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199988

1 IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

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3 CHRISTINE B. KOCSIS, et al.)
)
4 Plaintiffs,)
)
5 vs) Case No. 346346
)
6 METROHEALTH SYSTEM, dba,)
METROHEALTH MEDICAL CENTER,)
7 et al.,)
)
8 Defendants.)
)

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12 DEPOSITION OF DOUGLAS EINETADTER, M.D.

13 TUESDAY, NOVEMBER 3, 1998

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15 The deposition of DOUGLAS EINSTADTER, M.D.,

16 the Witness herein, called by counsel on behalf of

17 the Plaintiff for examination uhder the statute,

18 taken before me, Vivian L. Gordon, a Registered

19 Diplomate Reporter and Notary Public in and for

20 the state of Ohio, pursuant to agreement of

21 counsel, at the offices of MetroHealth Medical

22 Center, Cleveland, Ohio, commencing at 10:50

23 o'clock a.m. on the day and data above set forth.

24

25

1 APPEARANCES:

2

3 On behalf of the Plaintiff
Becker & Mishkind
4 BY: HOWARD D. MISHKIND, ESQ.
Skylight Office Tower Suite 660
5 Cleveland, Ohio 44113

6
On behalf of the Defendant MetroHealth
7 Weston, Hurd, Fallon, Paisley & Howley
BY: DEIRDRE HENRY, ESQ.
8 2500 Terminal Tower
Cleveland, Ohio 44323
9
On behalf of the Defendant The Patrician
10 Buckingham, Doolittle & Burroughs
DIRK E. RIEMENSCHNEIDER, ESQ.
11 One Cleveland Center
Cleveland, Ohio 44115
3.2
ALSO PRESENT:
13
Kelly Gale
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1 DOUGLAS EINSTADTER, M.D., a witness herein,
2 called for examination, as provided by the Ohio
3 Rules of Civil Procedure, being: by me first duly
4 sworn, as hereinafter certified, was deposed and
5 said as follows:
6 EXAMINATION OF DOUGLAS EINSTADTER M.D.
7 BY-MR. MISHKIND:
8 Q. Would you please state your name,
9 A. Douglas Einstadter.
10 Q. What area of medicine do you specialize in,
11 doctor?
12 A. General internal medicine.
13 Q. Would you trace for me your educational
14 background, beginning with medical school?
15 A. University of Illinois medical school,
16 graduated in 1986. Residency, internship and
17 residency at MetroHealth. Chief residency
18 MetroHealth in internal medicine. General
19 medicine Fellowship in masters public health
20 degree at University of Washington.
21 Q. What year was that?
22 A. 1992. And I have been on staff since '92
23 back here.
24 Q. Are you board certified?
25 A. Yes.

1 Q. Internal medicine?
2 A. Yes.
3 Q. Any subboards?
4 A. No.
5 Q. Have you done any writing, doctor?
6 A. In what sense? Articles?
7 Q. Articles.
8 A. I have several articles published in
9 various areas, I guess, in abstracts.
10 Q. Number wise, how many articles or abstracts
11 have you published?
12 A. Three peer review journal articles and six,
13 seven abstracts.
14 Q. I am going to ask if you would provide Ms.
15 Henry with a copy of your CV.
16 A. Sure.
17 Q. Would you do that for me?
18 A. Sure.
19 Q. Thank you.
20 Do you do any teaching, doctor?
21 A. Yes.
22 Q. Where at?
23 A. At the medical school.
24 Q. What do you teach?
25 A. I teach clinical epidemiology,

1 biostatistics.
2 Q. Have you been deposed bafore?
3 A. No.
4 Q. Have you ever served as an expert witness?
5 A, No.
Have
7 A. No.
8 Q. Would you tell me what a fistula is,
9 please?
10 A. It's generally a connection between two
11 organs, usually from a bowel outward to some other
12 organ or to the surface.
23 Q. Would you define what an abscess is?
14 A. Enclosed infection.
15 a. In the perirectal area, do you need tu have
16 a fistula in order to have an abscess?
17 A. I don't know for certain.
18 Q. Is it because that's not your area of
19 expertise?
20 A. I guess so.
22 a. What area of expertise would that fall
22 within?
23 A. Probably gastroenterology or surgery.
24 a. Can you have a fistula without the
25 existence of an abscess?

1 A. Yes.
2 Q. And can you have a fistula in the
3 perirectal area without the existence of an
4 abscess?
5 A. Yes.
6 Q. As an internist, are you mindful of the
7 potential for infection or an abscess developing
8 in a fistula in the perirectal space?
9 A. Yes.
10 Q. And are you aware of in the perirectal
11 space whether or not abscess formation can cause
12 necrotic tissue in a relatively short period of
13 time?
14 A. Whether *abscess* formation can do that?
15 Q. Yes?
16 A. Yes.
17 Q. What is your understanding as to the time
18 periods that you are dealing with when there is
19 abscess formation in the perirectal space until
20 necrotic tissue occurs?
21 A. I don't know an exact time.
22 Q. And again, is that because you are not
23 familiar with the studies that deal with that type
24 of pathology?
25 A. Yes. And it may be variability.

1 Q. What kind of conditions would control the
2 variability?
3 A. I guess the reason for the abscess or for
4 the fistula could control it, but I don't know
5 exactly.
6 Q. In the area of internal medicine, do you
7 have a particular subspecialty?
8 A. No.
9 Q. Would you briefly differentiate for me
10 inflammatory bowel disease from ischemic colitis?
11 A. Inflammatory bowel disease is usually
12 classified into one of several types. The two
13 most common would be Crohn's disease and ulcerated
14 colitis. It has specific pathologic findings in
15 sort of a specific epidemiology. Ischemic colitis
16 is just any -- is a broad term referring to
17 inflammation of the colon due to lack of blood
18 flow.
19 Q. Can you tell me what the specific
20 epidemiology is for inflammatory bowel disease?
21 A. It's usually familial. There is a
22 difference between Crohn's disease and ulcerated
23 colitis. In terms of parts of the bowel which are
24 affected, Crohn's disease can affect basically any
25 portion of the bowel from mouth to anus.

