

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

*Mehler & Hagestrom
Court Reporters
1750 Midland Building
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Cleveland, OH 44115*

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[1] IN THE COURT OF COMMON PLEAS
[2] CUYAHOGA COUNTY, OHIO
[3] ESTATE OF PETER RESTIVO,
[4] etc.,
[5] Plaintiff,
[6] JUDGE FRIEDLAND
[7] -vs- CASE NO. 445734
[8]
[9] COMMUNITY HEALTH CARE
[10] PARTNERS, et al.,
[11] Defendants.
[12]
[13] Deposition of AHMED K. ELGHAZAWI, M.D.,
[14] taken as if upon cross-examination before
[15] Katherine A. Koczan, a Notary Public within and
[16] for the State of Ohio, at the offices of Lowe,
[17] Eklund, Wakefield & Mulvihill, 610 Skylight
[18] Office Tower, Cleveland, Ohio, at 4:10 p.m. on
[19] Tuesday, May 20, 2003, pursuant to notice and/or
[20] stipulations of counsel, on behalf of the
[21] Plaintiffs in this cause.
[22]
[23] MEHLER & HAGESTROM
[24] Court Reporters
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[9] On behalf of the Plaintiffs;
[10]
[11] Johanna M. Stisko, Esq.
[12] 35888 Center Ridge Road, Unit 3
[13] North Ridgeville, Ohio 44039
[14] (440) 327-1542,
[15] On behalf of the Defendants
[16] Community Health Care Partners
[17] and Alana Verlei, R.N.;
[18] Tracey McGurk, Esq. (Via telephone)
[19] Reminger & Reminger
[20] 1400 Midland Building
[21] Cleveland, Ohio 44114
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[23] On behalf of the Defendant
[24] Elyria Memorial Hospital;
[25]
[26] Beverly Harris, Esq.
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[31]
[32] On behalf of the Defendant
[33] Marion Carroll, M.D.
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[1] (Thereupon, Plaintiff's Exhibit 1
[2] was marked for purposes of identification.)
[3]
[4]
[5] AHMED K. ELGHAZAWI, M.D., of lawful age,
[6] called by the Plaintiffs for the purpose of
[7] cross-examination, as provided by the Rules of
[8] Civil Procedure, being by me first duly sworn, as
[9] hereinafter certified, deposed and said as
[10] follows:
[11] CROSS-EXAMINATION OF AHMED K. ELGHAZAWI, M.D.
[12] BY MR. MULVIHILL:
[13] Q: Doctor, would you please state your name.
[14] A: First name is Ahmed, A-h-m-e-d, and last name is
[15] Elghazawi, it's E-l-g-h-a-z-a-w-i.
[16] Q: Elghazawi?
[17] A: Yes, sir.
[18] Q: Okay. Just want to make sure I was pronouncing
[19] it correctly.
[20] And before we get into any of the substance
[21] of this, I just want to identify that we have
[22] marked what you provided to me just before the
[23] deposition started as a current copy of your
[24] resume, is that right?
[25] A: That's correct.

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[1] Q: Okay. And we marked that as Exhibit 1, and then
[2] I'm looking through your file in this case, is
[3] this, did you bring your entire file?
[4] A: Most of it, because it was in two different
[5] piles, but I think this is almost all of it, I
[6] think.
[7] Q: Why don't you tell me what you didn't bring and
[8] then we will start with what you did bring.
[9] A: I think I did bring pretty much all of it what
[10] you have.
[11] Q: I'm going to identify, and you can look across
[12] the table here and make sure I'm identifying the
[13] contents, the first is a copy of your September
[14] 4th, 2002 report, correct?
[15] A: Yes.
[16] Q: Then your February 17th, 2003 report, correct?
[17] A: Yes.
[18] Q: And then there's a February 18th, 2003, is that
[19] kind of —
[20] A: Yeah.
[21] Q: — another report?
[22] A: It's not a report. Like a follow-up letter.
[23] Q: Follow-up letter. Then we have a letter from
[24] October 29th, 2002 from Ms. Sfisco's office?
[25] A: Yes, sir.

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[1] Q: The report of Dr. Herman, is that right?
[2] A: Yes, sir.
[3] Q: And the report of Dr. Armitage?
[4] A: Yes.
[5] Q: All right. And then another October 25th, 2002
[6] correspondence from Ms. Sfisco, correct?
[7] A: Yes, sir.
[8] Q: And then it looks like you have some sort of
[9] deposition starting at Page 43?
[10] A: Yeah.
[11] Q: What deposition is that?
[12] MS. SFISCO: It looks like it
[13] could be the nurse's.
[14] Q: I guess the first question is, I assume somewhere
[15] you have the first 42 pages of the deposition,
[16] correct?
[17] MS. SFISCO: It should be here.
[18] A: It should be here.
[19] MS. SFISCO: Katherine Restivo.
[20] A: The deceased's wife.
[21] Q: Okay.
[22] A: Yeah.
[23] Q: Do you know where the rest of the deposition is?
[24] A: Probably in the office, most likely.
[25] Q: Okay.

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[1] A: These are not medical records, obviously, this
[2] was just —
[3] Q: Right, a deposition. Okay. And then there's a,
[4] apparently another copy of this February 17th,
[5] 2003 report, correct?
[6] A: Yes.
[7] Q: And then there is a February 19th, 2003 letter
[8] from Ms. Sfiscko. And that is the deposition of
[9] Deborah Schwan?
[10] A: Yes.
[11] Q: Okay. Deposition of Dr. Carroll?
[12] A: Yes.
[13] Q: And then a February 14th, 2003 letter, which
[14] apparently contained the home health care chart,
[15] correct?
[16] A: That's correct.
[17] Q: All right. And then is the, is this the home
[18] health care chart?
[19] A: Yes. Some of the material was repetitive, like
[20] vital signs, and so we pretty much have the
[21] relevant information here.
[22] Q: Okay. But is this, as far as you know, the
[23] entire home health care chart?
[24] A: Yes.
[25] Q: Okay. What about the medical records from Elyria

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[1] Memorial Hospital, do you have any of those?
[2] A: I probably, probably in the office with the other
[3] records. It was too much to carry with me, but
[4] this is —
[5] Q: Doctor, I —
[6] A: — the list that I have was the report that I
[7] reviewed, the record I reviewed.
[8] Q: Well, doctor, it's important I know what you
[9] reviewed and what you relied on in formulating
[10] your opinions. So — hold on, don't interrupt
[11] me.
[12] So when I asked you earlier if this was the
[13] entire file, you had indicated that it was.
[14] A: Yes.
[15] Q: Okay. However, obviously it's not because you
[16] have medical records from the hospital that are
[17] not contained in this package, correct?
[18] A: That's possible, yes.
[19] Q: I mean, you have reviewed the Elyria Memorial
[20] records?
[21] A: Yes, I list it in the records that I reviewed in
[22] the front page of my letter to Ms. Sfiscko.
[23] Q: In fact, I see a death certificate which isn't in
[24] this pile, correct?
[25] A: Correct.

