In The Matter Of:

Estate of Peter Restivo, etc. v. Community Health Partners Home Health Care, et al.

Ahmed K. Elghazawi, M.D.
May 20, 2003

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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
ESTATE OF PETER RESTIVO, etc.,

Plaintiff,

JUDGE FRIEDLAND
-vs- CASE NO. 445734

COMMUNITY HEALTH CARE PARTNERS, et al.,

Defendants.

Deposition of AHMED K. ELGHAZAWI, M.D., taken as if upon cross-examination before Katherine A. Koczan, a Notary Public within and for the State of Ohio, at the offices of Lowe, Eklund, Wakefield & Mulvihill, 610 Skylight Office Tower, Cleveland, Ohio, at 4:10 p.m. on Tuesday, May 20, 2003, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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EXHIBITINDEX

EXHIBIT MARKED

(Thereupon, Plaintiff's Exhibit 1 was marked for purposes of identification.)

AHMED K. ELGHAZAWI, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF AHMED K. ELGHAZAWI, M.D.

BY MR. MULVIHILL:

Q: Doctor, would you please state your name.

A: First name is Ahmed, A-h-m-e-d, and last name is Elghazawi, it's E-l-g-h-a-z-a-w-i.

Q: Elghazawi?

A: Yes, sir.

Q: Okay. Just want to make sure I was pronouncing it correctly.

And before we get into any of the substance of this, I just want to identify that we have marked what you provided to me just before the deposition started as a current copy of your resume, is that right?

A: That's correct.

Q: Okay. And we marked that as Exhibit 1, and then I'm looking through your file in this case, is this, did you bring your entire file?

A: Most of it, because it was in two different piles, but I think this is almost all of it, I think.

Q: Why don't you tell me what you didn't bring and then we will start with what you did bring.

A: I think I did bring pretty much all of it what you have.

Q: I'm going to identify, and you can look across the table here and make sure I'm identifying the contents, the first is a copy of your September 4th, 2002 report, correct?

A: Yes.

Q: Then your February 17th, 2003 report, correct?

A: Yes.

Q: And then there's a February 18th, 2003, is that kind of —

A: Yeah.

Q: — another report?

A: It's not a report. Like a follow-up letter.

Q: Follow-up letter. Then we have a letter from October 29th, 2002 from Ms. Sfiscko's office?

A: Yes, sir.

Q: The report of Dr. Herman, is that right?

A: Yes, sir.

Q: And the report of Dr. Armitage?

A: Yes.

Q: All right. And then another October 25th, 2002 correspondence from Ms. Sfiscko, correct?

A: Yes, sir.

Q: And then it looks like you have some sort of deposition starting at Page 43?

A: Yeah.

Q: What deposition is that?

MS. SFISCKO: It looks like it could be the nurse's.

Q: I guess the first question is, I assume somewhere you have the first 42 pages of the deposition, correct?

MS. SFISCKO: It should be here.

A: It should be here.

MS. SFISCKO: Katherine Restivo.

A: The deceased's wife.

Q: Okay.

A: Yeah.

Q: Do you know where the rest of the deposition is?

A: Probably in the office, most likely.

Q: Okay.

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A: These are not medical records, obviously, this was just —
Q: Right, a deposition. Okay. And then there's a, apparently another copy of this February 17th, 2003 report, correct?
A: Yes.
Q: And then there is a February 19th, 2003 letter from Ms. Sfiscko. And that is the deposition of Deborah Schwan?
A: Yes.
Q: Okay. Deposition of Dr. Carroll?
A: Yes.
Q: And then a February 14th, 2003 letter, which apparently contained the home health care chart, correct?
A: That's correct.
Q: All right. And then is the, is this the home health care chart?
A: Yes. Some of the material was repetitive, like vital signs, and so we pretty much have the relevant information here.
Q: Okay. But is this, as far as you know, the entire home health care chart?
A: Yes.
Q: Okay. What about the medical records from Elyria

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Memorial Hospital, do you have any of those?
A: I probably, probably in the office with the other records. It was too much to carry with me, but this is —
Q: Doctor, I —
A: — the list that I have was the report that I reviewed, the record I reviewed.
Q: Well, doctor, it's important I know what you reviewed and what you relied on in formulating your opinions. So — hold on, don't interrupt me.
So when I asked you earlier if this was the entire file, you had indicated that it was.
A: Yes.
Q: Okay. However, obviously it's not because you have medical records from the hospital that are not contained in this package, correct?
A: That's possible, yes.
Q: I mean, you have reviewed the Elyria Memorial records?
A: Yes, I list it in the records that I reviewed in the front page of my letter to Ms. Sfiscko.
Q: In fact, I see a death certificate which isn't in this pile, correct?
A: Correct.

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Q: The autopsy report which isn't in this pile, correct?
A: Yes.
Q: Elyria Memorial consultative report is not in this pile, correct?
A: Yes.
Q: There's multiple, I'm just going over the list.
MS. HARRIS: Including records.
MS. SFISCKO: Including records.
MR. MULVIHILL: Yes.
MS. HARRIS: Number four, right.
Q: We didn't see the deposition of the nurse, is it Verlei — how do you pronounce it?
MS. HARRIS: Verlei.
Q: Verlei, thank you. Her deposition isn't in here, is it?
A: No, not in this records, no.
Q: Okay. Well, in fact, doctor, in your September 4th, 2002 report, you'd indicated that you had reviewed records one through ten, correct?
A: Yes.
Q: And in fact, none of those are here in this pile that you brought with you, are they?
A: Well, my secretary — they delivered this stuff to me in my office downtown, and it may not be

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here, that's correct.
Q: All right. So in no way is this a complete file in this case?
A: Yeah, there are other records, yes.
Q: Okay. What I'm particularly interested in is the medical summary prepared by Ms. Sfiscko's office. You see that, number nine?
A: Yes.
Q: You didn't bring that with you?
A: It may not be in this, in this —
Q: All right.
A: — pile.
Do you have a copy of it, Ms. Sfiscko?
MS. SFISCKO: No, I don't have a copy of it with me. It could very well be my cover letter or something.
MR. MULVIHILL: Well, it says medical summary, so I'll take the doctor's words.
MS. SFISCKO: That's, I do a medical summary.
Q: I would ask that be produced immediately.
A: Sure.
Q: If you would give that to Ms. Sfiscko so she could turn it over to us.

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Did you take any notes in this case?
A: No. I usually dictate my notes as I work, and then when I finish, I basically dictate a full report and then I proof it, I review it, make sure there are no errors, grammatical errors, and then I send it to Ms. Sfiscko.
Q: Let's back up here a second. Do you dictate the report or do you dictate notes before the report?
A: Well, I sit down, I do, and I review the records in front of me. I may take a note and then I may just use this as I'm dictating my report.
Q: Do you have any of those notes you took in this case?
A: Of course not. When I review records, these notes are to remind me as I'm dictating, and once I dictate, I don't need these notes.
Q: Did you retain the notes in this case?
A: No.
Q: Okay. What did you do with them?
A: I don't keep the notes. I shred them because I don't need them. You know, I need the note to remind me as I'm dictating dates and events because I can't memorize every date in the record.
Q: Sure. Someone else may need them.

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You realize that you've been retained to offer opinions in this case, right?
A: I've never had this question before.
Q: I would ask that you look through your entire file and I would ask you to produce the medical summary that was prepared by Ms. Sfiscko's office.
MR. MULVIHILL: Off the record.

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

A: I actually have a box, the rest of the records. I can't carry a box to here.
Q: All right.
MS. SFISCKO: Next time we will do it at your office.
THE WITNESS: Yeah, I have a box.
MS. SFISCKO: So you can have everything there.
THE WITNESS: I'm not used to walking around carrying a box.
Q: All right. And again, referencing your report of September 4th, 2002 —
A: Yes, sir.

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Q: — item number eight, full medical charts part one and part two?
A: Um-hum.
Q: What does that mean?
A: Just that it says medical chart part one and two. There was, there was a file of the patient's medical chart that was provided to me and they were in two separate parts.
Q: Do you know from where, are those the Elyria Memorial records or —
A: Yes, probably the hospital records.
Q: Why don't you tell me what medical records you reviewed in this case.
A: Everything I listed to you on page one of September 4th report, and then there were additional, if you can give me my file back, I can help you with that.
So on September 4th, 2002 letter to Ms. Sfiscko, I listed ten records. I'd be happy to bring you the box so you have it.
Q: I just want to know what they are —
A: Yes.
Q: — right now.
A: Everything that's listed, the deposition of Miss Alana Verlei, the home health care nurse, the

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death certificate, the autopsy report of Mr. Restivo, the Elyria Memorial Hospital consultation reports, the diagnostic studies including blood work, cultures, x-rays, the complaint that was filed, the answers and interrogation that was filed.
Q: Let me stop you there. Number seven, answers to what interrogatories?
A: Interrogatories that were sent to the nurse, I'm assuming Miss Verlei.
Q: Okay.
A: That she answered, like any other case, you know. And then the full medical chart part one and two.
Q: Well, that's, that's the most vague description of them all.
A: Yeah.
Q: Is that the Elyria records or does it include something other than the Elyria records?
A: I think it's the Elyria records, because this is, is most of the records the patient had, it was the hospital he went to before also, and then there was a medical summary, like I mentioned earlier, by Ms. Sfiscko, and the Plaintiff expert reports that was of Dr. Herman and Nurse Bennett.
Q: Okay. The other thing —

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A: And then October —
Q: I'm sorry.
A: There were some other experts' reports which was pretty much the same ones that she had here that I reviewed, and another letter that I sent to Ms. Sfiscko on February 17th, 2003, there was record from the home health care and the Grace Hospital records, and I gave an opinion in reference to these records from Grace Hospital and that, and there was records of Nurse Debra Schwan that also was reviewed.
Q: Okay.
A: And that's about it.
Q: Can you hand me the February 18th letter, please.
A: Sure.
Q: I'd like to mark that as Exhibit 2 if I could, and we will maybe go make a copy of that for you so I can keep it.

(Thereupon, Plaintiff's Exhibit 2 was marked for purposes of identification.)

MS. SFISCKO: Okay. I probably have it. It's probably in my correspondence file.