1 Ulcerated colitis generally is just
2 contained within the colon itself, the large
3 bowel. Ulcerated colitis, at least, has sort af
4 genetic determinants and so can be, you know,
5 inherited in a familial fashion.
6 Crohn's disease is probably also inherited
7 in a similar manner, although I am not familiar
8 with the mechanism there. Crohn's disease has
9 variable onset, age of onset, but I believe two
10 peaks, one early teens, early 20s, and then one
11 later in life. Although I think it can probably
12 occur at any time. Crohn's disease similar,
13 usually onset early in life, meaning, you know,
14 before 20s or 30s.
15 Q. Thank you. Would you tell me in your
16 opinion, doctor, what caused Mrs. Lynch to develop
17 the ischiorectal fistula?
18 A. It was not -- in my opinion it's not clear,
19 I guess, whether it was due to ischemia or to an
20 inflammatory process of some other nature. I
21 don't know exactly why she developed a fistula.
22 Q. Were you considering various etiologies
23 within those areas of inflammatory bowel disease
24 and ischemic disease as factors for the cause of
25 the fistula?

1 A. Yes.
2 Q. And what issues were you mulling around in
3 your mind?
4 A. Generally fistulas are more Likely to be
5 associated with Crohn's **disease** in terms of the
6 bowel, inflammatory bowel disease, So that would
7 be a little, you **know,** would sort of tend to rule
a or go **more in** favor of Crohn's disease as an
9 etiology, but it wasn't clear at the time exactly
10 why **she** had fistula **there.**
11 Q. **There** are certain anatomic classifications
12 that exist for fistulas; correct?
13 A. **Uh-huh.**
14 Q. And certain anatomic classifications **even**
15 when you are dealing with ischiorectal fistula;
16 correct?
17 A. I would **assume** so.
18 *a.* Do you know what type of anatomic
19 classification her ischiorectal fistula fits into?
20 A. No.
21 Q. Is the significance of the anatomic
22 classification of the ischiorectal fistula of
23 significance in terms **of** the clinical treatment of
24 that phenomenon?
25 A. I don't know.

1 Q. That again would be outside of your area of
2 expertise?
3 A. Yes.
4 Q. That would be something that you would call
5 in either a GI consultant or a surgeon for
6 consultation?
7 A. Yes.
8 Q. Is the standard of care where there is a
9 concern about the clinical course that an
10 ischiorectal fistula will follow, is the standard
11 of care from an internal medicine standpoint to
12 request consultation?
13 A. Yes.
14 Q. Do you know -- strike that. Do you have an
15 opinion as to how long Mrs. Lynch likely had the
16 ischiorectal fistula that was detected during the
17 July '96 hospitalization?
18 A. I guess she had had rectal bleeding for, as
19 1 recall, one to two months. I mean, it's
20 possible that the fistula, the fistula could have
21 been there longer, I mean, I don't know otherwise.
22 Q. Again, I don't want you to speculate
23 outside of areas where you are comfortable saying
24 that it's likely that it occurred, so I will bring
25 the question back to you.

1 A" I guess I don't know.
2 Q. The Pact that she had rectal bleeding by
3 history when she presented to the hospital, is
4 that a clinical symptom that is seen in patients
5 that have ischiorectal or perirectal fistulas?
6 A. Possibly. But I mean, I don't know for
7 certain that all people with that condition would
8 also have rectal bleeding.
9 Q. If you wanted information, doctor, as an
10 internal medicine specialist in the area of the
11 diagnosis and treatment of perirectal or anal
12 rectal fistulas, where would you turn to in the
13 medical literature for reliable data?
14 MS. HENRY: Objection. Go ahead
15 and answer if you can,
16 A. Probably to a variety of places. I would
17 start with the general textbook of medicine to see
1% if there was anything there. I would move on to
19 any one of a number of general GI textbooks and
20 then probably a literature search using Medline or
21 same other electronic search.
22 Q. In terms of textbooks that you would look
23 ta as the front line, if you will, or the ones
24 that you would look to first for information on
25 anal rectal or perirectal fistulas, which books in

1 your area of practice would you direct yourself
2 to?
3 A" GI books or just any?
4 Q. Which ones would you feel to be most
5 reliable as an internal medicine specialist?
6 A. I don't have an opinion as to overall.
7 reliability, There is some that I look to because
8 I have used them in the past, but I don't have any
9 one particular one I would go to sort of
10 exclusively.
11 Q. Which ones have you looked to in the past?
12 A. Probably two main ones, Fortran and
13 Schlesiger is the GI textbook and the other one,
14 Bachus Gastroenterology, which is a multi-volume
15 text.
16 Q. In the course of treating Mrs. Lynch, did
17 you refer to any medical literature?
18 A. I don't recall.
19 Q. In the course of preparing for this
20 deposition, or since this lawsuit has been pending
21 against Metro, have you done any medical research?
22 A. No.
23 Q. Which journals would you normally look to
24 as front line for information relative to anal.
25 rectal or perirectal fistulas?