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[1] Q: The autopsy report which isn't in this pile,
[2] correct?
[3] A: Yes.
[4] Q: Elyria Memorial consultative report is not in
[5] this pile, correct?
[6] A: Yes.
[7] Q: There's multiple, I'm just going over the list.
[8] MS. HARRIS: Including records.
[9] MS. SFISCKO: Including records.
[10] MR. MULVIHILL: Yes.
[11] MS. HARRIS: Number four, right.
[12] Q: We didn't see the deposition of the nurse, is it
[13] Verlei — how do you pronounce it?
[14] MS. HARRIS: Verlei.
[15] Q: Verlei, thank you. Her deposition isn't in here,
[16] is it?
[17] A: No, not in this records, no.
[18] Q: Okay. Well, in fact, doctor, in your September
[19] 4th, 2002 report, you'd indicated that you had
[20] reviewed records one through ten, correct?
[21] A: Yes.
[22] Q: And in fact, none of those are here in this pile
[23] that you brought with you, are they?
[24] A: Well, my secretary — they delivered this stuff
[25] to me in my office downtown, and it may not be

Page 10

[1] here; that's correct.
[2] Q: All right. So in no way is this a complete file
[3] in this case?
[4] A: Yeah, there are other records, yes.
[5] Q: Okay. What I'm particularly interested in is the
[6] medical summary prepared by Ms. Sfiscko's office.
[7] You see that, number nine?
[8] A: Yes.
[9] Q: You didn't bring that with you?
[10] A: It may not be in this, in this —
[11] Q: All right.
[12] A: — pile.
[13] Do you have a copy of it, Ms. Sfiscko?
[14] MS. SFISCKO: No, I don't have a
[15] copy of it with me. It could very well be
[16] my cover letter or something.
[17] MR. MULVIHILL: Well, it says
[18] medical summary, so I'll take the doctor's
[19] words.
[20] MS. SFISCKO: That's, I do a
[21] medical summary.
[22] Q: I would ask that be produced immediately.
[23] A: Sure.
[24] Q: If you would give that to Ms. Sfiscko so she
[25] could turn it over to us.

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[1] Did you take any notes in this case?
[2] **A:** No. I usually dictate my notes as I work, and
[3] then when I finish, I basically dictate a full
[4] report and then I proof it, I review it, make
[5] sure there are no errors, grammatical errors, and
[6] then I send it to Ms. Sfiscko.
[7] **Q:** Let's back up here a second. Do you dictate the
[8] report or do you dictate notes before the report?
[9] **A:** Well, I sit down, I do, and I review the records
[10] in front of me. I may take a note and then I may
[11] just use this as I'm dictating my report.
[12] **Q:** Do you have any of those notes you took in this
[13] case?
[14] **A:** Of course not. When I review records, these
[15] notes are to remind me as I'm dictating, and once
[16] I dictate, I don't need these notes.
[17] **Q:** Did you retain the notes in this case?
[18] **A:** No.
[19] **Q:** Okay. What did you do with them?
[20] **A:** I don't keep the notes. I shred them because I
[21] don't need them. You know, I need the note to
[22] remind me as I'm dictating dates and events
[23] because I can't memorize every date in the
[24] record.
[25] **Q:** Sure. Someone else may need them.

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[1] You realize that you've been retained to
[2] offer opinions in this case, right?
[3] **A:** I've never had this question before.
[4] **Q:** I would ask that you look through your entire
[5] file and I would ask you to produce the medical
[6] summary that was prepared by Ms. Sfiscko's
[7] office.
[8] **MR. MULVIHILL:** Off the record.
[9]
[10] (Thereupon, a discussion was had off
[11] the record.)
[12]
[13] **A:** I actually have a box, the rest of the records.
[14] I can't carry a box to here.
[15] **Q:** All right.
[16] **MS. SFISCKO:** Next time we will do
[17] it at your office.
[18] **THE WITNESS:** Yeah, I have a box.
[19] **MS. SFISCKO:** So you can have
[20] everything there.
[21] **THE WITNESS:** I'm not used to
[22] walking around carrying a box.
[23] **Q:** All right. And again, referencing your report of
[24] September 4th, 2002 —
[25] **A:** Yes, sir.

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

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

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[1] A: And then October —
[2] Q: I'm sorry.
[3] A: There were some other experts' reports which was
[4] pretty much the same ones that she had here that
[5] I reviewed, and another letter that I sent to
[6] Ms. Sfiscko on February 17th, 2003, there was
[7] record from the home health care and the Grace
[8] Hospital records, and I gave an opinion in
[9] reference to these records from Grace Hospital
[10] and that, and there was records of Nurse Debra
[11] Schwan that also was reviewed.

[12] Q: Okay.

[13] A: And that's about it.

[14] Q: Can you hand me the February 18th letter, please.

[15] A: Sure.

[16] Q: I'd like to mark that as Exhibit 2 if I could,
[17] and we will maybe go make a copy of that for you
[18] so I can keep it.

[19]
[20] (Thereupon, Plaintiff's Exhibit 2
[21] was marked for purposes of identification.)

[22]
[23] MS. SFISCKO: Okay. I probably
[24] have it. It's probably in my
[25] correspondence file.

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[1] Q: Okay. And if you remind me to make a copy of
[2] that before you leave.

[3] A: Okay. Let me mark it so I won't forget that.

[4] Q: All right. Doctor, I want to go over your
[5] background a little bit if we can.

[6] A: Sure.

[7] Q: And we have marked your resume —

[8] A: I have a copy of that.

[9] Q: — as Exhibit 1.

[10] And I kind of want to just go through this if
[11] we can.

[12] A: Sure.

[13] Q: You were born in Cairo, Egypt?

[14] A: Yes, sir.

[15] Q: And you were educated in Egypt as well, correct?

[16] A: Most of my education, yes.

[17] Q: Your premedical education was at —

[18] A: Ain Shams, A-i-n Sh-a-m-s, University in Cairo.

[19] Q: And you spent two years in your premedical
[20] education, is that right, '71 to '72?

[21] A: Yes. This actually is called premed, which is
[22] like studying biochemistry, you know, premed
[23] sciences, basically.

[24] Q: And your degree was Bachelor of Science?

[25] A: M.B., Ch.B, which stands for — yeah, the first

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[1] one, yes, Bachelor of Science, B.SC, that's

[2] correct.

[3] Q: And then you immediately enrolled in the same
[4] university in medical school?

[5] A: That's correct.

[6] Q: Okay. And your degree was M.B., Ch.B?

[7] A: Yes.

[8] Q: What does that stand for?