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Q: Okay. And if you remind me to make a copy of that before you leave.
A: Okay. Let me mark it so I won't forget that.
Q: All right. Doctor, I want to go over your background a little bit if we can.
A: Sure.
Q: And we have marked your resume —
A: I have a copy of that.
Q: — as Exhibit 1.
And I kind of want to just go through this if we can.
A: Sure.
Q: You were born in Cairo, Egypt?
A: Yes, sir.
Q: And you were educated in Egypt as well, correct?
A: Most of my education, yes.
Q: Your premedical education was at —
A: Ain Shams, A-i-n S-h-a-m-s, University in Cairo.
Q: And you spent two years in your premedical education, is that right, '71 to '72?
A: Yes. This actually is called premed, which is like studying biochemistry, you know, premed sciences, basically.
Q: And your degree was Bachelor of Science?
A: M.B., Ch.B, which stands for — yeah, the first

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one, yes, Bachelor of Science, B.SC, that's correct.
Q: And then you immediately enrolled in the same university in medical school?
A: That's correct.
Q: Okay. And your degree was M.B., Ch.B?
A: Yes.
Q: What does that stand for?
A: Medical Bachelor, Bachelor of Chirurgiae, which is a British degree. This is equivalent if you go to Oxford or Cambridge or something like that, same degree.
Q: Ch.B is what?
A: Chirurgiae baccalaureus, chirurgiae, like surgery. This is the Latin, and if you go to a school at say Oxford, Cambridge in England, you would get M.B., Ch.B.
Q: You didn't go to Oxford, correct?
A: Correct, but we have a British curriculum and that's why we have these abbreviations.
Q: Now, when did you obtain the M.D. degree?
A: In 1972. I'm sorry, '78.
Q: I thought you just got finished saying it was a British system, you have an M.B., Ch.B?
A: When did I finish the school you said?

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Q: No, when did you get your M.D. degree?
A: Well, this is equivalent to M.D. degree.
Q: Okay. Did you get an M.D.?
A: Yes, I got this because I came to the United States. I went through the United States qualification exams, we passed them all and we became certified here.
Q: Who's we?
A: Any doctor, foreign physician who comes here.
Q: Okay. And do they give you an M.D. then when you pass the exam?
A: Yes.
Q: Is that the FLEX exams?
A: Yes.
Q: Did you, did you ever fail the FLEX exam?
A: Never.
Q: All right. And not being familiar with the British system or the Egyptian equivalent of the British system, what did you do when you graduated? Did you have a typical residency somewhere or —
A: Yeah, we typically do a year of residency in general medicine and surgery prior to any subspecialization you want to do later on. So the first year we do after that would be spent in

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the hospital basically.
Q: Just kind of on rotation?
A: Yes. There's some elective, if you're interested in certain areas, you may spend some more time more than the other.
Q: Let me ask you this. Did you have a specific residency in Egypt?
A: Yes.
Q: And what was it?
A: One year medicine and surgery.
Q: Medicine and surgery?
A: That's what it's called, yes.
Q: And where is it on your resume?
A: I can look at it and tell you. This would be in the final year of 1978, basically that's part of the six-year training program.
Q: And then what did you do after that one year of medicine and surgery residency?
A: Well, I came to the United States at the, in 1979. I was a scout leader in the Boy Scouts and I represented my country in common to the international Boy Scout leaders in the United States. That's how I came here.
Then I worked in the Saudi Arabian Embassy in Washington, D.C., as I said here, in my rest of

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my curriculum in the medical division through 1984, and then I joined the Cleveland Clinic in 1985.
Q: Okay. Let me just back up. You came to the United States in '79?
A: Um-hum.
Q: And you came in cooperation with the Boy Scouts?
A: Yeah, these are program that they do every four years where they invite Scout leaders from all over the world, and I was —
Q: You weren't invited to America because of your medical training, you were invited to America because of your Scout training, correct?
A: Because of my leadership in scouting, yes.
Q: And how long were you in the Boy Scouts in the United States?
A: Like three, four months. I think it was going through the different areas in the country, you know, we went through Pennsylvania and then New York, and it was international gathering of all the people from all over the world basically.
Q: And then later in '79 you started at the Saudi Arabian Embassy?
A: Yeah, I applied for a job there basically and I joined the Embassy around that time.

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Q: Maybe I'm not understanding what's going on here, but it looks like on your resume you have Saudi Arabian Embassy from '83 to '85?
A: Yes, I missed this. This is 20 years ago. Let me help you. Yeah, I worked with a group of orthopedic surgeons in Washington, D.C. area from '81 to '83.
MS. SFISCKO: It's on here.
A: It's here, it's number two, if you can see it.
Q: Is it Drs. Azer, Jackson —
A: Yes.
Q: — Emich, et cetera?
A: Emich, Maximous, Muwwad, from '81 to '83.
Q: All right. Let me back up. When did you leave Egypt in 1979?
A: Sometime after July.
Q: Okay. And you came to the United States and worked with the Scouts until sometime later in '79?
A: Yeah.
Q: And then —
A: Approximately.
Q: — what did you do from '79 to '81 until you started at the Orthopedic Clinics?
A: Touring this beautiful country.

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Q: You weren't practicing medicine in America, correct?
A: No, no. You can't practice medicine before you get your qualification exams.
Q: So I want to be clear. You were not practicing medicine in America from '79 to '81, correct?
A: Yeah, correct.
Q: Okay. And then in '81 you started with a group of orthopedic doctors in Washington, D.C.?
A: Yes.
Q: Okay.
A: Area. They have offices in Virginia and Maryland as well, but their main office is in Washington.
Q: In here you have that it included both clinical and administrative aspects?
A: I seen patients, examining patients with them. And I did not have my license at the time, I couldn't have my own practice, so I was working with them in their practice.
Q: And how much of your time was devoted to clinical versus administrative at that time?
A: I'd say probably 80 percent clinical, 20 percent administrative.
Q: And did you get your license to practice in the United States in that time when you were with

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those orthopedic doctors?
A: Yeah, I was studying at that time for my ACFMG.
Q: For your what?
A: ACFMG, it's the Accreditation Commission for Foreign Medical Graduates, that's what it stands for. And so that's what I was preparing myself for.
Q: When did you take that exam?
A: I think it was 1983, if I'm not mistaken. It's —
Q: Is that about —
A: I can send you a copy of it if you like. I think it was '83 or '84.
Q: Is that the time you transferred over to the Saudi Arabian Embassy then?
A: Around that time, yeah.
Q: And what did you do for the Saudi Arabian Embassy?
A: We did the review of patients' care. We had overseas patients that came from the middle east, they came for specialized care, such as kidney transplant, mostly cancer care, you know, complex medical care, and my job was to go over the files to review and assess the need for further treatment, and if they need to have any further

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consultation, the referrals, the Embassy acted as a liaison between the hospitals overseas and the hospitals here.
Q: Okay. These were patients who needed medical care that they could only get in the United States?
A: For the most part, yes.
Q: And you were acting as a liaison with the Embassy between the hospitals overseas and the hospitals in America?
A: You acting as a medical expert, so to speak, to, to decide if this patients need to come or not and what care they need.
Q: Okay. Well, you didn't actually treat these people who needed kidney transplants and things like that?
A: This was basically mostly administrative work.
Q: Okay.
A: You go over the file, you look at the medical records and you make a decision based on what you have.
Q: And so then in 1985 you came to the Cleveland Clinic here in Cleveland?
A: Yes, sir.
Q: And you're a resident in internal medicine for

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three years?
A: Yes.
Q: Did you complete the residency program in internal medicine?
A: Yes.
Q: Did you ever sit for the board certification in internal medicine?
A: Yes, I did.
Q: And did you pass that?
A: No, I did not pass that.
Q: How many times did you take the board certification for internal medicine?
A: Two times.
Q: And you did not pass either one of them?
A: That's correct.
Q: Have you ever taken any other board certification exams?
A: Yes, I have a list of the board certification exams I had.
Q: Okay.
A: I took the —
Q: Okay. Let me stop you there because we will get to those in just a minute.
A: Sure.
Q: Did you ever take any other board certifications

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that you did not pass?
A: No.
Q: Did you ever follow up with any of your work in orthopedics that you were doing from '81 to '83, did you sit for the boards in orthopedics?
A: Well, I couldn't sit for the board of orthopedics. I could sit for the boards for pain management, which became an area of interest later on, and basically in order to sit for the board of orthopedics, you have to do five years of orthopedic training.
Q: Which you didn't have?
A: No, it's not my specialty.
Q: All right. And then you left the Clinic in '88, it looks like you went to Switzerland?
A: Sweden, I did a fellowship in Sweden.
Q: I see spine division, Basel, Switzerland?
A: No, I think you're getting your dates — this, this was just a brief few months in Switzerland, yes, 1988, yes, that's correct, yes.
And then after that I went to Vermont in the rehabilitation center in the back center there, and then I went to Sweden after that. That was my fellowship over there.
Q: Okay. Your fellowship in what?

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A: Spinal disorders.
Q: Did that, does that fall under the umbrella of orthopedics?
A: Oh, of course, because we had spine center in the Cleveland Clinic. I actually was one of the people who started the spine center in the Cleveland Clinic in 1989; '88, '89.
Q: Wait a minute. Now, did you start a spine center in — you weren't an orthopedic doctor?
A: The spine center was not an orthopedic center. The spine center was a rheumatology and internal medicine.
Q: What rheumatology had you had up to this point?
A: The spine center included different disciplines.
Q: Okay. What rheumatology training did you have up to that point?
A: I did not have — I have my spine fellowship, as I mentioned to you earlier, and the Cleveland Clinic asked me actually to stay and set the program for them because they wanted medical people to oversee spine patients, because most of these patients are not orthopedics or rheumatologic, most of them are occupational and most of them need medical care. So the spine center is not an orthopedic department in the

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Cleveland Clinic. It's a separate entity basically.
Q: Who did you set the center up with?
A: Dr. Boumphrey, Francis Boumphrey, who is the chief of the spine center at the Clinic. At the time I worked with Dr. Russ Hardy, who is the chief of neurosurgery who is now at University Hospital, and I have a whole list of other names if you like.
MR. MULVIHILL: Let's go off the record a second.

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

Q: Doctor, your pager just went off.
A: I'm sorry about that.
Q: And I assume you've had your deposition taken before?
A: I can't — yeah. You want me to turn it off, throw it away?
MS. HARRIS: No, what he's trying to say, doctor, if you need to take the page, do so.
Q: Doctor, we didn't go over the ground rules for

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the deposition.
A: That's okay.
Q: If you need to take a break, just let me know.
A: That's very kind of you.
Q: We're not here to make this inconvenient for you.
A: That's all right.
Q: Okay. And then, so you were at the Cleveland Clinic back again then in '89 to '92, center for the spine?
A: That's right. And let me just help you here.
Q: Sure.
A: The center for the spine at the Cleveland Clinic, as a center, was established 1988. I was one of the founders for the spine center. They said the center based on medical nonorthopedic people to see all people with spinal problem. The one who needs surgery then will be referred. And so often you acted more like a medical diagnostic group.
Q: Is that center still in existence?
A: Oh, yeah. Much bigger and more famous.
Q: And then it looks like for the next three years, from '92 to '95, you were somehow affiliated with Mt. Sinai?
A: Yes.