1 A. I don't know. It would be based on if 1
2 had done a literature review, what the results of
3 that are. I do not read a GT ar surgery journal
4 routinely.
5 Q. The leading textbook in internal medicine
6 in your opinion that has information relative to
7 anal rectal, fistulas, and abscesses in the anal
8 rectal area would be what?
9 A. I don't know. In general internal
10 medicine?
11 Q. Right.
12 A. I know I use texts that I like, I can't
13 say that they are the leading textbook.
14 Q. Which ones do you like that you consider?
15 A. I use Harrison's Textbook of Medicine
16 because that's the one I am most familiar with.
17 Q. And whether it's leading to other people,
18 is that a textbook that you consider to be
19 reliable for general information in the area?
20 A. It's reliable for general information.
21 Q. And in particular, it would have areas
22 relative to anal rectal or perirectal?
23 A. It might, although I suspect that it would
24 not have much.
25 Q. Okay. If a patient has positive fecal

1 leukocytes, is there reason to be concerned about
2 the potential for development of an infection in
3 the ischiorectal fistula?
4 A. Not that I'm aware of.
5 Q. What is the significance of positive
6 leukocytes?
7 A. Generally it means inflammation of the
8 bowel.
9 Q. And can infection cause positive
10 leukocytes?
11 A. I think so.
12 Q. The existence of positive fecal leukocytes,
13 does that mean that the patient may have an
14 inflammatory process going on?
15 A. Yes.
16 Q. Does that also mean that the patient may
17 have an infection, infectious process going on?
18 A. Yes,
19 Q. Kow do you go about ruling out or
20 confirming what is causing positive fecal
21 leukocytes?
22 A. Some would depend on the presentation, so
23 the symptoms and the history, time course.
24 Obviously a prior history of inflammatory bowel
25 disease might play a role. Direct examination of

1 the bowel, looking for inflammatory bowel disease,
2 and culture of the stool, Looking for infection in
3 the bowel.
4 Q. Was infection in the bowel ruled out in
5 Mrs. Lynch's case during her hospitalization in
6 July of 1996?
7 A. I don't recall.
8 Q. I want to understand when you say you don't
9 recall.
10 A. I don't remember if she had, for instance,
11 stool cultures sent, looking for abnormal
12 infection or abnormal bacteria in the bowel.
13 Q. Would that be reasonable step to take where
14 you have positive fecal leukocytes in a patient
15 that has a documented ischiorectal fistula?
16 A. It might be a reasonable, might be
17 reasonable to do, yes.
18 a. Do you have an opinion as to the probable
19 cause for Mrs. Lynch's rectal bleeding?
20 A. Well, the ultimate or the direct cause was
21 inflammation of the bowel. As to what was causing
22 that inflammation, I don't know,
23 Q. Okay. what clinical evidence would you
24 look for that would be consistent with a
25 perirectal abscess in a patient that's in the

1 hospital?
2 A. We would be looking for pain, tenderness,
3 signs of inflammation or infection in the area,
4 redness, warmth, systemic findings, fever, you
5 know, other signs of infection, increased white
6 count. I mean, that would be pretty much -- it's
7 usually a fairly, you know, it's a clinical
8 diagnosis for the most part.
9 Q. Do you need to have all of those conditions
10 or any one or more of them raise at least an index
11 of suspicion?
12 A. I think certainly tenderness, redness and
13 warmth around the rectum or a ffuctuance would
14 certainly lead one to believe there is an abscess
15 there, but the absence of that, there still could
16 be an abscess, I guess.
17 Q. Can pain in the hip area be associated with
18 an ischiorectal abscess?
19 A. I don't know.
20 Q. Was there ever, to your knowledge -- and
21 you were the attending during that
22 hospitalization; correct?
23 A. Yes.
24 Q. Dr. Nunez, she was the resident under your
25 direction?

1 A. She was the intern, yes.
2 Q. Was she first year?
3 A. Yes.
4 Q. Where is Dr. Nunez now?
5 A. She is in her third year here.
6 MS. HENRY: She is on vacation
7 right now which is why she is not here.
8 MR. MISHKIND: Don't be paranoid,
9 I am asking a question.
10 MS. HENRY: I told you she was
11 still here.
12 MR. MISHKIND: I don't remember
13 that and I am asking the doctor.
14 MS. HENRY: she is on vacation
15 this week,
16 MR. MISHKIND: Thank you very
17 much. Can you tell me where she is?
18 MS. HENRY: No, but that's why she
19 wasn't scheduled.
20 Q. Do you know whether the pain in Mrs.
21 Lynch's hip was ever considered to be a sign of a
22 perirectal or ischiorectal abscess -- ischiorectal
23 fistula?
24 A. I don't know.
25 Q. Would it be reasonable to consider pain in

1 the hip as a possible symptom of an ischiorectal
2 fistula?
3 A. 3 don't know.
4 Q. And you don't know why?
5 a. If a patient; presented to me with hip pain,
6 I generally would not leap to an ischiorectal
7 fistula as the cause.
8 Q. If you knew that the patient had an
9 ischiorectal fistula, and you knew that the
10 patient had positive fecal leukocytes and you knew
11 the patient is complaining of hip pain, would it
12 be reasonable to consider hip pain in connection
13 with ruling out or confirming the existence of an
14 ischiorectal abscess?
15 A. Again, it's not something that would leap
16 to my mind.
17 Q. Could you automatically conclude --
18 exclude, I'm sorry -- hip pain from the
19 symptomatology differential if you had a patient
20 that had an ischiorectal fistula, had positive
21 fecal leukocytes in determining whether or not
22 that pain was developing an ischiorectal
23 abscess?
24 MS. HENRY: Can I hear that again,
25 please?