[9] A: Medical Bachelor, Bachelor of Chirurgiae, which
[10] is a British degree. This is equivalent if you
[11] go to Oxford or Cambridge or something like that,
[12] same degree.

[13] Q: Ch.B is what?

[14] A: Chirurgiae baccalaureus, chirurgiae, like
[15] surgery. This is the Latin, and if you go to a
[16] school at say Oxford, Cambridge in England, you
[17] would get M.B., Ch.B.

[18] Q: You didn't go to Oxford, correct?

[19] A: Correct, but we have a British curriculum and
[20] that's why we have these abbreviations.

[21] Q: Now, when did you obtain the M.D. degree?

[22] A: In 1972. I'm sorry, '78.

[23] Q: I thought you just got finished saying it was a
[24] British system, you have an M.B., Ch.B?

[25] A: When did I finish the school you said?

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[1] Q: No, when did you get your M.D. degree?

[2] A: Well, this is equivalent to M.D. degree.

[3] Q: Okay. Did you get an M.D.?

[4] A: Yes, I got this because I came to the United
[5] States. I went through the United States
[6] qualification exams, we passed them all and we
[7] became certified here.

[8] Q: Who's we?

[9] A: Any doctor, foreign physician who comes here.

[10] Q: Okay. And do they give you an M.D. then when you
[11] pass the exam?

[12] A: Yes.

[13] Q: Is that the FLEX exams?

[14] A: Yes.

[15] Q: Did you, did you ever fail the FLEX exam?

[16] A: Never.

[17] Q: All right. And not being familiar with the
[18] British system or the Egyptian equivalent of the
[19] British system, what did you do when you
[20] graduated? Did you have a typical residency
[21] somewhere or —

[22] A: Yeah, we typically do a year of residency in
[23] general medicine and surgery prior to any
[24] subspecialization you want to do later on. So
[25] the first year we do after that would be spent in

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[1] the hospital basically.
[2] Q: Just kind of on rotation?
[3] A: Yes. There's some elective, if you're interested
[4] in certain areas, you may spend some more time
[5] more than the other.
[6] Q: Let me ask you this. Did you have a specific
[7] residency in Egypt?
[8] A: Yes.
[9] Q: And what was it?
[10] A: One year medicine and surgery.
[11] Q: Medicine and surgery?
[12] A: That's what it's called, yes.
[13] Q: And where is it on your resume?
[14] A: I can look at it and tell you. This would be in
[15] the final year of 1978, basically that's part of
[16] the six-year training program.
[17] Q: And then what did you do after that one year of
[18] medicine and surgery residency?
[19] A: Well, I came to the United States at the, in
[20] 1979. I was a scout leader in the Boy Scouts and
[21] I represented my country in common to the
[22] international Boy Scout leaders in the United
[23] States. That's how I came here.
[24] Then I worked in the Saudi Arabian Embassy in
[25] Washington, D.C., as I said here, in my rest of

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[1] my curriculum in the medical division through
[2] 1984, and then I joined the Cleveland Clinic in
[3] 1985.
[4] Q: Okay. Let me just back up. You came to the
[5] United States in '79?
[6] A: Um-hum.
[7] Q: And you came in cooperation with the Boy Scouts?
[8] A: Yeah, these are program that they do every four
[9] years where they invite Scout leaders from all
[10] over the world, and I was —
[11] Q: You weren't invited to America because of your
[12] medical training, you were invited to America
[13] because of your Scout training, correct?
[14] A: Because of my leadership in scouting, yes.
[15] Q: And how long were you in the Boy Scouts in the
[16] United States?
[17] A: Like three, four months. I think it was going
[18] through the different areas in the country, you
[19] know, we went through Pennsylvania and then New
[20] York, and it was international gathering of all
[21] the people from all over the world basically.
[22] Q: And then later in '79 you started at the Saudi
[23] Arabian Embassy?
[24] A: Yeah, I applied for a job there basically and I
[25] joined the Embassy around that time.

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[1] Q: Maybe I'm not understanding what's going on here,
[2] but it looks like on your resume you have Saudi
[3] Arabian Embassy from '83 to '85?
[4] A: Yes, I missed this. This is 20 years ago. Let
[5] me help you. Yeah, I worked with a group of
[6] orthopedic surgeons in Washington, D.C. area from
[7] '81 to '83.
[8] MS. SFISCKO: It's on here.
[9] A: It's here, it's number two, if you can see it.
[10] Q: Is it Drs. Azer, Jackson —
[11] A: Yes.
[12] Q: — Emich, et cetera?
[13] A: Emich, Maximous, Muwwad, from '81 to '83.
[14] Q: All right. Let me back up. When did you leave
[15] Egypt in 1979?
[16] A: Sometime after July.
[17] Q: Okay. And you came to the United States and
[18] worked with the Scouts until sometime later in
[19] '79?
[20] A: Yeah.
[21] Q: And then —
[22] A: Approximately.
[23] Q: — what did you do from '79 to '81 until you
[24] started at the Orthopedic Clinics?
[25] A: Touring this beautiful country.

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[1] Q: You weren't practicing medicine in America,
[2] correct?
[3] A: No, no. You can't practice medicine before you
[4] get your qualification exams.
[5] Q: So I want to be clear. You were not practicing
[6] medicine in America from '79 to '81, correct?
[7] A: Yeah, correct.
[8] Q: Okay. And then in '81 you started with a group
[9] of orthopedic doctors in Washington, D.C.?
[10] A: Yes.
[11] Q: Okay.
[12] A: Area. They have offices in Virginia and Maryland
[13] as well, but their main office is in Washington.
[14] Q: In here you have that it included both clinical
[15] and administrative aspects?
[16] A: I seen patients, examining patients with them.
[17] And I did not have my license at the time, I
[18] couldn't have my own practice, so I was working
[19] with them in their practice.
[20] Q: And how much of your time was devoted to clinical
[21] versus administrative at that time?
[22] A: I'd say probably 80 percent clinical, 20 percent
[23] administrative.
[24] Q: And did you get your license to practice in the
[25] United States in that time when you were with

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[1] those orthopedic doctors?
[2] A: Yeah, I was studying at that time for my ACFMG.
[3] Q: For your what?
[4] A: ACFMG, it's the Accreditation Commission for
[5] Foreign Medical Graduates, that's what it stands
[6] for. And so that's what I was preparing myself
[7] for.
[8] Q: When did you take that exam?
[9] A: I think it was 1983, if I'm not mistaken.
[10] It's —
[11] Q: Is that about —
[12] A: I can send you a copy of it if you like. I think
[13] it was '83 or '84.
[14] Q: Is that the time you transferred over to the
[15] Saudi Arabian Embassy then?
[16] A: Around that time, yeah.
[17] Q: And what did you do for the Saudi Arabian
[18] Embassy?
[19] A: We did the review of patients' care. We had
[20] overseas patients that came from the middle east,
[21] they came for specialized care, such as kidney
[22] transplant, mostly cancer care, you know, complex
[23] medical care, and my job was to go over the files
[24] to review and assess the need for further
[25] treatment, and if they need to have any further