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Q: What was that?
A: Mt. Sinai has a group called Business Health Networks, which staffed the outpatient clinic for the hospital that took care of employees, it took care of work-related injuries, it took care of primary care, general medicine, it was more like an outpatient clinic basically.
Q: Did you actually practice medicine in that clinic or were you —
A: Of course, of course. We see patients every day.
Q: Let me finish my question. Did you actually treat patients in that clinic or were you more administrative?
A: I treat patient every day.
Q: Did you have an administrative component to your job?
A: No, not really, more that the, the paperwork like people have off work times, slip to take off a few days for an injury, something like that.
Q: What's Business Health?
A: That's the name of the group that staffed Mt. Sinai called Business Health Network. They staff the primary care division of the hospital.
Q: Then looks like the next long-term thing you have here is Associate of Family Physicians in

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Cleveland, Ohio. What's that? '92 to 2001.
A: This is a primary care group that do our nursing home and geriatric care. I worked with them as a physician who see patient in nursing homes as a part-time work, basically, beside my other activities. I took care of large geriatric patients. I was a medical director for one of the larger nursing homes that they did work for on the west side called Royal Oak Nursing Home.
Q: Where's that located?
A: Royal Oak. Pearl Road.
Q: I beg your — Pearl Road?
A: Pearl Road, yes.
Q: What city is that?
A: That's Broadview Heights, I think. No, Middleburg Heights.
Q: You were actually seeing patients then with your Associate of Family Physicians?
A: Yes, I would basically have, you know, a number of patients in the nursing home and I would follow them on a regular basis throughout their stay or as needed.
Q: All right. And then you also have Medical Directors, Cuyahoga County Corrections Center Health Services?

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A: Yes.
Q: Is that the jail downtown?
A: This is the correction center downtown, yes.
Q: And are you still affiliated with them?
A: Yes.
Q: Okay. And what is your position with them?
A: I oversee 13 physicians who will provide different disciplines, primary care — we have five primary care physicians, we have three psychiatrists.
Q: Where are they located?
A: Downtown in the Justice Center.
Q: There is a medical office in the Justice Center?
A: Yes, large medical clinic there and then there's also OB/GYN and dental services there. It's pretty, pretty nice. You should come visit.
MS. SFISCKO: Never did criminal law. I know where it's at.
Q: I hope not to, other than social visit.
A: To visit. I'm not saying —
MS. HARRIS: No, we don't even want to do that, doctor.
Q: How much time do you currently spend at the Justice Center then at that clinic?
A: Two days, two-and-a-half days and then the rest of the week is my practice.

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Q: And what is your practice?
A: I have a clinic that's called Regional Spine Clinic. I take care of people with musculoskeletal problems, back problems.
Q: Is that Cleveland — say that again, Cleveland Spine Clinic?
A: Regional Spine Clinic.
Q: Regional Spine Clinic. And is that at the Parma and Painesville and Cleveland Heights and Olmsted Falls addresses?
A: Yes.
Q: Okay. And tell me again what you do at the Regional Spine Clinic.
A: I see patients who have problems with their spines, their back, their neck.
Q: Do you actually treat those people or —
A: Oh, yeah.
Q: — are you doing evaluations for employers and other people?
A: Pretty much everything to do with the spine other than surgery. So we take care of people who have like Workers' Compensation injuries, people who have car accident injuries, people who have sports injuries, people who have osteoporosis,

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people who have arthritis, people who have any kind of bone disease. We basically, we do an x-ray, an MRI or CAT scan or whatever, whatever we need to do to make a diagnosis, and then we have a physical therapy.
When I say we, there are people in the same building that provide physical therapy, and then we treat them with medications, ultrasound, whatever they need to have.
Q: What I want to try to divide out, doctor, is in the Regional Spine Clinic, how much of your time is devoted to actually treating patients versus your independent medical exam work?
A: I — 90 plus percent is my Regional Spine Clinic taking care of patients every day. I mean the independent medical exams, probably two a month.
Q: And are, and typically how are you hired to do independent medical exams?
A: People who look into the directory for the board certified independent medical examiners, my name is there. People who want to have an opinion, attorneys like yourself who want to get an opinion about a patient's disability, so —
Q: Are you hired by any governmental agencies?
A: Workers' Compensation, which is a State agency,

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you know, so yes.
Q: How often do you do work for the Bureau?
A: All the time. I mean I take care of patient for the Bureau almost every week, but as far as doing, doing independent medical exams, is that what you're asking me?
Q: I think we are getting confused here.
My understanding of the Bureau is the Bureau doesn't send people to you for treatment, they will go to their doctors for treatment. The Bureau might want an independent exam?
A: Yes.
Q: And that's what I'm trying to figure out the difference between. You may have patients who also happen to have a Workers' Compensation claim and may be being paid by the Bureau because it's a work-related injury. But the Bureau isn't involved in their care.
What I want to find out is the time difference between actually doing an independent evaluation, whether it be for the Bureau or an insurance company or a lawyer versus actually treating patients who may happen to have a Workers' Compensation claim.
A: I don't understand anything you told me.

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Q: All right. Let me back up then. I think you said earlier you do about two independent exams per month?
A: Yeah, approximately, yes.
Q: Okay. And does that include independent exams for the Bureau?
A: Yes. I mean, I don't count them like this because the Workers' Compensation referral come for what we call C-92s, okay, these people come for permanent rating. So you examine the patients, you give them percentage of impairment and so on.
I do this for plaintiff, like yourself, or for the defense, like the Bureau, or somebody else because I give an honest opinion. The Bureau or the employer or the agency may ask you to do an independent medical exam on a Workers' Comp patient for an opinion. Now, I can — that patient is not my patient. That patient is for that purpose.
Q: Right.
A: I have also my patients. My patients the majority of the workload. Occasionally I get referrals for IMEs, which is independent medical exams.

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Q: And that's what I want to know. Give me your best evaluation as to the amount of time you spend doing independent medical exams versus treating patients in the clinical setting.
A: 90 percent plus treating patients and 10 percent or less doing independent medical exams.
Q: And at the Justice Center, how much time do you spend in the administrative side versus actually treating patients?
A: I'd say about 50/50.
Q: Okay. And lastly, doctor, you've got house officer, Barberton Citizens Hospital?
A: Yes.
Q: What's a house officer?
A: We cover intensive care unit, hospitalis, this is a new name.
MS. HARRIS: You work with ICU?
A: Yes, yes, I cover the intensive care units, take care of critically ill patients couple times a month to help pay for my bills.
Q: So you're an employee of the Barberton Citizens Hospital?
A: Yes, yes.
Q: And how much time do you actually spend down in Barberton?

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A: Few times a month, you know, depending. Sometime I work 24-hours shifts in the weekends, sometimes I work more or less depending if I want to or not.
Q: And your privileges, doctor, you've indicated here that you've got Barberton Citizens Hospital and St. Vincent Charity?
A: That's correct.
Q: Have you ever had any privileges denied anywhere?
A: Never.
Q: Any privileges revoked anywhere?
A: Never.
Q: Okay. If you've got offices — I'm just kind of curious, if you've got offices in Parma, why don't you have privileges at Parma Community Hospital?
A: Because my Regional Spine Clinic, almost all my patients are outpatients, meaning that they are people who need outpatient care. I don't take care of general medical problems that they need admission and so on.
Q: When's the last time you actually admitted a patient to St. Vincent's Charity?
A: We admit — actually, when? Three days ago. We admit all our patients from downtown from the

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Justice Center to St. Vincent Charity Hospital for various care, surgical and so on.
Q: And I appreciate that answer and I guess I would then draw the distinction between the Regional Spine Center —
A: Yes.
Q: — patients versus the Justice Center patients.
A: I just answered the question you asked me, that's all.
Q: You're right. I'm not upset with your answer, I just need to know in terms of the Regional Spine Center, how many — when's the last time you admitted a patient to St. Vincent's?
A: About a month ago we had a patient that needed, needed to have surgery and he was admitted to the surgeon's service.
Q: Your board certifications, doctor, why don't you just run through those. How do you become board certified in independent medical examiners?
A: The American Academy of Occupational Medicine is a sponsor of the Board of Independent Medical Examiners. You have to go through clinical training courses with the academy over a two-year period. You have to become a fellow before that, fellow of the American Academy of Disability.

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Q: How many courses did you have to take?
A: Ton of courses. I mean we have, I must have taken in the two-year period, probably at least four or five courses.
Q: How many total hours would that be?
A: Well, every course about five days to a week, and then you have to have a certain degree of previous experience, certain number of publications, certain number of work-related activities in the area of disability, then you sit for an exam by the board and then you take the exam and hopefully you pass it.
Q: You never failed that exam?
A: No.
Q: Is it a written and verbal?
A: It's written exam.
Q: No verbal component?
A: No.
Q: How about the American College of Forensic Examiners, why don't you explain that?
A: The American College of Forensic Examiners are the group that sponsor physicians who have interest in medicolegal, such as trauma-related accidents, forensic issues, like what we do in the correction system. It also called forensic

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medicine. And the college, basically if you work in the correction system for so long, you have previous experience in primary care, in addition to working in medicolegal environment and giving legal opinions, then you can sit for that. There is no exam for the forensic examiners board.
Q: Is there an exam for the forensic medicine?
A: No, this is based on qualifications, publications and level of experience.
Q: Is there an exam for the Board of Pain Management?
A: Yes, there is.
Q: Okay. Why don't you explain that to me, please.
A: The American Academy of Pain Management is in California, Los Angeles, California and they do the exam twice a year. The exam cover vast array of fields in the pain arena including musculoskeletal problems, cardiovascular problems and so on, and you study the course materials for the exam over a six-month period, then you sit for the examination and hopefully you pass.
Q: Okay. Did you ever fail that?
A: No.
Q: Okay. And how about the American Academy of Experts in Traumatic Stress?

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A: That is based on — this, there's no exam for that board. This board is based on your experience in working in trauma area such as accidents, again, medicolegal aspects and forensics as well.
Q: How many employees does the Regional Spine Center have?
A: Three.
Q: And who are they?
A: Me and two more.
Q: Who are they?
A: Sharon Hough, H-o-u-g-h, she's a full-time assistant to me.
Q: Is she a physician?
A: No, no, this is, she's a nurse's assistant.
Q: Okay.
A: And I have Jan, who is a bookkeeper, and she help in the office sometime when I need her to.
Q: So do you share space with people at these four locations?
A: Parma is my main office, so I don't share space in Parma. The other addresses are other physicians who using this addresses, yes.
Q: Okay. Where do you live, doctor?
A: Cleveland Heights. For three more days. I'm

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moving to Geauga County.