1 MS. HENRY: Objection. Reask that.
2 Q. Doctor, given the contents of the patient
3 that had a documented radiological finding showing
4 fistula formation, and positive fecal leukocytes,
5 and then demonstrates hip pain, would the presence
6 of hip pain cause you to exclude the possibility
7 that the patient is developing a perirectal
8 abscess?
9 MS. HENRY: Objection. Go ahead.
10 A. Well, I guess you can essentially never
11 exclude everything, and so in a certain sense, I
12 could say I couldn't exclude it.
13 However, I think the possibility that that
14 would be the case would be extremely rare and so
15 low that I just wouldn't normally consider it.
16 Q. What did you consider to be the cause of
17 her hip pain?
18 A. Probably arthritis.
19 Q. Can you consider any other causes other
20 than arthritis?
21 A. 1 don't remember,
22 Q. You have had a chance to review the
23 hospital records concerning your involvement;
24 correct?
25 A. One time, yes.

1 Q. How long ago? You can't ask Dierdre. As
2 much as she wants to testify, she tries to hold
3 back occasionally.
4 A. It's probable,
5 MS. HENRY: I am going to ask that
6 that part be stricken.
7 A. It's probably about a month ago, but I
8 don't remember exactly.
9 Q. Okay. You were involved in the
10 hospitalization from July 16th to July 31;
11 correct?
12 A. Yes.
13 Q. You weren't involved in any aspect of the
14 treatment at the Patrician Nursing Home, were you?
15 A. No.
16 Q. You weren't involved when she was
17 readmitted to Metro, were you?
18 A. No.
19 Q. You never saw the Patrician Nursing Home
20 records?
21 A. No.
22 Q. So you don't know what transpired by way of
23 her clinical course at the nursing home?
24 No.
25 Q. You don't know how quickly or how slowly

1 the caregivers at the Patrician Nursing Home
2 responded to her clinical condition, do you?
3 MR. RIEMENSCHNEIDER: Objection.
4 A. No.
5 Q. You don't know what the cause of her
6 clinical condition was from the time she left
7 Metro on the 31st up until the time that she came
8 back; correct?
9 A. That's correct.
10 Q. And I take it you also don't know what
11 information was provided by Metro to the people at
12 the Patrician Nursing Home when she was
13 transferred?
14 A. That's correct.
15 Q. Okay. If a patient has an ischiorectal
16 fistula, doctor, that is experiencing diarrhea, is
17 they at increased risk Ear the development of an
18 infection?
19 A. I don't know.
20 Q. Are you aware of any studies or articles
21 that touch on the increased risk of infection in a
22 patient that has diarrhea that also has documented
23 ischiorectal fistulas?
24 A. I am not aware of any.
25 a. And the fact that you don't know whether

1 there is an increased risk, is that because it is
2 outside of your area of expertise?
3 A. Yes.
4 Q. Besides Dr. Nunez, did you have any other
5 interns or residents working under yau that were
6 involved in Mrs. Lynch's care?
7 A. The senior resident would have also been
8 involved.
9 Q. And who was that?
10 A. I believe that was Dr. Wohl W-O-H-L.
11 Q. He was the senior attending resident?
12 A. The senior resident, yes.
13 Q. And is he still here at Metro?
14 A. I believe so. He is in -- I believe so.
15 Q. Is he in a Fellowship now?
16 A. He is in a Fellowship.
17 Q. Was there anyone else in your team, if you
18 will, that was involved either as an intern or as
19 a resident during the July confinement?
20 A. Generally the interns cross cover for each
21 other on weekends and at night, so my guess is
22 that other interns were involved in the care, but
23 I don't know exactly the names.
24 Q. Do you remember Mrs. Lynch?
25 A. Vaguely, after having reviewed the chart.

1 Q. What is it that you remember about her,
2 even if it's vague?
3 A. I remember she presented with rectal
4 bleeding. I mean, I remember that she was there
5 for two weeks.
6 Q. Anything else that you remember about her,
7 other than that which is reflected in the hospital
8 chart?
9 A. No.
10 Q. Do you have a recollection of having any
11 conversations with any family members or perhaps
12 just meeting family members during the course of
13 her hospitalization?
14 A. I don't recall.
15 Q. But you may have, you just don't have an
16 independent recollection?
17 A. Right.
18 Q. What about after transfer to the nursing
19 home, did you have any further contact by any
20 family members?
21 A. No.
22 Q. Do you recall anything, doctor, after
23 reviewing the hospital records as it relates to
24 your involvement from the 16th Until the time of
25 transfer on the 31st that is not recorded in the

1 record? And what I mean by that is anything
2 relative to conversations with any doctors or
3 nurses or consults that were obtained.
4 A. No.
5 Q. So that --
6 A. I don't recall.
7 Q. So the entirety of what you recall as it
8 relates to Mrs. Lynch's care is reflected in the
9 hospital record, other than you remembering that
10 she had rectal bleeding when she presented and you
11 remember that she was there for several weeks?
12 A. Yes.
13 Q. Okay. Christine Kocsis is the daughter of
14 Mrs. Lynch. Do you specifically or generally have
15 recollection of meeting the daughter?
16 A. No.
17 Q. Or any family members, for that matter?
18 A. No.
19 Q. Do you have a private file that you
20 maintained at all relative to Mrs. Lynch?
21 A. Meaning, how would you define file? I have
22 a copy of her discharge record.
23 a. The clinical resume?
24 A. Probably which is what you have there,
25 which I generally receive a copy of all discharge

1 records. That would be the only information I
2 would have on her.
3 Q. Nothing else written down, any paper?
4 A. No.
5 Q. Okay. Who recommended the colonoscopy?
6 A. I believe we asked for a GI consultation
7 and they recommended the colonoscopy.
8 Q. By the way, the clinical resume, which is a
9 three page clinical resume, the one that I have in
10 the chart is signed by Dr. Nunez, it's not signed
11 by you. Can you explain why?
12 A. That had been the policy up until just
13 recently that the discharge summary was signed by
14 the person dictating. So I would not normally
15 have signed it.
16 Q. Did you review the clinical resume at some
17 time?
18 A. I received copies of all clinical resumes
19 and I generally read through them.
20 Q. Did you do that in Mrs. Lynch's case?
21 A. I don't recall.
22 a. As you look at the clinical resume now
23 after the fact, is these anything that is
24 contained in that clinical resume that you
25 disagree with?