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[1] consultation, the referrals, the Embassy acted as
[2] a liaison between the hospitals overseas and the
[3] hospitals here.
[4] Q: Okay. These were patients who needed medical
[5] care that they could only get in the United
[6] States?
[7] A: For the most part, yes.
[8] Q: And you were acting as a liaison with the Embassy
[9] between the hospitals overseas and the hospitals
[10] in America?
[11] A: You acting as a medical expert, so to speak, to,
[12] to decide if this patients need to come or not
[13] and what care they need.
[14] Q: Okay. Well, you didn't actually treat these
[15] people who needed kidney transplants and things
[16] like that?
[17] A: This was basically mostly administrative work.
[18] Q: Okay.
[19] A: You go over the file, you look at the medical
[20] records and you make a decision based on what you
[21] have.
[22] Q: And so then in 1985 you came to the Cleveland
[23] Clinic here in Cleveland?
[24] A: Yes, sir.
[25] Q: And you're a resident in internal medicine for

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[1] three years?
[2] A: Yes.
[3] Q: Did you complete the residency program in
[4] internal medicine?
[5] A: Yes.
[6] Q: Did you ever sit for the board certification in
[7] internal medicine?
[8] A: Yes, I did.
[9] Q: And did you pass that?
[10] A: No, I did not pass that.
[11] Q: How many times did you take the board
[12] certification for internal medicine?
[13] A: Two times.
[14] Q: And you did not pass either one of them?
[15] A: That's correct.
[16] Q: Have you ever taken any other board certification
[17] exams?
[18] A: Yes, I have a list of the board certification
[19] exams I had.
[20] Q: Okay.
[21] A: I took the —
[22] Q: Okay. Let me stop you there because we will get
[23] to those in just a minute.
[24] A: Sure.
[25] Q: Did you ever take any other board certifications

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[1] that you did not pass?
[2] A: No.
[3] Q: Did you ever follow up with any of your work in
[4] orthopedics that you were doing from '81 to '83,
[5] did you sit for the boards in orthopedics?
[6] A: Well, I couldn't sit for the board of
[7] orthopedics. I could sit for the boards for pain
[8] management, which became an area of interest
[9] later on, and basically in order to sit for the
[10] board of orthopedics, you have to do five years
[11] of orthopedic training.
[12] Q: Which you didn't have?
[13] A: No, it's not my specialty.
[14] Q: All right. And then you left the Clinic in '88,
[15] it looks like you went to Switzerland?
[16] A: Sweden, I did a fellowship in Sweden.
[17] Q: I see spine division, Basel, Switzerland?
[18] A: No, I think you're getting your dates — this,
[19] this was just a brief few months in Switzerland,
[20] yes, 1988, yes, that's correct, yes.
[21] And then after that I went to Vermont in the
[22] rehabilitation center in the back center there,
[23] and then I went to Sweden after that. That was
[24] my fellowship over there.
[25] Q: Okay. Your fellowship in what?

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[1] A: Spinal disorders.
[2] Q: Did that, does that fall under the umbrella of
[3] orthopedics?
[4] A: Oh, of course, because we had spine center in the
[5] Cleveland Clinic. I actually was one of the
[6] people who started the spine center in the
[7] Cleveland Clinic in 1989; '88, '89.
[8] Q: Wait a minute. Now, did you start a spine center
[9] in — you weren't an orthopedic doctor?
[10] A: The spine center was not an orthopedic center.
[11] The spine center was a rheumatology and internal
[12] medicine.
[13] Q: What rheumatology had you had up to this point?
[14] A: The spine center included different disciplines.
[15] Q: Okay. What rheumatology training did you have up
[16] to that point?
[17] A: I did not have — I have my spine fellowship, as
[18] I mentioned to you earlier, and the Cleveland
[19] Clinic asked me actually to stay and set the
[20] program for them because they wanted medical
[21] people to oversee spine patients, because most of
[22] these patients are not orthopedics or
[23] rheumatologic, most of them are occupational and
[24] most of them need medical care. So the spine
[25] center is not an orthopedic department in the

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[1] Cleveland Clinic. It's a separate entity
[2] basically.
[3] Q: Who did you set the center up with?
[4] A: Dr. Boumphrey, Francis Boumphrey, who is the
[5] chief of the spine center at the Clinic. At the
[6] time I worked with Dr. Russ Hardy, who is the
[7] chief of neurosurgery who is now at University
[8] Hospital, and I have a whole list of other names
[9] if you like.
[10] MR. MULVIHILL: Let's go off the
[11] record a second.
[12]
[13] (Thereupon, a discussion was had off
[14] the record.)
[15]
[16] Q: Doctor, your pager just went off.
[17] A: I'm sorry about that.
[18] Q: And I assume you've had your deposition taken
[19] before?
[20] A: I can't — yeah. You want me to turn it off,
[21] throw it away?
[22] MS. HARRIS: No, what he's trying
[23] to say, doctor, if you need to take the
[24] page, do so.
[25] Q: Doctor, we didn't go over the ground rules for

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[1] the deposition.
[2] A: That's okay.
[3] Q: If you need to take a break, just let me know.
[4] A: That's very kind of you.
[5] Q: We're not here to make this inconvenient for you.
[6] A: That's all right.
[7] Q: Okay. And then, so you were at the Cleveland
[8] Clinic back again then in '89 to '92, center for
[9] the spine?
[10] A: That's right. And let me just help you here.
[11] Q: Sure.
[12] A: The center for the spine at the Cleveland Clinic,
[13] as a center, was established 1988. I was one of
[14] the founders for the spine center. They said the
[15] center based on medical nonorthopedic people to
[16] see all people with spinal problem. The one who
[17] needs surgery then will be referred. And so
[18] often you acted more like a medical diagnostic
[19] group.
[20] Q: Is that center still in existence?
[21] A: Oh, yeah. Much bigger and more famous.
[22] Q: And then it looks like for the next three years,
[23] from '92 to '95, you were somehow affiliated with
[24] Mt. Sinai?
[25] A: Yes.