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

Q: Doctor, you don't have any particular expertise in infectious disease, do you?
A: Well, when you do primary care over 20 some years that I've had taking care of primary care, you deal with it almost every day. In the county, for instance, we see infections almost every day.
Q: You're not board certified in infectious disease, correct?
A: No.
Q: Do you have any particular expertise in urology?
A: No.
Q: When's the last time you actually inserted a Foley catheter into a male patient?
A: Yesterday.
Q: How often do you do that in your practice?
A: In the hospital every week, because I work in intensive care unit, so I do it almost every week when I work in the hospital.
Q: At Barberton?
A: At Barberton, and then downtown, sometime when we

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have an older patient that have problem with prostate, or they can't urinate, they ask the doctors sometime to put it in if they have a difficult time inserting it.
Q: Midwest Medical Staffing, what is that?
A: That's the company that staff the Cuyahoga County Correction Center that I work for.
Q: Are you a shareholder in that company?
A: No.
Q: You're just an employee of the company?
A: Yes. I'm not an employee, I'm an independent medical contractor, basically.
Q: Do you get a 1099 from them at the end of the year?
A: Yes.
Q: Do you know whether Midwest Medical Staffing helps staff Elyria Memorial Hospital?
A: No, they don't do any hospitals. They do basically correctional systems.
Q: Do you know anybody at Elyria Memorial Hospital involved in this case —
A: No.
Q: — from the records you reviewed, any of the names?
A: No, sir.

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Q: Okay. How about Alana Verlei, do you know her?
A: Never met her.
Q: Never spoken to her?
A: Never spoken to her.
Q: Dr. Marion Carroll?
A: No.
Q: What do you charge, doctor, for your review in this case?
A: Depending on the amount of time that I spend with the file, I charge $150 per hour for my review. So depending how many hours, occasionally I have to research a particular problem, like if I'm asked an opinion about a particular problem that needed further research to give an accurate opinion, whatever time I invest in that.
Q: That's also at $150 an hour?
A: Yes, sir.
Q: Okay. Do you know how much time you devoted to this case so far?
A: No, but I can send you a copy of the bill if you'd like.
Q: That would be fine. I appreciate that. Now, you said also you might do research, correct?
A: Yes, I would. For instance, if there's a very

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unique topic or unique diagnosis that I'd like to look at the latest literature and articles in that particular field to —
Q: Sure.
A: — be up to date.
Q: Right, and I think you referenced in your primary report of September 4th in this case, you have two references, Managing the Foley Catheter by Cancio Sabanegh —
A: Cancio, Sabanegh, Thompson. This is the Journal of the American Family Physician. This is a journal that comes once a month from the American Academy of Family Physicians. It's sort of the bible for the family practitioners. And the other one was the Clinical Nursing Skills and Techniques by Perry & Potter.
Q: Is that an article also or is that a textbook?
A: This is a review article. Actually, the second one was a book. The first one was an article, like a review article.
Q: You consulted those in writing this report?
A: I, I basically reviewed them because they were very focused on the relationship between catheterization and complication.
Q: Okay. And those are reliable in that regard?

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A: The people who did them very reliable people. There was other reports, I just quoted a couple of them basically.
Q: I appreciate that, and I can only go with what we are given.
A: Sure.
Q: And these references are reliable in terms of how to properly catheterize someone and the complications that may arise, is that fair?
A: Yes.
Q: Did you review any other articles or research?
A: Yes, I did.
Q: And do you know what those are?
A: I did not list them here because it didn't provide me with any different information.
Q: Okay. Have you ever worked with Ms. Sfiscko before?
A: Yes, sir.
Q: On how many occasions?
A: Maybe two or three occasions.
Q: How about anybody in her office?
A: No.
Q: Okay. And do you recall the other occasions with which you've worked with Ms. Sfiscko?
A: The particular cases you mean?

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Q: Yeah. What were the issues in those cases, if you recall?
A: One of them was a personal injury case she send me over a year ago and —
Q: Was that to do an independent medical evaluation?
A: That was to treat, that was the patient that needed treatment basically. That was in my office in Olmsted Falls.
THE WITNESS: You remember her?
MS. SFISCKO: Yes.
THE WITNESS: Good memory.
MS. SFISCKO: I know exactly who it is. Maria.
THE WITNESS: Right, Maria.
MS. SFISCKO: She was a plaintiff. She was in a car accident, hurt her back.
A: Then maybe one or two occasions, and I think they were independent medical exams.
THE WITNESS: I think when you worked for Mr. Kenneally. It was Mr. Kenneally probably.
MS. SFISCKO: Yes.
A: That's about it.
Q: How about anybody at Ms. Harris' office, have you ever worked with her or anybody at her office at

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Weston Hurd?
A: No, I don't know who the names are. If you tell me a list of people —
MS. HARRIS: There's 60, doctor, we are not going there.
THE WITNESS: Okay.
MS. HARRIS: Okay.
A: You would —
MS. SFISCKO: Gallagher — not Gallagher. Weston Hurd?
A: No.
Q: How about Reminger & Reminger, have you ever worked with them?
A: I did actually C-92s, permanent impairment evaluation for the plaintiff for Reminger & Reminger a few months ago.
Q: All right. And I want to get into, you know, some of your opinions in this case, doctor, if we can, but maybe before, maybe we could just talk a little bit about the catheter, how it works, and then we will get into specific opinions in this case.
You'll agree the bladder is a hollow organ?
A: Yes.
Q: And if the catheter is placed properly and then

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the balloon is inflated, if it's in the bladder, there will not be any resistance to the inflation of the balloon, correct?
A: Assuming the bladder is normal and the urethra is normal, yes.
Q: And the opposite of that is if it's not placed properly, you're likely to get resistance if it's not fully in the bladder, correct?
A: No, you can get resistance from a lot of other diseases, so I mean depending — so if the bladder is normal and the urethra is normal, you're correct.
Q: And if the bladder and urethra are normal and you try to inflate in the urethra somewhere, you're going to get resistance, correct?
A: Yeah, you shouldn't, you should not inflate it in the urethra in the first place.
Q: Are you aware of any abnormalities in Mr. Restivo's bladder or urethra in this case?
A: Yes.
Q: And what are those?
A: He has bilateral prostatic hypertrophy, which is hyperenlargement of the prostate. Basically that encases the urethra, the prostate's around the urethra, and that caused an abnormal urethra

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because it compresses on it and becomes narrow.
Q: Is the abnormality in the urethra then the narrowing of the urethral tract?
A: Yes, because it becomes abnormal. Normal urethra have a certain diameter, and when it's squeezed, it is not normal anymore.
Q: What is the diameter of a normal urethra?
A: Six to eight millimeters, few millimeters.
Q: And what was Mr. Restivo's?
A: Dimensions?
Q: Dimensions, do you know?
A: I don't know dimensions, no.
Q: Can you quantify at all the constriction in his urethra?
A: Well, when you look at the size of the prostate, according to the autopsy report, I think it was like 68 grams, something like that. That's more than the normal. It should be 10, 15 grams. So that's a large prostate.
Q: His prostate was five to six times larger?
A: I think it was, yeah, around that number. It was larger, and actually it was diagnosed having prostate hypertrophy and it was comment next to it, benign basically.
Q: Just because you have an enlarged prostrate —

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prostate — geez.
Just because you have an enlarged prostate, does that mean that you're going to have a compressed urethra?
A: It depends on the degree of the enlargement. If the enlargement is large, I mean if you have a big enlargement, the narrowing will be significant. Also depends on the elasticity of the bladder and the urethra. In this case, he has what we call neurogenic bladder. So the bladder's not emptying properly, and because not emptying properly, the muscle tone around the bladder neck, around the urethra is impaired, and that makes it even more vulnerable to be compressed because it's not as viable.
Q: Do you know the degree of impairment around the bladder?
A: No, I didn't examine him, so I couldn't tell you that.
Q: Do you know how long he'd had an enlarged prostate?
A: Has to be many, many years because there are references in the medical records of him having history of prostate problems for a number of years.

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Q: Do you know how many times Nurse Verlei saw Mr. Restivo prior to January 19th, 2000?
A: I do not know how many times, no.
Q: Do you know, can you give me a ballpark?
A: I can't give you a ballpark, I don't know how many times she saw him.
Q: Do you know how many times there was difficulty in catheterizing Mr. Restivo prior to January 19th, 2000?
A: I do not know.
Q: You would agree that the skill of the person attempting to insert the urethra —
MS. HARRIS: Catheter?
Q: Pardon me. Thank you. Let's strike that, start all over.
A: That would be a new procedure.
Q: You would agree that the skill of the person attempting to catheterize is an important factor in the success of the attempt at catheterization, correct?
A: Yes, of course.
Q: How do you know, when you're catheterizing someone, that the, his catheter is actually in the bladder?
A: Well, the easiest thing is urine start to come in

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the bag, right. Number two, there's a length of the Foley, there's different sizes, there's size 12, 14, 16, 16's a larger size. So if you have somebody that you insert the catheter in, the urethra is only the length, little bit more than the length of the male penis, so as you pass this length, within about an inch or two, it should be in. So looking at the distance of the entire Foley, the actual tubing, you can tell how close you are, but obviously the visible sign of having urine in the bag is the most confirmatory sign.
Q: Can you get urine to come down the catheter if it is not fully placed within the bladder?
A: Of course not. You know, the bladder have a neck, and the neck of the bladder in a normal individual would be constricted. Okay? In Mr. Restivo's case, because of his eurogenic — neurogenic bladder, this neck is no longer efficient. There's no places in the urinary tract that have urine except the bladder.
In his case, or in an older patient or somebody who have a neurogenic bladder or a stroke, this elasticity of the urethra that closes the neck is no longer there. This is why they have diapers in older person in a nursing

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home, they keep losing the urine, so they put a diaper on because the neck is no longer strong enough to hold the urine in.

Q: Precisely. So if the neck isn't closed, there can be a flow of urine into the urethra, correct?

A: When it's time to urinate, when the bladder becomes full, it there's a pressure that exerts on the wall of the bladder, it stimulate a system called the parasympathetic system, and then another impulse come from the central nervous system to empty the bladder.