1 A. No.
2 Q. Did you actually -- strike that.
3 How are the results of the colonoscopy
4 memorialized?
5 a. I am not sure I understand the term
6 memorialized.
7 Q. There is a videotape of the colonoscopy;
8 correct?
9 A. I don't know. I guess so. I don't do
10 colonoscopies so I am not sure of the procedures.
11 Q. In your training you did colonoscopies?
12 A. No.
13 Q. You avoided that?
14 A. I am not a GI Fellow.
15 Q. Okay. Are you aware, just from your being
16 an internist, that routinely there is some type of
17 a tape made or a film made of the results of the
18 colonoscopy?
19 A. I know they take pictures.
20 Q. Whether or not they retain any type of a
21 film, you are just not certain?
22 A. Right.
23 Q. Did you ever see any of the pictures of the
24 various sections of the colon from the
25 colonoscopy?

1 A. I don't recall exactly. If it's in the
2 chart, I probably saw it.
3 Q. The procedure report itself, which was
4 prepared by those that were involved in the
5 colonoscopy, Dr. Worth and Dr. Kyprianou, did you
6 read aver those reports at the time that you were
7 involved in treating Mrs. Lynch?
8 A. Yes.
9 Q. Do you know why there are two colonoscopy
10 reports?
11 A. No.
12 Q. Did you know that there were two
13 colonoscopy reports with different terminology
14 under the diagnosis section?
15 A. I don't remember there being two.
16 Q. Now, counsel has put in front of you the
17 two reports, and under the diagnosis section, you
18 will see one says impressive proctitis with
19 fistula formation as well as nodules. And then
20 DDX includes Crohn's, ischemia, malignancy and
21 that's signed by Dr. Horth. And then the other
22 one has proctitis, and then it goes on with
23 additional verbiage and that's signed by Dr.
24 Kyprianou.
25 Are you able at all to tell me why there

1 are two reports, and the significance, if any, of
2 the difference in language?
3 MS. HENRY: Can we straighten
4 those out? Does he know why there *is* two
5 reports? I mean, because you have it
6 together.
7 A. Can I speculate?
a MS. HENRY: No, you are not to
9 speculate.
10 Q. Do you know, doctor?
11 MS. HENRY: Do you know or not
12 know? If you don't know, tell him you
13 don't know.
14 Q. Doctor, do you know?
3.5 A. No.
16 Q. Did you ever talk to the two doctors as to
17 why there was two reports?
1% A. No.
19 Q. Do you have any knowledge as to why there
20 is different language in the two reports?
21 A. No.
22 Q. Do you have an opinion as to why there are
23 two different reports?
24 A. One is written by Dr. Kyprianou and one by
25 Dr. Horth.

1 Q. Is it customary when a colonoscopy is done
2 to have two reports, one written by the operator
3 and one written by the procedure attending?
4 A. I don't know.
5 Q. Did you discuss the results of the
6 colonoscopy with either of those two doctors at
7 the time that Mrs. Lynch was in the hospital?
8 A. I don't recall exactly, but usually my
9 procedure would be to discuss that with the people
10 doing the procedure.
11 Q. In your note, doctor, on July 16th, you
12 indicate that the colonoscopy today demonstrates
13 ischemic colitis.
14 MS. HENRY: Wait a minute, Howard,
15 let me get tu it,
16 MR. MISHKIND: July 16th.
17 Q. Do you see that?
18 A. Uh-huh.
19 Q. Would you tell me on what you were basing
20 that statement, what information had been provided
21 to you?
22 A. I don't recall exactly. I mean, generally
23 we will get a phone call or an initial report.
24 Q. Are you routinely notified by the person
25 that performed the procedure or by the attending?

1 A. Yes.
2 Q. Which?
3 A. Generally by the person performing the
4 procedure, although, I guess to clarify that, I
5 might not be notified directly. They may speak
6 with the internist or one of the other physicians
7 taking care of the patient.
8 Q. What does impressive proctitis mean?
9 A. What does it mean to me?
10 Q. Yes.
11 A. Or what does it mean?
12 Q. What does impressive proctitis mean?
13 Define it for me, please.
14 A. That they had significant inflammation of
15 the distal segment of the rectum.
16 Q. Doctor, what is your understanding as to
17 the number of fistula tracks that were detected on
18 the colonoscopy?
19 A. I don't know.
20 Q. It says multiple fistula tracks. I am
21 trying to determine as the attending what you
22 understood multiple to mean,
23 A. More than two.
24 Q. And were you, from an internal medicine
25 standpoint, concerned given the patient's symptoms

1 and history with the possibility that the patient
2 was developing an infection in the area of the
3 perirectal space?
4 (Record read.)
5 A. I don't remember my exact thought process
6 at the time.
7 Q. Would it be fair to say that a reasonable
8 practitioner should consider in a differential the
9 possibility of infection, given the history, given
10 the patient's symptoms and given the findings that
11 were presented to you from the colonoscopy?
12 A. I think that's reasonable.
13 Q. Is there anything noted in the records by
14 you or to your knowledge by Dr. Nunez that
15 infection was considered as a cause of the
16 patient's symptomatology?
17 A. Not that I'm aware of.
18 Q. Do you have any explanation for why that
19 is?
20 A. No.
21 Q. Okay. Now, after the colonoscopy that was
22 performed on July 16th, it's my understanding that
23 an abdominal pelvic CT scan was ordered; correct?
24 A. Yes.
25 Q. And that was to evaluate for questionable