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[1] Q: What was that?
[2] A: Mt. Sinai has a group called Business Health
[3] Networks, which staffed the outpatient clinic for
[4] the hospital that took care of employees, it took
[5] care of work-related injuries, it took care of
[6] primary care, general medicine, it was more like
[7] an outpatient clinic basically.
[8] Q: Did you actually practice medicine in that clinic
[9] or were you —
[10] A: Of course, of course. We see patients every day.
[11] Q: Let me finish my question. Did you actually
[12] treat patients in that clinic or were you more
[13] administrative?
[14] A: I treat patient every day.
[15] Q: Did you have an administrative component to your
[16] job?
[17] A: No, not really, more that the, the paperwork like
[18] people have off work times, slip to take off a
[19] few days for an injury, something like that.
[20] Q: What's Business Health?
[21] A: That's the name of the group that staffed
[22] Mt. Sinai called Business Health Network. They
[23] staff the primary care division of the hospital.
[24] Q: Then looks like the next long-term thing you have
[25] here is Associate of Family Physicians in

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

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[1] **A:** Yes.
[2] **Q:** Is that the jail downtown?
[3] **A:** This is the correction center downtown, yes.
[4] **Q:** And are you still affiliated with them?
[5] **A:** Yes.
[6] **Q:** Okay. And what is your position with them?
[7] **A:** I oversee 13 physicians who will provide
[8] different disciplines, primary care — we have
[9] five primary care physicians, we have three
[10] psychiatrists.
[11] **Q:** Where are they located?
[12] **A:** Downtown in the Justice Center.
[13] **Q:** There is a medical office in the Justice Center?
[14] **A:** Yes, large medical clinic there and then there's
[15] also OB/GYN and dental services there. It's
[16] pretty, pretty nice. You should come visit.
[17] **MS. SFISCKO:** Never did criminal
[18] law. I know where it's at.
[19] **Q:** I hope not to, other than social visit.
[20] **A:** To visit. I'm not saying —
[21] **MS. HARRIS:** No, we don't even
[22] want to do that, doctor.
[23] **Q:** How much time do you currently spend at the
[24] Justice Center then at that clinic?
[25] **A:** Two days, two-and-a-half days and then the rest

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[1] of the week is my practice.
[2] **Q:** And what is your practice?
[3] **A:** I have a clinic that's called Regional Spine
[4] Clinic. I take care of people with
[5] musculoskeletal problems, back problems.
[6] **Q:** Is that Cleveland — say that again, Cleveland
[7] Spine Clinic?
[8] **A:** Regional Spine Clinic.
[9] **Q:** Regional Spine Clinic. And is that at the Parma
[10] and Painesville and Cleveland Heights and Olmsted
[11] Falls addresses?
[12] **A:** Yes.
[13] **Q:** Okay. And tell me again what you do at the
[14] Regional Spine Clinic.
[15] **A:** I see patients who have problems with their
[16] spines, their back, their neck.
[17] **Q:** Do you actually treat those people or —
[18] **A:** Oh, yeah.
[19] **Q:** — are you doing evaluations for employers and
[20] other people?
[21] **A:** Pretty much everything to do with the spine other
[22] than surgery. So we take care of people who have
[23] like Workers' Compensation injuries, people who
[24] have car accident injuries, people who have
[25] sports injuries, people who have osteoporosis,

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

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[1] you know, so yes.

[2] Q: How often do you do work for the Bureau?

[3] A: All the time. I mean I take care of patient for
[4] the Bureau almost every week, but as far as
[5] doing, doing independent medical exams, is that
[6] what you're asking me?

[7] Q: I think we are getting confused here.

[8] My understanding of the Bureau is the Bureau
[9] doesn't send people to you for treatment, they
[10] will go to their doctors for treatment. The
[11] Bureau might want an independent exam?

[12] A: Yes.

[13] Q: And that's what I'm trying to figure out the
[14] difference between. You may have patients who
[15] also happen to have a Workers' Compensation claim
[16] and may be being paid by the Bureau because it's
[17] a work-related injury. But the Bureau isn't
[18] involved in their care.

[19] What I want to find out is the time
[20] difference between actually doing an independent
[21] evaluation, whether it be for the Bureau or an
[22] insurance company or a lawyer versus actually
[23] treating patients who may happen to have a
[24] Workers' Compensation claim.

[25] A: I don't understand anything you told me.

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[1] Q: All right. Let me back up then. I think you
[2] said earlier you do about two independent exams
[3] per month?

[4] A: Yeah, approximately, yes.

[5] Q: Okay. And does that include independent exams
[6] for the Bureau?

[7] A: Yes. I mean, I don't count them like this
[8] because the Workers' Compensation referral come
[9] for what we call C-92s, okay, these people come
[10] for permanent rating. So you examine the
[11] patients, you give them percentage of impairment
[12] and so on.

[13] I do this for plaintiff, like yourself, or
[14] for the defense, like the Bureau, or somebody
[15] else because I give an honest opinion. The
[16] Bureau or the employer or the agency may ask you
[17] to do an independent medical exam on a Workers'
[18] Comp patient for an opinion. Now, I can — that
[19] patient is not my patient. That patient is for
[20] that purpose.

[21] Q: Right.

[22] A: I have also my patients. My patients the
[23] majority of the workload. Occasionally I get
[24] referrals for IMEs, which is independent medical
[25] exams.

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[1] Q: And that's what I want to know. Give me your
[2] best evaluation as to the amount of time you
[3] spend doing independent medical exams versus
[4] treating patients in the clinical setting.

[5] A: 90 percent plus treating patients and 10 percent
[6] or less doing independent medical exams.

[7] Q: And at the Justice Center, how much time do you
[8] spend in the administrative side versus actually
[9] treating patients?

[10] A: I'd say about 50/50.

[11] Q: Okay. And lastly, doctor, you've got house
[12] officer, Barberton Citizens Hospital?

[13] A: Yes.

[14] Q: What's a house officer?

[15] A: We cover intensive care unit, hospitalis, this is
[16] a new name.

[17] MS. HARRIS: You work with ICU?

[18] A: Yes, yes, I cover the intensive care units, take
[19] care of critically ill patients couple times a
[20] month to help pay for my bills.

[21] Q: So you're an employee of the Barberton Citizens
[22] Hospital?

[23] A: Yes, yes.

[24] Q: And how much time do you actually spend down in
[25] Barberton?

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[1] A: Few times a month, you know, depending. Sometime
[2] I work 24-hours shifts in the weekends, sometimes
[3] I work more or less depending if I want to or
[4] not.

[5] Q: And your privileges, doctor, you've indicated
[6] here that you've got Barberton Citizens Hospital
[7] and St. Vincent Charity?

[8] A: That's correct.

[9] Q: Have you ever had any privileges denied anywhere?

[10] A: Never.

[11] Q: Any privileges revoked anywhere?

[12] A: Never.

[13] Q: Okay. If you've got offices — I'm just kind of
[14] curious, if you've got offices in Parma, why
[15] don't you have privileges at Parma Community
[16] Hospital?

[17] A: Because my Regional Spine Clinic, almost all my
[18] patients are outpatients, meaning that they are
[19] people who need outpatient care. I don't take
[20] care of general medical problems that they need
[21] admission and so on.