Now, in a normal person who is, have normal neurologic function and so on, that is voluntary. In an elderly person, obviously a stroke, history of diseased bladder like Mr. Restivo does, then this control is no longer there, so they have to put a Foley in to keep draining the urine.

Q: Okay. And maybe I'm not understanding this whole thing, but doesn't that by itself indicate that there can be drainage through the neck of the bladder without the catheter being in place?

A: Not enough to make urine pass to the bag. See, you may get like a cc or two, but if you have a urine flow that goes through the entire tubing of the Foley catheterization, you have to be in the

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bladder. Because there's not, the urethra is so small, it cannot hold that much urine. Otherwise be like a big balloon. So you may have a drip or two, but not large amount of urine.

Q: Tell me the anatomy of the neck of the bladder going into the urethra.

A: Well, it's made of smooth muscles and it has a sphincter and it's a circular, you know, fibromuscular layer surrounding the top of the urethra, and then based on neurological control, the sphincter closes as long as there is no urine needed to be disposed of.

Now, as the pressure in the bladder increase from the urine that's coming from the kidneys, there's a threshold after which the bladder will be distended, stretched so to speak. Then it send the signal to your head, say it's time to go to the bathroom. Then you go to the bathroom, then it's another signal, it relaxes this neck, it opens it and then you urinate.

Q: The end of the Foley catheter that gets into the bladder, what do you call the hole at the end of the catheter, what is there?

A: The tip.

Q: Tip?

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A: Tip of the catheter.

Q: And then behind the tip, kind of downstream there is the part where the balloon expands, correct?

A: Correct.

Q: Would it be possible to get urine out of the catheter if just the tip gets through the sphincter but the balloon does not?

A: No. Not a large amount, let's put it that way.

Q: How much could you get out if the tip is through, where the hole in the catheter is but not the balloon portion?

A: But the balloon is not supposed to be inside the bladder. Obviously the balloon has to be inflated before you get inside the bladder because you cannot inflate the balloon in the bladder.

Q: Why not?

A: Because you want to inflate it against a wall so it inflates, you know, it sits in an area where it can — the whole idea of the balloon is to prevent the thing from sliding out again, see? And when you, when you inflate the balloon, it's about this, this wide, right, the bladder's bigger than that, so, so the balloon should be inflated lower so it can hold the catheter by

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tugging it along the walls.

Q: All right. Why don't you do your best effort and —

A: Diagram?

Q: — diagram it for me, please.

A: Sure. This is the bladder.

Q: Why don't you just write bladder in where you've got bladder?

A: Bladder. Prostate is here. And when it's enlarged, this is narrow.

Q: Draw an arrow to the prostate if you could, please.

A: Prostate. And then when you put the catheter in, it goes like that, okay? You want to inflate the balloon somewhere there. You don't want to inflate it here.

Q: Okay. And if you can just draw an arrow to the balloon, please.

A: To the balloon?

Q: Sure.

A: Now, when you advance the catheter, okay, and then you're in the right place and then insertion is noncomplicated, then you're going to see in the bag an amount of urine.

Q: Realizing that this is just a diagram and no

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one's holding you to any, any specific —
MS. SFISCKO: He's not an art
major.
Q: Right. Other than just general orientation, and I recognize it's general orientation, if we could mark that as Exhibit 3, I'd appreciate it.

(Thereupon, Plaintiff's Exhibit 3 was marked for purposes of identification.)

Q: Is the balloon — we marked your diagram as Exhibit 3. Is the balloon inflated then inside the top of the urethra?
A: Not the top. Top of the urethra's here. This is the neck of the urethra here, the neck of the bladder here. So you want to inflate the balloon before it gets to the bladder. Oh, you can inflate it anywhere around this area would be appropriate.
Q: Maybe I've just got my anatomy wrong, and I apologize. You've got this going through the penis of a man?
A: Yes.
Q: You've got the urethra?
A: Right.

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Q: Then you get to the prostate gland, correct?
A: No. The prostate gland's outside this whole area.
Q: Correct. I understand that, but the urethra goes through the prostate, correct?
A: The prostate surrounds, it doesn't go through the prostate.
Q: Prostate surrounds the urethra, correct?
A: Yes, the prostate gland have two glands, you know, so when you say through it, like a puncture through it, it does not.
Q: I apologize for that and I appreciate the clarification. The prostate glands are around —
A: That's right.
Q: — the urethra?
A: That's right.
Q: And then the urethra works its way into the bladder, correct?
A: To the neck.
Q: To the neck of the bladder?
A: Yes.
Q: Where does the urethra end and the neck of the bladder begin relative to the prostate?
A: It's about between 10 to 20 millimeter depending on —

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Q: Okay.
A: — the individual. Women, I mean, I'm sorry, there's no women here, if somebody have very large prostate, that can expand up and down. So it depends. So if it enlarges, it can encompass a large area upwards and sideways.
Q: Does the urethra extend beyond, extend beyond the prostate or is that where the neck of the bladder extends into the top?
A: The urethra, the urethra extend beyond the prostate, of course.
Q: So the balloon then is actually inflated in the neck of the bladder and not in the urethra; is that what you're telling me?
A: No. The balloon is inflated in the urethra.
Q: Okay. I thought I'd asked that earlier and that's what led to the whole anatomy discussions here.
A: No. I said as long as you do it anywhere before the neck area. See, you want to do it in a way to have the Foley tucked in so it keeps in place. That's the whole purpose of the balloon; no other purpose to it.
Q: Just so we can clarify this and then move on —
A: Yeah.

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Q: — the balloon of the Foley catheter is inflated in the urethra?
A: Yes, it's inflated somewhere in the upper part of the urethra.
Q: And that holds it in place?
A: Yes.
Q: Okay.
A: Yeah, as long as it's not inside the bladder where it would be useless.
Q: Okay.
A: Now, I want to augment on this. Once it goes through the urethra, okay, if you inflate it inside the bladder, will still do the job, okay? Because imagine now that the balloon — can I do some more artistic work up here?
Q: You know what, let me do — let's just do another page so we don't mess that up.
A: You know, the bladder is here, you know, imagine here's a part of the catheter, tip of the catheter, okay, and there's the balloon, right? And the rest of the Foley here, right? As long as the balloon can prevent the catheter from slipping away, it should be okay. So if you inflate it here, that's appropriate.
Q: So you can inflate it inside the bladder then?

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A: You shouldn't, but if it's inflated, if — you can lose the catheter, see, it wouldn't be tucked in. The catheter can float in and just go inside.

MR. MULVIHILL: We will mark this as Exhibit 4.

(Thereupon, Plaintiff's Exhibit 4 was marked for purposes of identification.)

Q: Doctor, you also made a drawing which we have now marked as Exhibit 4 which I think shows the balloon being inflated really inside the bladder, correct?

A: Yes, I'm showing you that if it's inflated inside the bladder it can still function. The Foley can still function, but it's not going to be, it's going to drain but it's not going to be very efficient if it keeps moving, and the idea of putting the balloon is to have it snug basically.

Q: Okay.

A: You know, or tucked in. So this area will be appropriate around the neck, upper urethra, you know, into the bladder.

Q: Do you have any idea how much, if any, urine

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drained when Nurse Verlei inserted the Foley catheter in Mr. Restivo on the 19th of January?

MS. HARRIS: After she inserted it, is that what you're referring to?

Q: Yes.

And what you're looking at is your report of —

A: Page 2, sir.

Q: — September 4th?

A: September 4th. Yeah, there was no number of cc's as far as the volume of the urine. I did not see the actual amount.

Q: Does the standard of care require a nurse to measure that?

A: No, not routinely when you put a Foley cath. It depend on what purpose. If you are putting it in just to keep a Foley in the patient, it's not to document it, yeah.

Q: Why is that?

A: Because it's nice to document it to say how many cc's, you know, so it can help someone else if the number of cc's is less or more.

Q: So it's nice to document it but the standard of care does not require it, is that what you're telling me?

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A: Well, the standard of care varies from a place to another in the sense that if you work in intensive care unit, somebody have congestive heart failure, that's critical, but if you work in a nursing home setting and the purpose of the, inserting the Foley is to keep the urine draining, then it's not that critical.

Q: How about when he was transferred to Elyria Memorial Hospital, would it be critical at that point to measure that?

A: Afterwards —

MS. McGURK: Objection.

MS. HARRIS: I have an objection, too, as to where are you referring to, because he was in the ER, he was in the, on a regular floor and then in the ICU. It's kind of too general a question.

Q: We will get there. When he was taken to Elyria Memorial, would it be the standard of care, does the standard of care require measuring the urine output in the emergency room?

MS. McGURK: Objection by Tracy McGurk.

A: It depends what the patient is in the emergency room for.

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Q: Well, what was he in the emergency room for?

A: He was there for, look like seizures. That's much more serious to manage than measuring how many cc's of urine is in the bag. When somebody work in the emergency room, you have to prioritize your efforts.

Q: Okay. Well, in this case, did the standard of care require measuring the urine output in the emergency room for Mr. Restivo?

A: Not initially, because he had a more serious problem.

Q: Okay. When he was transferred to the regular floor, did the standard of care require measuring the urine output?

A: Yes.

Q: How about when he was in the intensive care unit, did the standard of care require measuring the output?

A: Yes.

Q: Now, with respect to the nurse at the home, Nurse Verlei, you're saying that all she needed to do was visualize some urine flow through the catheter?

A: What I'm saying is that once you insert the catheter and you ensure that the catheter is

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draining properly, that is the purpose of the Foley catheterization for Mr. Restivo.
Q: Well, how do you know what's proper?
A: By seeing the urine in the bag.
Q: How much?
A: That mean — I just mentioned to you. It varies. He may not have much in his bladder, see? I mean at the time of, of insertion, she does not know if he had 50 cc's or a hundred cc's or 500 cc's. So if you have a patient who is like Mr. Restivo who's debilitated who needed to have a Foley catheterization in and she came to insert it, she doesn't know how much in the bladder, so she may have 15 cc's or a thousand cc's.
Q: You would agree Nurse Verlei had a difficult time inserting the catheter into Mr. Restivo?
A: Yes, sir.
Q: Okay. Given — and what were her difficulties? And again, you're referring to your report?
A: Yes. She had difficulty using the, during the insertion, as she was inserting it and as she was advancing the Foley catheterization in.
Q: And can you quantify that at all, that she had difficulty advancing it?
A: Yes, yes. There was some bright red blood that

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came from the urethra opening, which is the opening of the tip of the penis, and that was, that she reported and it was noted. And at that time when she noted some blood in the area, she deflated the balloon, which is appropriate. The whole setting was sterile still because she's gloved and she have everything sterile.
Then she deflated the balloon, she advance it some more and then inflated it, then the urine start to flow, then she knew she was in the right place.
Q: What do you make of the fact that Mrs. Restivo indicated there was a large quantity of blood on the bed after the nurse left?
A: That's her say. I wasn't there.
Q: Okay. Are you discounting that in your opinion in this case or are you accepting that as true?
A: It wouldn't make a difference, because during a difficult insertion, the amount of blood that can come either from the tip of the urethra or from the difficult insertion can vary from a person to another.
What matters to me is that the blood did not continue extensively and that the urine was flowing easily. That's what matters to me.