1 abdominal mass?
2 a. Yes.
3 Q. And an abdominal pelvic CT scan in addition
4 to evaluating for an abdominal mass can also give
5 you further information as to the pathology that
6 is causing the patient's symptoms in addition to
7 the potential for an abdominal mass; correct?
8 MS. HENRY: Objection.
9 Q. Do you understand the question, doctor?
10 A. Well, it can't tell you anything about the
11 pathology of the bowel disease.
12 Q. Okay, What else can a CT scan tell you
13 more than the colonoscopy does?
14 A. It would tell. you extent.
15 Q. Extent of what?
16 A. Disease, in terms of if there is any other
13 problem outside of the bowel.
18 Q. What about evaluating whether or not there
19 is evidence of infection or abscess?
20 A. It would also help with that, yes,
21 Q. Okay. And when you are looking for
22 evidence of infection or abscess; on a CT scan,
23 what signs or presentations do you normally see?
24 A. We would look for an abnormal collection of
25 fluid or material.

1 Q. Your note on July 28th seems to reflect --
2 MS. HENRY: Just a minute, Let's
3 get it because you are asking him. Where
4 is this now, Howard?
5 MR. MISHKIND: July 18th.
6 Q As I started to say, your note on July
7 18th, 1996 seems to suggest that at that point you
8 had the results from the CT scan; is that correct?
9 A. Yes,
10 Q. Basically the same question I asked about
11 the colonoscopy, how was that information on the
12 CT scan conveyed to you?
13 A. I don't recall exactly in this instance.
14 Generally the report is present and available
15 either by phone or on the computer within several
16 hours of the procedure being done.
17 Q. You have no reason to believe that the
18 information from the GT scan would not have been
19 available to you at or around the time of your
20 note, do you?
21 A. No.
22 Q. In the report itself, the actual printed
23 note from radiology, there is a reference to
24 a tiny amount of air as seen in the left
25 ischiorectal fascia and then it goes on to say

1 tiny collections of air are also seen adjacent to
2 the rectum bilaterally.
3 As a clinician, treating a patient with the
4 history and symptoms that she had, of what concern
5 is there to you on a differential basis when you
6 see air in the areas described?
7 A. Concern would be for fistula.
8 Q. And what else?
9 A. I don't know. That would be the number one
10 thing I would be thinking.
11 Q. Would air also in the ischiorectal fascia
12 be consistent with an evolving abscess or
13 infection?
14 A. I don't know.
15 Q. Do you know whether it can be consistent
16 with an evolving --
17 A. I don't know.
18 Q. That's not within your area of expertise?
19 A. NU.
20 Q. That would be an issue that -- strike
21 that.
22 If the patient is developing an abscess in
23 the area of the ischiorectal fistula, is that a
24 surgical issue?
25 A. If there is an abscess, this generally

1 would be treated surgically, yes.
2 Q. If there is evidence of an abscess in the
3 ischiorectal fistula, can that condition be
4 treated medically?
5 A. I don't know. My surgery would be the
6 primary treatment.
7 Q. Okay. Does an ischiorectal fistula,
8 doctor, permit stool or fecal material to leave
9 the GI track and enter the ischial tissue?
10 A. It's hard to answer yes or no.
11 Q. If you can't answer yes or no, you can
12 qualify it and tell me why.
13 A. I guess it's possible, It does not have to
14 happen, let's put it that way.
15 Q. I am not suggesting it has to happen.
16 A. It's possible.
17 Q. Is there an increased opportunity, if you
18 will, for stool or fecal material to leave the GI
19 track and enter the ischial tissue if there is an
20 ischiorectal fistula present?
21 A. Yes.
22 Q. What precautions, if any, can be taken to
23 reduce the likelihood of stool or fecal material
24 from entering the track of an ischiorectal
25 fistula?

1 A. I don't know-

2 Q. Again, that would be either a surgical --

3 A. Surgical or GI.

4 Q. And the presence of air adjacent to the

5 rectum bilaterally, that is in addition to the

6 area that was described on colonoscopy, in terms

7 of the position of the ischiorectal fistula, is it

8 not?

9 A. The area adjacent to the rectum would not

10 be Seen on colonoscopy, because you are looking

11 inside sort of a tube.

12 Q. Okay.

13 A. So the CT scan gives you an additional view

14 outside.

15 Q. Are you able to correlate the presence of

16 air bilaterally in relationship to the rectum to

17 the ischiorectal fistula that had been described

18 on colonoscopy?

19 A. I don't know.

20 Q. They may be correlated or it may be

21 additional findings outside of the ischiorectal

22 fistula?

23 A. Yes.

24 Q. And again, that would be a surgical, issue

25 or a GI issue?

1 A. Yes.
2 Q. Doctor, would you agree that the patient
3 that has a perirectal fistula or an ischiorectal
4 fistula, specifically, and has diarrhea, that you
5 need to carefully monitor the patient to make sure
6 that the patient does not develop an infection or
7 an abscess?
8 A. Yes.
9 Q. And would you agree that a failure to
10 carefully monitor such a patient would not be in
11 compliance with the standard of care?
12 MS. HENRY: Objection.
3.3 MR. RIEMENSCHNEIDER: Objection.
14 Q. You can answer the question, The objection
15 is €or the record.
16 A. It depends how you define carefully
17 monitor.
18 Q. On a regular basis, a daily basis,
19 monitoring the patient.
20 A. I don't know.
21 Q. To watch for clinical signs.
22 MS. HENRY: Objection.
23 A. I mean, I guess that's true for just about
24 anything, but --
25 Q. Well, certainly you recognize that there is