[22] Q: When's the last time you actually admitted a
[23] patient to St. Vincent's Charity?

[24] A: We admit — actually, when? Three days ago. We
[25] admit all our patients from downtown from the

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[1] Justice Center to St. Vincent Charity Hospital
[2] for various care, surgical and so on.

[3] Q: And I appreciate that answer and I guess I would
[4] then draw the distinction between the Regional
[5] Spine Center —

[6] A: Yes.

[7] Q: — patients versus the Justice Center patients.

[8] A: I just answered the question you asked me, that's
[9] all.

[10] Q: You're right. I'm not upset with your answer, I
[11] just need to know in terms of the Regional Spine
[12] Center, how many — when's the last time you
[13] admitted a patient to St. Vincent's?

[14] A: About a month ago we had a patient that needed,
[15] needed to have surgery and he was admitted to the
[16] surgeon's service.

[17] Q: Your board certifications, doctor, why don't you
[18] just run through those. How do you become board
[19] certified in independent medical examiners?

[20] A: The American Academy of Occupational Medicine is
[21] a sponsor of the Board of Independent Medical
[22] Examiners. You have to go through clinical
[23] training courses with the academy over a two-year
[24] period. You have to become a fellow before that,
[25] fellow of the American Academy of Disability.

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[1] Q: How many courses did you have to take?

[2] A: Ton of courses. I mean we have, I must have
[3] taken in the two-year period, probably at least
[4] four or five courses.

[5] Q: How many total hours would that be?

[6] A: Well, every course about five days to a week, and
[7] then you have to have a certain degree of
[8] previous experience, certain number of
[9] publications, certain number of work-related

[10] activities in the area of disability, then you
[11] sit for an exam by the board and then you take
[12] the exam and hopefully you pass it.

[13] Q: You never failed that exam?

[14] A: No.

[15] Q: Is it a written and verbal?

[16] A: It's written exam.

[17] Q: No verbal component?

[18] A: No.

[19] Q: How about the American College of Forensic
[20] Examiners, why don't you explain that?

[21] A: The American College of Forensic Examiners are
[22] the group that sponsor physicians who have
[23] interest in medicolegal, such as trauma-related
[24] accidents, forensic issues, like what we do in
[25] the correction system. It also called forensic

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[1] medicine. And the college, basically if you work
[2] in the correction system for so long, you have
[3] previous experience in primary care, in addition
[4] to working in medicolegal environment and giving
[5] legal opinions, then you can sit for that. There
[6] is no exam for the forensic examiners board.

[7] Q: Is there an exam for the forensic medicine?

[8] A: No, this is based on qualifications, publications
[9] and level of experience.

[10] Q: Is there an exam for the Board of Pain
[11] Management?

[12] A: Yes, there is.

[13] Q: Okay. Why don't you explain that to me, please.

[14] A: The American Academy of Pain Management is in
[15] California, Los Angeles, California and they do
[16] the exam twice a year. The exam cover vast array
[17] of fields in the pain arena including
[18] musculoskeletal problems, cardiovascular problems
[19] and so on, and you study the course materials for
[20] the exam over a six-month period, then you sit
[21] for the examination and hopefully you pass.

[22] Q: Okay. Did you ever fail that?

[23] A: No.

[24] Q: Okay. And how about the American Academy of
[25] Experts in Traumatic Stress?

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[1] A: That is based on — this, there's no exam for
[2] that board. This board is based on your
[3] experience in working in trauma area such as
[4] accidents, again, medicolegal aspects and
[5] forensics as well.

[6] Q: How many employees does the Regional Spine Center
[7] have?

[8] A: Three.

[9] Q: And who are they?

[10] A: Me and two more.

[11] Q: Who are they?

[12] A: Sharon Hough, H-o-u-g-h, she's a full-time
[13] assistant to me.

[14] Q: Is she a physician?

[15] A: No, no, this is, she's a nurse's assistant.

[16] Q: Okay.

[17] A: And I have Jan, who is a bookkeeper, and she help
[18] in the office sometime when I need her to.

[19] Q: So do you share space with people at these four
[20] locations?

[21] A: Parma is my main office, so I don't share space
[22] in Parma. The other addresses are other
[23] physicians who using this addresses, yes.

[24] Q: Okay. Where do you live, doctor?

[25] A: Cleveland Heights. For three more days. I'm

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[1] moving to Geauga County.

[2]

[3] (Thereupon, a discussion was had off
[4] the record.)

[5]

[6] Q: Doctor, you don't have any particular expertise
[7] in infectious disease, do you?

[8] A: Well, when you do primary care over 20 some years
[9] that I've had taking care of primary care, you
[10] deal with it almost every day. In the county,
[11] for instance, we see infections almost every day.

[12] Q: You're not board certified in infectious disease,
[13] correct?

[14] A: No.

[15] Q: Do you have any particular expertise in urology?

[16] A: No.

[17] Q: When's the last time you actually inserted a
[18] Foley catheter into a male patient?

[19] A: Yesterday.

[20] Q: How often do you do that in your practice?

[21] A: In the hospital every week, because I work in
[22] intensive care unit, so I do it almost every week
[23] when I work in the hospital.

[24] Q: At Barberton?

[25] A: At Barberton, and then downtown, sometime when we

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[1] have an older patient that have problem with
[2] prostate, or they can't urinate, they ask the
[3] doctors sometime to put it in if they have a
[4] difficult time inserting it.

[5] Q: Midwest Medical Staffing, what is that?

[6] A: That's the company that staff the Cuyahoga County
[7] Correction Center that I work for.

[8] Q: Are you a shareholder in that company?

[9] A: No.

[10] Q: You're just an employee of the company?

[11] A: Yes. I'm not an employee, I'm an independent
[12] medical contractor, basically.

[13] Q: Do you get a 1099 from them at the end of the
[14] year?

[15] A: Yes.

[16] Q: Do you know whether Midwest Medical Staffing
[17] helps staff Elyria Memorial Hospital?

[18] A: No, they don't do any hospitals. They do
[19] basically correctional systems.

[20] Q: Do you know anybody at Elyria Memorial Hospital
[21] involved in this case —

[22] A: No.

[23] Q: — from the records you reviewed, any of the
[24] names?

[25] A: No, sir.

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[1] Q: Okay. How about Alana Verlei, do you know her?

[2] A: Never met her.

[3] Q: Never spoken to her?

[4] A: Never spoken to her.

[5] Q: Dr. Marion Carroll?

[6] A: No.

[7] Q: What do you charge, doctor, for your review in
[8] this case?

[9] A: Depending on the amount of time that I spend with
[10] the file, I charge \$150 per hour for my review.

[11] So depending how many hours, occasionally I have

[12] to research a particular problem, like if I'm
[13] asked an opinion about a particular problem that
[14] needed further research to give an accurate
[15] opinion, whatever time I invest in that.