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Q: What's the basis of your opinion that the urine was flowing easily?
A: The fact that the Foley catheter was draining urine, according to Miss Verlei's record, and then later on she called the patient's wife to check on the patient. She put in the record that she asked the patient if the Foley was still draining, and Ms. Restivo assured the nurse it was draining.
Q: Draining what?
A: Fine, beautifully.
Q: Have you read —
A: That was the words.
Q: Have you read Ms. Restivo's deposition?
A: If I noted it in my records, I must have. Obviously she said something different.
Q: Have you read Ms. Restivo's deposition?
A: Yes, I did.
Q: And what did she say with respect to that telephone call with the nurse?
A: I have to look at it if I can.
Q: Do you recall as you sit here?
A: You know, I don't. I think, I think probably something different. I don't know. You tell me if you have it.

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Q: Well, I get to ask the questions, doctor.
A: Sure. I apologize, sir.
Q: So have you ever inserted a Foley catheter where you get such a large amount of blood that it leaves stains on the sheets?
A: Oh, sure. I mean we have people who have bladder problems in the hospital, you have like huge prostate, somebody have bladder cancer, prostate cancer, somebody have an inflammation where you have a lot of swelling in the urethra that the, that the wall of the urethra is so frail and so fragile that as you advance the catheter in, it becomes so sensitive and start to bleed, it does happen at times, yes.
Q: Were you aware of the fact that later on, and it may even have gotten past midnight into the 20th when Mr. Restivo was taken to the hospital that Mrs. Restivo was concerned about the fact that the night bag didn't have much urine in it at all?
A: Yeah, there was a mention of that.
Q: Okay. What do you make of that observation by Mrs. Restivo?
A: A lot of thing can lead to that. Number one, how much intake does the patient have, so if the

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patient have enough fluids in, then you will have enough fluids out. So there's really, there's no exact calculation of how much fluids he got in to really indicate. So that can be, that can be one factor, depending how much fluids you got in.

And also another issue, if you have, if you have problems with your kidneys, like if you have kidney disease, people with kidney failure or kidney insufficiency like Mr. Restivo will not really drain as efficiently as everybody else. So there's so many factors.

Q: Sure, there are, and you would agree that Mrs. Restivo's observations were based on what Mr. Restivo generally voided, correct?

A: I don't know that. That was what she probably noticed, so she commented on what she noticed, yes.

Q: Well, the fact that he may have had kidney disease, he was not — are you aware — pardon me. Let me start that again.

Are you aware of any evidence that in prior catheterizations he had difficulty voiding?

MS. HARRIS: Objection.

MS. SFISCKO: That's right.

MS. HARRIS: I think that's —

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A: You know, there's really —

MS. SFISCKO: You don't void in catheterization.

MR. MULVIHILL: I beg your pardon?

MS. SFISCKO: You don't void in catheterization.

Q: Let me say it again. Getting rid of urine in catheterizations?

MS. SFISCKO: Draining?

Q: Draining?

A: There was no, he had catheters so many times and there was no record of every, every individual catheter how difficult or easy it is. You just put it in. It's done with.

Q: I'm not worried about the difficulty right now. I'm worried about the amount that came through the catheter.

A: There's no records from the previous Foley catheterization attempts to indicate how much urine was flowing in previous attempts.

Q: Then wouldn't it make sense to listen to the observations that Mrs. Restivo, who would see those bags on a daily basis, as to whether or not he was draining as much after this catheterization attempt by Nurse Verlei as

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opposed to prior ones?

A: Yes, of course, every observation has its value.

Q: And you had indicated that there were a couple of possibilities with his less drainage on the 19th and the 20th, including kidney problems, and that he may just not have been consuming much, correct?

A: Kidney problems, prostate problems, kidney disease, as I said earlier, infection of the bladder, then not enough fluids in his system.

Q: And one of those also is improper placement of the catheter, correct?

A: If it was improper, it wouldn't be draining in the first place. So the fact that the catheter was draining, according to the records that we have from Miss Verlei and the follow-up phone call, according to the records also that the catheter was draining, so if the catheter was draining, then it's in the right place.

Q: That's what I was just going to ask you. If it's draining anything more than I think you said a cc or two, then it's in the right place, is that correct?

A: Well, usually. I mean, you know, you don't get large amount of urine if the catheter was in the

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wrong place. It's not possible.

Q: How much can you get quantitatively if the catheter's in the wrong place?

A: Not much at all, like a cc or two.

Q: Right. So getting back to my original question —

A: Yeah.

Q: — if Mr. Restivo drained more than a cc or two of urine, it's your opinion then that, by necessity, the Foley catheter had to be properly inserted?

A: Remember, there's a distance from the tip of the catheter on the Foley to the bag. In order for the urine to make it all the way to the bag, you have to have enough urine. So if you have few cc's in the bag, you have some cc's also in the tube. So in order to have that much urine, it has to be in the bladder in the right place, that's correct.

Q: All right. Let me ask it again and then maybe you can answer yes or no.

With the Foley catheter being inserted, the way you know it's done properly is the fact that it has drained more than a cc or two, because if it did, then it has to be, by definition,

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inserted properly, correct?
A: When there's urine noted in the bag, urine flowing in the bag, the catheter is in the right place.
Q: Okay. There's no way that it can be partially inserted properly and get some flow rather than complete flow, is that what you're telling me?
A: It's unlikely. If you have enough urine in the bag, it's unlikely.
Q: Well, how much is enough urine in the bag to know whether it's inserted properly?
A: You have more than the few cc's I mentioned to you.
Q: All right. What I want to try to do here is make a distinction between — let me strike that.
On Exhibit 3 and 4, which are your, just general diagrams, particularly Exhibit 4, you had given that as an example of it can be inserted that way and you will get some drainage, but the concern is, is that the catheter may move up and down within the bladder, correct?
A: Yeah. The best place for the balloon to be in and to be tucked in in the neck here, see.
Q: Right.
A: That's the best place. If the balloon's inflated

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in the urethra, you still get some drainage, but the best place is to be tucked in right here, because there's a weight to the bag. So the weight to the bag pull this thing down. Here's the neck, the thing is tucked in here, there's the weight, the tube go down, everything's working beautifully.
Now this can move also, I mean, you know, if you, when you put the Foley in, Foleys can move. The patient turn around the wrong way, if he shake or have any type of sudden movement, it can move inside the urinary tract and then you have problems.
Q: How much can it move before you get a problem?
A: Depends where it moved. If it moves downward, major problems because it can bleed. If it moves sideways, you may not get any problems, so —
Q: All right. Can the Foley catheter be inserted and the balloon inflated in such a way that you're going to get partial drainage and not full drainage?
A: Not usually. The nurse, as she put, especially an experienced nurse, as she put the Foley in, even though you may experience some resistance initially, you've done this hundred of times, you

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see the urine's just coming out, you're in the bladder, case closed.
Q: Do you know how many Nurse Verlei had done, an insertion of a Foley catheter in a male patient before?
A: Well, she's been a nurse for many years, from what I understand. So any nurse who have number of years of experience, she must have put hundreds or even thousands of Foleys. This is part of the nursing duties in hospital, and usually it's a very important portion of their training because it's such a common procedure.
Q: Doctor, can you define urosepsis for me, please?
A: Urosepsis is infection of the blood via the urine.
Q: Okay. And can you define — I'm probably going to mispronounce this, but pyelonephritis?
A: Pyelonephritis is inflammation of the kidneys.
Q: Due to what?
A: Due to bacteria, virus, HIV, other things.
Q: Is it an infection or an inflammation?
A: Pyelonephritis is inflammation that usually accompany infection.
Q: You had mentioned earlier, doctor, that Nurse Verlei said that the catheter was draining

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beautifully. Do you know when she made that entry?
A: I think it was made later on that she, as she was documenting her encounter.
Q: Do you know how far later on, how far in the future?
A: No, no.
Q: Would it make a difference to you in relying on that account that it was draining beautifully to know exactly when that entry was made?
A: Usually if somebody make a positive comment, it's not forgotten. So if somebody said to a nurse this was working beautifully, she'd remember it today or a few days later. So it doesn't really make a difference to me. And the best thing is to write it and then if you — oftentimes you're busy and you will do it later.
Q: Do you know how long she stayed with the Restivos on the 19th?
A: No. I know she stayed long enough to make sure that the Foley was working. As far as number of minutes, I don't know.
Q: Okay. So in your report when you say on page, Page 5, the end of the first — actually, the end of the, the continued paragraph where it says,

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"For urine to be flowing into the bag properly, the catheter has to be in the bladder."
A: Yes.
Q: That's if you're getting anything more than just a couple of cc's of urine in the bag?
A: Few cc's, that's right.
Q: But again, there is, there's just no way to quantify that, correct?
A: It depends on how much the patients have urine in his system. So if he had drank a lot of fluids, he have a lot of urine. If he drank few, he had few.
Q: Is it your opinion in this case that somehow Mr. Restivo, in his seizures or convulsions or whatever you want to call them, somehow dislodged the Foley catheter?
A: It's a possibility, because seizure patients, usually they lose control and they have involuntary, jerky, violent like movements, their extremities and their body, and during the seizure episodes you can, you can lose a cath, you know, you can break a tube, you can get an IV out, you can get a Foley out.
Q: I'm not talking about what's possible. I'm talking about is it your opinion. Is it your

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opinion in this case that Mr. Restivo somehow, somehow dislodged or changed the location of the catheter due to a seizure in this case?
A: My opinion was the catheter eventually was not in the right position later on; could be from seizure, could be from movement, it could be from other factors.
Q: Do you know?
A: Is it seizure for sure? I don't know if it's for sure or not.
Q: Do you know when that took place?
A: I do not know.
Q: Do you know why it took place in that the position of the catheter had changed?
A: The ideas, as I told you, it can change for variety of reasons. I don't know which one can do it, but I know it was working properly, and when he went to the emergency room it wasn't. So between that time and that time, something happened that moved the catheter.
Q: Okay. When the catheter moves and the balloon is inflated, would you expect bleeding?
A: Sometimes yes, sometimes no, depending how violent the movement is. If you rip it off, you know, some patients do, patient in the psych unit

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in the mental hospital, you have a Foley in, and they just don't know what they doing, they just pull this whole thing out. Of course you're going to have bleeding. But if, normally if it moves a little bit, it may not. So it depends on every patient.