1 a potential for serious complications if a patient
2 develops an abscess or an infection in a
3 perirectal fistula; correct?
4 A. Yes.
5 Q. And you would agree that if the care in
6 terms of monitoring that perirectal fistula when a
7 patient has diarrhea, the monitoring is not
8 reasonable and prudent, that would be a violation
9 of the standard of care; correct?
10 MS. HENRY: Objection.
11 MR. RIEMENSCHNEIDER: Objection.
12 A. Can you repeat that?
13 Q. If the monitoring of the perirectal fistula
14 in the face of diarrhea, if that monitoring is not
15 careful and it leads to the development of an
16 abscess, can we agree that that would be a
17 violation of the standard of care?
18 MS. HENRY: Objection.
19 MR. RIEMENSCHNEIDER: Objection.
20 A. I don't know.
21 Q. And why don't you know?
22 A. Well, one, I am not sure of the
23 significance of diarrhea or not, you know, whether
24 that makes any difference, and two, I don't know
25 what the standard of care is from a GI standpoint.

1 Q. Okay. What about standard of care from an
2 internal medicine standpoint?
3 A. Well, I think the standard of care would be
4 to monitor people for the onset of infection.
5 Q. Okay. And positive Eecal leukocytes, that
6 can be evidence of an infection; correct?
7 A. Could be evidence of an infection, yes.
8 Q. Can fecal incontinence also be caused by a
9 perirectal or a perianal infection?
10 A. Yes.
11 Q. Do you have an opinion as to whether the
12 fecal incontinence that Mrs. Lynch had was caused
13 by a perianal or perirectal infection?
14 A. My opinion is it was not.
15 Q. Why is that?
16 A. The diarrhea had been present for some time
17 and she had no other signs or symptoms consistent
18 with infection.
19 Q. Did you ever request a surgical consult?
20 A. I don't recall. I don't believe we did.
21 Q. Do you know why it is that upon readmission
22 to the hospital the attending at that point
23 indicated that surgery had been consulted during
24 the admission in July of 1996?
25 A. No.

1 Q. Would you agree that it would have been
2 reasonable to have obtained a surgical consult in
3 the July 1996 hospitalization?
4 MS. HENRY: Objection.
5 A. I don't know.
6 Q. You say that you didn't or you don't recall
7 requesting a surgical consult. Do you know
8 whether a surgical consult was requested by the
9 resident or the intern under your direction?
10 A. No, I don't know.
11 Q. Would you agree that immediate surgical
12 consult is always necessary, doctor, in a patient
13 that has a sign, signs of an abscess?
14 MS. HENRY: Objection,
15 A. I think with signs of an abscess, a
16 surgical consultation would be reasonable, of
17 course, to pursue.
18 Q. And that's something that should be done on
19 an immediate basis as apposed to on a whenever can
20 be done basis; correct?
21 A. Yes.
22 Q. Do you know how frequently ischiorectal
23 fistulas result or develop -- strike that.
24 Do you know how frequently abscesses
25 develop within ischiorectal fistulas?

1 A. No.
2 Q. Or around ischiorectal fistulas?
3 A. No.
4 Q Are you aware of the literature indicating
5 that a high percentage of ischiorectal fistulas do
6 ultimately result in abscess formation?
7 A. No.
8 Q. No, you are not aware of that, or no, the
9 literature --
10 A. I am not aware of the literature.
11 Q. You are not aware one way or the other?
12 A Right.
13 Q. Fair enough.
14 If you could look at the record and tell me
15 whether or not Mrs. Lynch was treated at all for
16 the positive fecal leukocytes that were detected,
17 I believe, on July 23rd.
18 A. She did have a stool culture done which was
19 negative for any unusual bacteria for parasites or
20 for C-difficile toxin, all which could be causes
21 for diarrhea.
22 She also received a Rowasa enema, which is
23 a steroid enema, which would be the generic
24 treatment for inflammation.
25 Q. Was E-coli ruled out?

1 A. E-coli is present in the bowel at all
2 times. And I don't: know if abnormal forms of
3 E-coli were ruled aut,
4 Q. What type of test would have had to have
5 been done to rule out abnormal forms of E-coli?
6 A. I don't know exactly.
7 Q. Was klebsiella ruled out?
8 A. I don't know.
9 Q. What type of test would have had to have
10 been done to rule out klebsiella?
11 A. Culture of the stool.
12 Q. A different culture than what was done?
13 MS. HENRY: Just answer his
14 question. A different culture --
15 A. I don't know exactly whether that's in the
16 standard culture for stool.
17 Q. Does a Rowasa enema treat inflammatory
18 bowel disease?
19 A. It can be used to treat inflammatory bowel
20 disease.
21 Q. Is it a treatment; of choice for
22 inflammatory bowel disease?
23 A, It would depend on the situation.
24 Q. Well, in the face of continual diarrhea, is
25 it appropriate to continue a Rowasa enema?

1 MS. HENRY: Objection.
2 MR. RIEMENSCHNEIDER: Objection.
3 A. I don't know.
4 Q. Do you know whether there are any down side
5 risks to a patient that has continued diarrhea in
6 terms of continuing the Rowasa enemas?
7 A. I don't know.
8 Q. Would you agree that a Rowasa enema is less
9 likely to be effective under circumstances where
10 the patient has diarrhea?
11 A. I don't know.
12 Q. And the reason that you have said I don't
13 know to these questions is it's outside your area
14 of expertise?
15 A. Yes.
16 Q. Fair enough.
17 When Mrs. Lynch was readmitted to the
18 hospital, she had extensive necrotizing soft
19 tissue involving the skin fat and vessels of the
20 perirectal and gluteal region.
21 Do you have an opinion, doctor, as to
22 whether or not the areas that are identified in
23 terms of the CT and the colonoscopy are the same
24 areas where the soft tissue involvement was
25 ultimately detected?