[16] Q: That's also at \$150 an hour?

[17] A: Yes, sir.

[18] Q: Okay. Do you know how much time you devoted to
[19] this case so far?

[20] A: No, but I can send you a copy of the bill if
[21] you'd like.

[22] Q: That would be fine. I appreciate that.

[23] Now, you said also you might do research,
[24] correct?

[25] A: Yes, I would. For instance, if there's a very

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[1] unique topic or unique diagnosis that I'd like to
[2] look at the latest literature and articles in
[3] that particular field to —

[4] Q: Sure.

[5] A: — be up to date.

[6] Q: Right, and I think you referenced in your primary
[7] report of September 4th in this case, you have
[8] two references, Managing the Foley Catheter by
[9] Cancio Sabanegh —

[10] A: Cancio, Sabanegh, Thompson. This is the Journal
[11] of the American Family Physician. This is a
[12] journal that comes once a month from the American
[13] Academy of Family Physicians. It's sort of the
[14] bible for the family practitioners. And the
[15] other one was the Clinical Nursing Skills and
[16] Techniques by Perry & Potter.

[17] Q: Is that an article also or is that a textbook?

[18] A: This is a review article. Actually, the second
[19] one was a book. The first one was an article,
[20] like a review article.

[21] Q: You consulted those in writing this report?

[22] A: I, I basically reviewed them because they were
[23] very focused on the relationship between
[24] catheterization and complication.

[25] Q: Okay. And those are reliable in that regard?

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- [1] A: The people who did them very reliable people.
[2] There was other reports, I just quoted a couple
[3] of them basically.
[4] Q: I appreciate that, and I can only go with what we
[5] are given.
[6] A: Sure.
[7] Q: And these references are reliable in terms of how
[8] to properly catheterize someone and the
[9] complications that may arise, is that fair?
[10] A: Yes.
[11] Q: Did you review any other articles or research?
[12] A: Yes, I did.
[13] Q: And do you know what those are?
[14] A: I did not list them here because it didn't
[15] provide me with any different information.
[16] Q: Okay. Have you ever worked with Ms. Sfiscko
[17] before?
[18] A: Yes, sir.
[19] Q: On how many occasions?
[20] A: Maybe two or three occasions.
[21] Q: How about anybody in her office?
[22] A: No.
[23] Q: Okay. And do you recall the other occasions with
[24] which you've worked with Ms. Sfiscko?
[25] A: The particular cases you mean?

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- [1] Q: Yeah. What were the issues in those cases, if
[2] you recall?
[3] A: One of them was a personal injury case she send
[4] me over a year ago and —
[5] Q: Was that to do an independent medical evaluation?
[6] A: That was to treat, that was the patient that
[7] needed treatment basically. That was in my
[8] office in Olmsted Falls.
[9] THE WITNESS: You remember her?
[10] MS. SFISCKO: Yes.
[11] THE WITNESS: Good memory.
[12] MS. SFISCKO: I know exactly who
[13] it is. Maria.
[14] THE WITNESS: Right, Maria.
[15] MS. SFISCKO: She was a plaintiff.
[16] She was in a car accident, hurt her back.
[17] A: Then maybe one or two occasions, and I think they
[18] were independent medical exams.
[19] THE WITNESS: I think when you
[20] worked for Mr. Kenneally. It was
[21] Mr. Kenneally probably.
[22] MS. SFISCKO: Yes.
[23] A: That's about it.
[24] Q: How about anybody at Ms. Harris' office, have you
[25] ever worked with her or anybody at her office at

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- [1] Weston Hurd?
[2] A: No, I don't know who the names are. If you tell
[3] me a list of people —
[4] MS. HARRIS: There's 60, doctor,
[5] we are not going there.
[6] THE WITNESS: Okay.
[7] MS. HARRIS: Okay.
[8] A: You would —
[9] MS. SFISCKO: Gallagher — not
[10] Gallagher. Weston Hurd?
[11] A: No.
[12] Q: How about Reminger & Reminger, have you ever
[13] worked with them?
[14] A: I did actually C-92s, permanent impairment
[15] evaluation for the plaintiff for Reminger &
[16] Reminger a few months ago.
[17] Q: All right. And I want to get into, you know,
[18] some of your opinions in this case, doctor, if we
[19] can, but maybe before, maybe we could just talk a
[20] little bit about the catheter, how it works, and
[21] then we will get into specific opinions in this
[22] case.
[23] You'll agree the bladder is a hollow organ?
[24] A: Yes.
[25] Q: And if the catheter is placed properly and then

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- [1] the balloon is inflated, if it's in the bladder,
[2] there will not be any resistance to the inflation
[3] of the balloon, correct?
[4] A: Assuming the bladder is normal and the urethra is
[5] normal, yes.
[6] Q: And the opposite of that is if it's not placed
[7] properly, you're likely to get resistance if it's
[8] not fully in the bladder, correct?
[9] A: No, you can get resistance from a lot of other
[10] diseases, so I mean depending — so if the
[11] bladder is normal and the urethra is normal,
[12] you're correct.
[13] Q: And if the bladder and urethra are normal and you
[14] try to inflate in the urethra somewhere, you're
[15] going to get resistance, correct?
[16] A: Yeah, you shouldn't, you should not inflate it in
[17] the urethra in the first place.
[18] Q: Are you aware of any abnormalities in
[19] Mr. Restivo's bladder or urethra in this case?
[20] A: Yes.
[21] Q: And what are those?
[22] A: He has bilateral prostatic hypertrophy, which is
[23] hyperenlargement of the prostate. Basically that
[24] encases the urethra, the prostate's around the
[25] urethra, and that caused an abnormal urethra

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

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[1] prostate — geez.
[2] Just because you have an enlarged prostate,
[3] does that mean that you're going to have a
[4] compressed urethra?
[5] A: It depends on the degree of the enlargement. If
[6] the enlargement is large, I mean if you have a
[7] big enlargement, the narrowing will be
[8] significant. Also depends on the elasticity of
[9] the bladder and the urethra. In this case, he
[10] has what we call neurogenic bladder. So the
[11] bladder's not emptying properly, and because not
[12] emptying properly, the muscle tone around the
[13] bladder neck, around the urethra is impaired, and
[14] that makes it even more vulnerable to be
[15] compressed because it's not as viable.
[16] Q: Do you know the degree of impairment around the
[17] bladder?
[18] A: No, I didn't examine him, so I couldn't tell you
[19] that.
[20] Q: Do you know how long he'd had an enlarged
[21] prostate?
[22] A: Has to be many, many years because there are
[23] references in the medical records of him having
[24] history of prostate problems for a number of
[25] years.