(Thereupon, a recess was had.)

Q: Doctor, have you ever treated anyone with urosepsis or pyelonephritis?
A: Yes, sir.
Q: How frequently?
A: You know, urosepsis, probably few times a month in the hospital; and pyelonephritis would be pretty much similar number can be related.
Q: When you're saying the hospital, are you talking about Barberton or St. Vincent?
A: Both. Mostly Barberton. There I see patients, lots of these people have complications and infections and so on.
Q: How large is Barberton?
A: Close to 200 beds, so medium size.
Q: And it has intensive care unit?
A: Oh, sure. Coronary care and intensive care.

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It's a teaching hospital, so —
Q: D.O.'s or M.D.'s?
A: M.D.'s.

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

Q: Is there any way to say what normal urine output for a 78-year-old male would be, or is it entirely dependent upon what he's drinking and how his kidneys are functioning?
A: Yeah, yeah, so many factors. Does he have renal disease, does he have bladder obstruction problems like Miss Verlei had few times before —
MS. HARRIS: Excuse me?
A: Mr. Restivo, pardon me. Mr. Restivo. How much, how much, how large the prostate is, does he have infection, how much fluids has he taken, is the heart okay, because the heart can affect that, too. Is the liver okay.
Q: Did Mr. Restivo have any heart problems?
A: Very severe, very severe coronary disease, yeah.
Q: So I think what we have pretty much discussed here at length is the fact that we know that it's your opinion, pardon me, that Nurse Verlei

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properly inserted the catheter when she was there the 19th as evidenced by the fact there was drainage into the bag, is that —

A: Yes, and also the follow-up call that she made to ensure that there was enough drainage in the bag, that's correct.

Q: Do you know whether or not Mrs. Restivo asked for another nurse to come out and check it that day?

A: I think she made a phone call, I think, later on.

Q: Do you know whether a nurse ever came out to check it?

A: I don't think somebody came that night.

Q: Okay. And is there any way to know exactly when the catheter became malpositioned before he got to the emergency room?

A: No.

MS. HARRIS: Objection.

MS. SFISCKO: What, he said it was malpositioned in the emergency room?

MR. MULVIHILL: I said before he got to the emergency room, and he says it in his report.

MS. HARRIS: Wait a minute. What does he say? Can we have the question back?

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MR. MULVIHILL: All right.

MS. HARRIS: Are you saying it was malpositioned at the time he went into the emergency room? That's the question? I'm not sure.

MR. MULVIHILL: That's what he said earlier, so I'm just, it's a follow-up. All right. Let's back up. Let me just start it all over again.

Q: Doctor, I think you said earlier that by the time he got into the emergency room, the catheter was malpositioned, correct?

A: It was not draining properly is what I'm saying.

MS. HARRIS: In the emergency room?

A: Yeah. It was not draining properly.

Q: Right. Therefore, it was malpositioned, correct?

A: That's a possibility.

Q: Okay.

A: It may not be draining because there's no urine to drain. So, so that's a possibility, you know, that it wasn't draining because it moved or it was not enough urine to drain.

Q: All right. Well, then, let me make sure I understand what you're saying here. You would

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agree that by the time he got to the emergency room there was no drainage, correct?

A: That's correct.

Q: Okay. You're not saying, and maybe this is where the confusion was, you're not saying it was malpositioned by the time he got to the emergency room, just that there was no drainage?

A: Yes, I wasn't there.

Q: It could have been that he simply had no urine to pass, correct?

A: Yes.

Q: Okay. At some point during his hospital stay, though, can you say that the catheter was malpositioned?

A: He was admitted to the unit, the intensive care unit because he had the seizures and other medical problems, and on the 21st, sometime on the 21st it was noted that the urine output was poor. And that's when a nurse asked the urologist, you know, to look at it. And the urologist was asked to check the catheter. He deflated the balloon and pushed it little bit further and then a large amount of urine was drained.

Q: How much?

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A: I don't know the exact amount, but it was a large amount, so I'm assuming, usually more than 200 cc's, you know.

Q: Based on that, the doctor repositioning the Foley catheter, can we say with some certainty that at some point the catheter was malpositioned?

A: The catheter, yes. Probably catheter moved, that's why it was not draining, that's correct.

Q: Do you know when that catheter moved?

A: No.

Q: Would, and I think I asked this earlier, but would you expect blood when the catheter moved, or not necessarily?

A: Not necessarily.

Q: But your opinion is that Nurse Verlei put it in properly and then ultimately the doctor, the urologist had to reposition it. Sometime, in your opinion, between the point where Nurse Verlei put the catheter in and it was repositioned, somehow it had come out of position, correct?

A: It moved, yes.

Q: But you just don't know when, correct?

A: Yes.

Q: And you don't know how much, correct?

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A: That's right.
Q: And you don't know what caused it to move, correct?
A: The exact cause is not, is not clear, but again, because the patient had a seizure and when he made it to the emergency room, it wasn't draining properly and later on his output was poor, so it's somewhere in this 24, 48-hour period.
Q: Are you critical of, I believe it was Dr. Larchian? I may be mispronouncing it.
MS. SFISCKO: Larchian.
Q: Larchian, for advancing the Foley into the bladder on January 21st?
A: Yes.
Q: Why is that?
A: Because this is not the standard procedure. When you have a problem with a patient in a hospital where the Foley does not drain properly, the proper procedure is to remove the old Foley, to get prepped again, clean the patient, put a brand new one in.
Q: Did that action by Dr. Larchian cause an infection?
A: More likely than anything else.
MS. McGURK: Objection.

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Q: Why is that?
A: Because the outside portion of the catheter beyond the tip of the penis to the bag is contaminated. I mean it's open in the air. So when you deflate the balloon and you put this contaminated portion back in, you bring infection right in.
Q: Did Mr. Restivo have any sort of urine infection or bladder infection prior to Dr. Larchian doing that?
A: It was some positive urine cultures, which is not surprising because anybody who have a, have a chronic and indwelling catheter would have some bacteria in the urine. It's almost hundred percent of patients who have that.
Q: Prior to Dr. Larchian inserting the catheter further into the bladder, what did the lab at Elyria Memorial say was growing?
A: There was some pseudomonas infection.
Q: And what is that?
A: It's a bacteria infection.
Q: Anything else?
A: There was other organisms later on, including staph, staphylococci gram positive.
Q: I'm going to stop you. I'm talking about prior

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to Dr. Larchian inserting it further.
A: I think pseudomonas was the predominant organism.
Q: And my question is was there anything else other than the pseudomonas?
A: I have to look at the urine culture to tell you that.
Q: You don't recall as you sit here?
A: No.
Q: What about MRSA?
A: There was MRSA.
Q: When?
A: Before.
Q: Before what?
A: There was two cultures for MRSA. There would have been for the sputum and one for the urine, and they were both positive for MRSA. I think I can tell you the date, I have it here somewhere.
MS. SFISCKO: Page 6.
A: I don't have the exact date, but probably was the 21st.
Q: Well, was it before Dr. Larchian —
A: It was after.
Q: — pushed the catheter in?
A: I think it was after, but I'm not hundred percent sure. I have to look at the dates and all that.

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Q: Okay. Just so we are clear, prior to the catheter, Elyria Memorial found the pseudomonas, and then after the catheter was pushed in by Dr. Larchian, they found the MRSA and other bacteria, is that right?
A: Yes.
Q: Okay. Doctor, what caused Mr. Restivo's death?
A: He has multiple, severe medical conditions including those that he had prior and what he acquired during his hospitalization. He has, as evidenced from the coroner's report, severe coronary artery disease. He had necrosis of the myocardium, which is consistent with previous heart attacks. He had severe bronchial pneumonia which he acquired during his hospital stay, you know, which he did not apparently have before. Had history of pulmonary emphysema.
Q: Do you know how he got the bronchial pneumonia?
A: Most likely he got it from a staph infection, because the sputum showed MRSA and that's a staph infection that probably made it to his lungs.
Q: Was he given any sort of medication for seizures that you're aware of?
A: Yes, and I don't have the exact names but he was treated for his seizures. I think he had

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Dilantin, if I'm not mistaken, but I don't have all, the list of the medication names in the record.
Q: Did he get Activan?
A: Ativan.
Q: Ativan?
A: Yeah. Ativan is not really a seizure medicine, per se. It's used when people are really hyper in the, in the acute setting. If somebody's very wild or, or having a lot of emotion and just anxious and so on, they use Ativan to calm them down a little bit. It's not really a long-term seizure medicine. It's more for acute problem.
Q: Is there any relationship between the medicine he got and the getting the pneumonia from the sputum?
A: Anytime you worry about aspiration pneumonia you have to worry about medications, because if somebody's out of it, like have a stroke or have the tube in or is not able to swallow his saliva properly, you can aspirate, and if you aspirate, you can get the wrong bacteria in the lungs and they get infection.
Q: And is there a causal link between the medication he got at the hospital and the bronchial

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pneumonia?
A: There's no evidence that there was. You know, people get pneumonia in hospitals all the time, especially ill people who have multiple chronic medical problems such as Mr. Restivo.
Q: We talked a minute ago about what his cause of death was, and what was the cause of death, doctor?
A: Can I borrow the coroner's report?
MS. SFISCKO: Yeah.
THE WITNESS: Thank you.
MS. SFISCKO: And here's the death certificate.
Q: And what are you referring to now, doctor?
A: This is the death certificate, and number one says CVA, which stands for cerebral vascular accident, the central nervous system disease, respiratory failure, which is in relationship to his pneumonia and his failing lungs and his emphysema, and then the third one, which is CAD, which stands for coronary artery disease.
Q: Was there an autopsy done?
A: Yes.
Q: And what does the autopsy say?
A: In the autopsy there are seven clinical

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diagnoses. The first one is status post seizure disorder. Remember, this is diagnosis. Hypertension, diabetes, respiratory failure, kidney failure, possible multiple myeloma.
Q: Wasn't that the clinical diagnosis, doctor?
A: Yes, sir.
Q: Why don't you look at Page 4 of the autopsy report.
A: Sure.
Q: The one sentence paragraph right above the gross description, you see that? The cause of death is the result of multisystem organ failure and sepsis?
A: That's correct.
Q: Okay. So what's the cause of death in Mr. Restivo?
A: Multisystem organ failure and sepsis. Sepsis was a clinical diagnosis. There was no positive blood cultures here, that I'm aware of. So when I reviewed the records, there was no positive blood cultures, so the sepsis was clinical diagnosis.
Q: Were there negative blood cultures?
A: Yes.
Q: What does that indicate to you about sepsis?