1 A. I don't know. I guess I don't have an
2 opinion.
3 Q. Do you have an opinion as to whether Mrs.
4 Lynch had an infection within the perirectal space
5 at the time that she was discharged from Metro and
6 transferred to the Patrician Nursing Home?
7 A. My opinion would be she did not,
8 Q. And what do you base that on?
9 A. She had no physical findings consistent
10 with infection. She had no fever or no pain
11 there, no tenderness, no other systemic findings
12 consistent with infection.
13 Q. Was she at increased risk of developing an
14 infection in the perirectal space given the
15 presence of the multiple fistula tracks, the air,
16 bilaterally, as well as the positive fecal
17 leukocytes?
18 A. I don't know.
19 Q. And do you know what the standard of care
20 is in terms of treating a patient, assuming they
21 are at increased risk for the development of
22 infection, where there is multiple fistula tracks,
23 as well as positive fecal leukocytes?
24 A. I don't know.
25 Q. I take it you are not going to provide any

1 opinions as to whether earlier recognition and
2 treatment of the abscess would have saved Mrs.
3 Lynch's life?
4 A. I don't know.
5 Q. You don't have any such opinions?
6 A. Right.
7 a. And you are not intending to offer such
8 opinions, are you?
9 A. No.
10 Q. Have you even seen the autopsy?
11 A. No.
12 a. Have you talked with any of the doctors
13 that were involved in the care of Mrs. Lynch when
14 she came back tu the hospital?
15 A. No.
16 Q. Have you seen the records for the second
17 hospitalization?
18 A. No.
19 Q. When did you first learn that she had come
20 back from the nursing home?
21 A. About a month ago.
22 Q. Okay. Why, doctor, was the plan to rescope
23 Mrs. Lynch set for three months from the time of
24 her discharge?
25 A. That was the recommendation of the GI

1 physicians.
2 Q. The fact that Mrs. Lynch continued to have
3 small loose stools and continued to complain of
4 pain in the hip area, you did not consider that
5 she was developing an infection, in the perirectal
6 area; is that correct?
7 MS. HENRY: Howard, when are you
8 talking about with the continued loose
9 stool? At the time of discharge?
10 Q. As we approach the date of discharge, the
11 29th, doctor, is it fair to say that you did not
12 consider infection as being a cause for the
13 patient's continued diarrhea and continued
14 complaints of pain?
15 A. Yes.
16 Q. Doctor, who was it that ordered the
17 discharge to the nursing home?
18 A. I don't know exactly. My guess is Dr.
19 Munez.
20 Q. Who was it that ordered the discharge
21 medications?
22 A. It would be the same person.
23 Q. And Dr. Nunez was a first year, first year
24 out of medical school; correct?
25 A. Yes'

a Q If appears that your involvement was more
2 in a supervisory capacity?
3 A Yes.
4 Q. But the hands-on monitoring of the patient
5 from an internal medicine standpoint on a
6 day-to-day basis seemed to be by Dr. Nunez; is
7 that fair?
8 A. That's correct,
9 Q. Did you actually examine Mrs. Lynch at any
10 time?
11 A Yes, probably every day
12 Q After Dr. Nunez had already been in to see
13 her?
14 A. It's probably sometime after, sometimes at
15 the same time.
16 Q. Would it be fair to say that the detailed
17 exams were done by Dr. Nunez?
I8 A. Yes.
19 Q. Doctor, it is 12:00 o'clock and as
20 promised, I am done, Thank you far your time.
21 EXAMINATION OF DOUGLAS FINSTADTER, M.D.
22 BY-MR. RIEMENSCHNEIDER:
23 Q. A real quick question. You did not review
24 any of the medical records from the nursing home;
25 correct?

1 A. That's correct.
2 Q. And so you are not critical of any of the
3 care delivered by the nursing staff at the
4 Patrician?
5 A. I don't know anything about the care there.
6 EXAMINATION OF DOUGLAS EINSTADTER, M.D.
7 BY-MR. MISHKIND:
8 Q. You have no basis one way or the other to
9 say whether the care was good or bad?
10 A. Yes.
11 MS. HENRY: We would like to read
12 it.
13 (Deposition concluded at 12:00
14 o'clock noon; signature not waived.)
15
16
17
18 ______________________________
DOUGLAS EINSTADTER, M.D.
19
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21
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23
24
25

1 **CERTIFICATE**

2 State of Ohio,)
) SS:
3 County of Cuyahoga,)

4

5 I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and
6 qualified, do hereby certify that the within named DOUGLAS EINSTADTER, M.D. was by me first duly
7 sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that
8 the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the
9 foregoing is a true and correct transcription of the testimony.

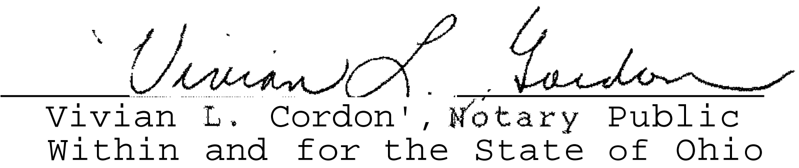
10

I do further certify that this deposition
11 was taken at the time and place specified and was completed without adjournment; that I am not a
12 relative or attorney for either party or otherwise interested in the event of this action,

13

IN WITNESS WHEREOF, I have hereunto set my
14 hand and affixed my seal of office at Cleveland, Ohio, on this 18th day of November, 1998.

15

16 

17 Vivian L. Cordon', Notary Public
Within and for the State of Ohio

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My commission expires May 22, 1999.

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