it did unless our conversation had jarred any new opinions. Since we've been just talking the last two hours or so, are there any additional opinions that you've not previously expressed, either by way of my questions or your report, that you hold in this case?
A Whether or not we've discussed them here no, ma'am.
Q *And* based on your report and our conversation, does this -- is this a totality of opinions you plan to express at the time of trial in this case?
A Well, I may be asked something at trial which is not specifically in my report but which would be an opinion; is that okay?
Q Have you discussed any such issue with Mr. Prislipsky?
A Not to my immediate knowledge, but things come up, of course.

Q Do you intend on testifying live in this case?

If I am so asked, I would be glad to.

Q Have you been asked?

I have

en asked, and I would be pleased to.

Do you know when trial is?

No, I do not. Do we have a date set?

Tuesday. For real.

Tuesday for real?

MS. DIXON: I don't have anything further. Thank you

or your time.

DR. DICKSTEIN: Thank you.

MS. DIXON: And I'll see you next week.

MR. PRISLIPSKY: Dr. Dickstein, you have the right tc

view this deposition to see if there are any errors in the

transcript.

DR. DICKSTEIN: I would, please.

I HAVE READ the foregoing transcript of my testimony,

nd it is true and correct.

SIGNATURE OF WITNESS

REPORTER'S CERTIFICATE

I DO HEREBY CERTIFY that the above and foregoing is a full, true and correct transcript of all the testimony introduced and proceedings had in the taking of the within named deposition, as shown by stenotype notes written by me, the presence of the witness, at the time the said deposition as being taken.

Grace D'Andrea

Certified Stenotype Reporter

TATE OF OHIO)
) SS NOTARY CERTIFICATE
IAHONING COUNTY)

by me transcribed; that the transcript of his testimony will b made available to said witness for signature; that the said witness shall read said transcript and affix his signature, at the end thereof, and that the said deposition was taken pursuant to Agreement and at the time and place therein specified.

I do further certify that I am not of counsel, attorney or relative of either party or otherwise interested in the event of this action or proceeding.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Youngstown, Ohio, this 27th day of April, A.D., 2001.

GRACE D'ANDREA, NOTARY PUBLIC
My Commission Expires 5/26/02