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A: It indicated that there was no bacteria in the blood. It was negative. Took some blood samples, tested it, and it was negative. The cultures that I reviewed was negative blood cultures. So when people make a diagnosis of sepsis, it's a clinical diagnosis, not definitive diagnosis.
Q: Is it always a clinical diagnosis?
A: No.
Q: Can you not diagnose sepsis based on cultures?
A: Well, it's unlikely. I mean usually people, when they use the term sepsis, they refer to a blood infection, and I did not see records here of evidence of positive blood cultures. I saw evidence of sputum from the lungs that was positive and from the urinary tract, in the urine.
Q: Okay. Are you telling me that the autopsy report that says the cause of death is a result of sepsis is incorrect?
A: I didn't say it is, I didn't say that at all. I did not.
Q: That's what I'm trying to get you to reconcile the position there was no positive blood —
A: No.

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Q: Doctor, let me finish.
A: Sure. Go ahead.
Q: There was no positive bloods culture and the fact that the autopsy report says sepsis?
A: All I'm saying, it was a clinical diagnosis. There was no objective blood cultures to confirm it.
Q: Do you have a reason to disagree with the autopsy report?
A: I agree with it. I agree with it. Clearly he had multisystem organ failure evident.
Q: Do you have any opinions as to whether or not Dr. Larchian contributed to the sepsis by further inserting the catheter on the 21st?
MS. McGURK: Objection.
A: I do not have an opinion about that.
Q: Okay. Do you have any opinion as to where the sepsis came from that ultimately caused his death?
A: He has different possibilities, including the pneumonia, including the urinary tract infection. It can come from the skin. Sepsis can come from so many sources.
Q: Do you have an opinion to a reasonable degree of medical certainty as to what caused the sepsis

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that killed him?
MS. HARRIS: Objection.
MS. SFISCKO: Yeah.
A: I do not have an opinion.
Q: Is it improper to inflate the Foley catheter in the prostatic urethra?
A: Is it improper to inflate it there?
Q: Yeah.
A: Yeah, it's improper.
Q: It has to be above the urethra?
A: Yes.
Q: Pardon me. It has to be above the prostate?
A: Yes, has to go through this area, then you can inflate it and have it positioned.
Q: I want you to assume just for a second that Nurse Verlei inflated the catheter in the prostatic urethra. If she did that and he wasn't drained for about another 53 hours, you know, two days and five hours, what impact would that have on a patient like Mr. Restivo?
MS. SFISCKO: Objection.
MS. McGURK: Objection.
A: You ask me to assume — again, it's a fact, the fact that she drained urine. How can I assume that? I mean, she's writing that the patient,

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the Foley was draining urine. How can I assume something that didn't happen?
Q: If — well, let's go back to Mrs. Restivo's comment that he wasn't, he was draining significantly less urine before she took him to the hospital than previously.
A: I commented on this earlier. I told you the small amount can be due to many reasons and I commented on this area.
Q: And can you exclude from those many reasons improper placement of the catheter?
A: Yes, because she had good drainage of the Foley.
Q: Does the pyelonephritis come from blockage of the urethra such that —
A: When —
Q: — or the ureter, such that urine works its way back to the kidney?
A: One of the causes. There's about 15 or 20 of them. That's just one of them.
Q: What are the other causes that come to mind?
A: Diabetic nephropathy, which is a kidney disease from diabetes, kidney stones, urethral stones, obstruction of the outlet of the bladder, call it bladder outlet obstruction, bacteria that can ascend the urinary tract. In female, it can come

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from the ovarian system, leads to ovarian infection, such as pelvic inflammatory disease, sexually transmitted disease such as gonorrhea can also lead to this, something called urine stasis, when the urine stay in different parts of the urinary tract for a long time it can harbor bacteria, and instrumentation is a condition when doctors do a cystoscopy or surgical, like putting in an instrument with a scope and so on. Prostatectomy, surgical procedures. The list goes on and on.
Q: Can you tell me from the autopsy report what the maximum volume of Mr. Restivo's bladder would be?
A: Says here probably — from the autopsy report how big his bladder was?
Q: Yes.
A: I have to look at it.
Q: Go ahead.
MS. HARRIS: Johanna, he needs the autopsy report.
A: Do you have the autopsy report? Doesn't say how large it is.
Q: Okay. If when Dr. Larchian advanced the catheter, I want you to assume 800 cc's of foul-smelling urine came out, and that that was

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cultured and they found the pseudomonas and the MRSAs. Can you tell me whether or not that urine backed up into the kidney to create the condition of pyelonephritis?

A: It can, when you have obstruction for a long time and there's infection in the urine, it can ascend to the kidneys.

Q: Can you tell me whether or not the pseudomonas and MRSA found in the urine actually caused the pyelonephritis in this case?

A: I have to look at the culture. They did not culture the pyelonephritis. They did not take a piece of the kidney to culture it, so I cannot answer that. You have to, if you want to, if you want to show the pyelonephritis is coming from the same organism in the urine, you have to take a tissue piece from the kidneys and culture it.

Q: Okay.

A: If it showed the same thing, then it is.

Q: So because the kidney was not cultured, there's no way to know that, is that what you're telling me?

A: Yeah, there's no, there's no way to say that it's from the MRSA, you know, from the urine or the sputum.

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Q: Can you say whether or not the urosepsis that he had was as a result of renal obstruction?

MS. HARRIS: Objection to the term urosepsis.

A: Sir —

MS. SFISCKO: Yeah, I object.

A: I just mentioned to you earlier that it was no positive blood culture.

Q: Okay.

A: I told you I didn't know. Why do you have to ask that five times. You know, I said it. You know, I have things to attend to as well. I hope you can appreciate that.

Q: I beg your pardon?

A: I mean, I answered you five times the same question, so —

Q: What do you mean you have things to attend to?

MS. SFISCKO: He reserved — maybe you don't know, 4 to 5:30. He was supposed to be done.

MR. MULVIHILL: No, I didn't know he's supposed to be done. He's offered as an expert in this case. I apologize for going a little over.

MS. SFISCKO: The time was 5:30.

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A: I answered the question there was no positive blood cultures. There was no, there was no positive blood cultures, so the diagnosis of urosepsis was based on clinical diagnosis. That's all I said.

Q: Does the lack of anything growing in the blood indicate that there was no infection?

A: There was no objective evidence that there was infection in the blood.

Q: Okay. Can you have an infection in the blood and not grow —

A: Yes. Yes, you can.

Q: Okay. And I just have a couple more questions, doctor.

A: Sure.

Q: Nurse Verlei, what were the — in your report on Page 46, she had some difficulty initially?

A: Yes.

Q: What specifically, what difficulty did she have?

A: Insertion, advancing the catheter.

Q: How about expanding the balloon?

A: Usually you don't get difficulty with that. Usually the most difficulty you get is when you insert it because the catheter is elastic, you know, structure and it goes through the penis.

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It, if there's something inside that's making the lumen or the hole narrow, it doesn't go as smooth, so you have to work your way through it. Now, once you, once you get to the right place and urine drains, then you inflate the balloon. So most likely, you know, she had difficulty with insertion.

Q: Do you know whether or not she had any difficulty inflating the balloon?

A: I don't believe she did.

Q: Okay. Do you believe that Mr. Restivo had the infection that, of the pseudomonas and MRSAs prior to Nurse Verlei coming out to see Mr. Restivo on the 19th?

A: I do not know the answer to that.

MR. MULVIHILL: Okay. I don't have any other questions. Thank you, doctor.

MS. HARRIS: Doctor, do you have a couple minutes?

THE WITNESS: Sure. Absolutely.

MS. HARRIS: I only have a couple questions.

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CROSS-EXAMINATION OF AHMED ELGHAZAWI

BY MS. HARRIS:

Q: I only have a few questions for you. I represent, as you know, the emergency medicine physicians —

A: Sure.

Q: — at EMH, and as I understand it, you have no criticisms of the care rendered or the treatment rendered by the emergency medicine physicians when he was taken to the hospital, is that correct?

A: Yes, ma'am.

Q: You have no criticism?

A: No, ma'am.

Q: Okay. Doctor, just so I'm clear, when, after he was admitted, Mr. Restivo was admitted to the hospital and placed on a regular floor, he had urine drainage for at least the first shift on the regular floor?

A: Yes.

Q: Do you agree with that?

A: Yes.

Q: Okay. Can we then agree that if it was draining on the floor, the catheter was, had not been dislodged previously during the time he was in

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the emergency room?

A: Most probably not.

Q: Okay. And there's nothing that you saw in the emergency medicine room report that the catheter was dislodged, correct?

A: No, there was no, there was no evidence of that.

Q: And can we agree that if the emergency medicine doctor, Dr. Carroll, is examining this patient and touching the abdomen, that she would be able to observe if the catheter is out too far or inserted, not inserted far enough in?

MR. MULVIHILL: Objection.

A: We can agree to that.

MS. HARRIS: Thank you. Nothing further.

MS. SFISCKO: Anything on the phone?

MS. McGURK: No, I have no questions, but I would like a copy of the transcript.

MS. SFISCKO: Okay. Anything else?

MR. MULVIHILL: Just one question, doctor.

THE WITNESS: Yes.

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FURTHER CROSS-EXAMINATION OF AHMED ELGHAZAWI, M.D.

BY MR. MULVIHILL:

Q: I thought we covered it, but I got a little confused, so I apologize for the repetition.

A: That's all right.

Q: Can you tell me when the Foley catheter became malplaced or maladjusted or dislodged?

A: It's sometime between the 19th and the 21st.

Q: And you can't be any more specific than that?

A: I cannot.

Q: Okay.

FURTHER CROSS-EXAMINATION OF AHMED ELGHAZAWI, M.D.

BY MS. HARRIS:

Q: But, doctor, there's nothing to suggest if the catheter was viewed that this catheter was dislodged at the time of the emergency room department visit, correct?

A: No.

Q: So most probably, more probably than not, it wasn't dislodged at the time she was in the, he was in the emergency room?

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MR. MULVIHILL: Objection.

A: Yes.

MS. HARRIS: Thank you.

THE WITNESS: Thank you.

AHMED ELGHAZAWI

CERTIFICATE

The State of Ohio,) SS:
County of Cuyahoga.)

I, Katherine A. Koczan, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 20____.

Katherine A. Koczan
Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 27, 2006

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