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[1] Q: Do you know how many times Nurse Verlei saw
[2] Mr. Restivo prior to January 19th, 2000?
[3] A: I do not know how many times, no.
[4] Q: Do you know, can you give me a ballpark?
[5] A: I can't give you a ballpark, I don't know how
[6] many times she saw him.
[7] Q: Do you know how many times there was difficulty
[8] in catheterizing Mr. Restivo prior to January
[9] 19th, 2000?
[10] A: I do not know.
[11] Q: You would agree that the skill of the person
[12] attempting to insert the urethra —
[13] MS. HARRIS: Catheter?
[14] Q: Pardon me. Thank you. Let's strike that, start
[15] all over.
[16] A: That would be a new procedure.
[17] Q: You would agree that the skill of the person
[18] attempting to catheterize is an important factor
[19] in the success of the attempt at catheterization,
[20] correct?
[21] A: Yes, of course.
[22] Q: How do you know, when you're catheterizing
[23] someone, that the, his catheter is actually in
[24] the bladder?
[25] A: Well, the easiest thing is urine start to come in

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[1] the bag, right. Number two, there's a length of
[2] the Foley, there's different sizes, there's size
[3] 12, 14, 16, 16's a larger size. So if you have
[4] somebody that you insert the catheter in, the
[5] urethra is only the length, little bit more than
[6] the length of the male penis, so as you pass this
[7] length, within about an inch or two, it should be
[8] in. So looking at the distance of the entire
[9] Foley, the actual tubing, you can tell how close
[10] you are, but obviously the visible sign of having
[11] urine in the bag is the most confirmatory sign.
[12] Q: Can you get urine to come down the catheter if it
[13] is not fully placed within the bladder?
[14] A: Of course not. You know, the bladder have a
[15] neck, and the neck of the bladder in a normal
[16] individual would be constricted. Okay? In
[17] Mr. Restivo's case, because of his neurogenic —
[18] neurogenic bladder, this neck is no longer
[19] efficient. There's no places in the urinary
[20] tract that have urine except the bladder.
[21] In his case, or in an older patient or
[22] somebody who have a neurogenic bladder or a
[23] stroke, this elasticity of the urethra that
[24] closes the neck is no longer there. This is why
[25] they have diapers in older person in a nursing

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

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

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

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

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

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

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

[5] Q: Tell me the anatomy of the neck of the bladder
[6] going into the urethra.

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

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

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

[24] A: The tip.

[25] Q: Tip?

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[1] A: Tip of the catheter.

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

[4] A: Correct.

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

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

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

[12] A: But the balloon is not supposed to be inside the
[13] bladder. Obviously the balloon has to be
[14] inflated before you get inside the bladder
[15] because you cannot inflate the balloon in the
[16] bladder.

[17] Q: Why not?

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

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[1] tugging it along the walls.

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

[4] A: Diagram?

[5] Q: — diagram it for me, please.

[6] A: Sure. This is the bladder.

[7] Q: Why don't you just write bladder in where you've
[8] got bladder?

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

[11] Q: Draw an arrow to the prostate if you could,
[12] please.

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

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

[19] A: To the balloon?

[20] Q: Sure.

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

[25] Q: Realizing that this is just a diagram and no

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[1] one's holding you to any, any specific —
[2] **MS. SFISCKO:** He's not an art
[3] major.

[4] **Q:** Right. Other than just general orientation, and
[5] I recognize it's general orientation, if we could
[6] mark that as Exhibit 3, I'd appreciate it.

[7]
[8] (Thereupon, Plaintiff's Exhibit 3
[9] was marked for purposes of identification.)

[10]
[11] **Q:** Is the balloon — we marked your diagram as
[12] Exhibit 3. Is the balloon inflated then inside
[13] the top of the urethra?

[14] **A:** Not the top. Top of the urethra's here. This is
[15] the neck of the urethra here, the neck of the
[16] bladder here. So you want to inflate the balloon
[17] before it gets to the bladder. Oh, you can
[18] inflate it anywhere around this area would be
[19] appropriate.

[20] **Q:** Maybe I've just got my anatomy wrong, and I
[21] apologize. You've got this going through the
[22] penis of a man?

[23] **A:** Yes.

[24] **Q:** You've got the urethra?

[25] **A:** Right.

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[1] **Q:** Then you get to the prostate gland, correct?

[2] **A:** No. The prostate gland's outside this whole
[3] area.

[4] **Q:** Correct. I understand that, but the urethra goes
[5] through the prostate, correct?

[6] **A:** The prostate surrounds, it doesn't go through the
[7] prostate.

[8] **Q:** Prostate surrounds the urethra, correct?

[9] **A:** Yes, the prostate gland have two glands, you
[10] know, so when you say through it, like a puncture
[11] through it, it does not.

[12] **Q:** I apologize for that and I appreciate the
[13] clarification. The prostate glands are around —

[14] **A:** That's right.

[15] **Q:** — the urethra?

[16] **A:** That's right.

[17] **Q:** And then the urethra works its way into the
[18] bladder, correct?

[19] **A:** To the neck.

[20] **Q:** To the neck of the bladder?

[21] **A:** Yes.

[22] **Q:** Where does the urethra end and the neck of the
[23] bladder begin relative to the prostate?

[24] **A:** It's about between 10 to 20 millimeter depending
[25] on —

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[1] **Q:** Okay.

[2] **A:** — the individual. Women, I mean, I'm sorry,
[3] there's no women here, if somebody have very
[4] large prostate, that can expand up and down. So
[5] it depends. So if it enlarges, it can encompass
[6] a large area upwards and sideways.

[7] **Q:** Does the urethra extend beyond, extend beyond the
[8] prostate or is that where the neck of the bladder
[9] extends into the top?

[10] **A:** The urethra, the urethra extend beyond the
[11] prostate, of course.

[12] **Q:** So the balloon then is actually inflated in the
[13] neck of the bladder and not in the urethra; is
[14] that what you're telling me?

[15] **A:** No. The balloon is inflated in the urethra.

[16] **Q:** Okay. I thought I'd asked that earlier and
[17] that's what led to the whole anatomy discussions
[18] here.

[19] **A:** No. I said as long as you do it anywhere before
[20] the neck area. See, you want to do it in a way
[21] to have the Foley tucked in so it keeps in place.
[22] That's the whole purpose of the balloon; no other
[23] purpose to it.

[24] **Q:** Just so we can clarify this and then move on —

[25] **A:** Yeah.

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[1] **Q:** — the balloon of the Foley catheter is inflated
[2] in the urethra?

[3] **A:** Yes, it's inflated somewhere in the upper part of
[4] the urethra.

[5] **Q:** And that holds it in place?

[6] **A:** Yes.

[7] **Q:** Okay.

[8] **A:** Yeah, as long as it's not inside the bladder
[9] where it would be useless.

[10] **Q:** Okay.

[11] **A:** Now, I want to augment on this. Once it goes
[12] through the urethra, okay, if you inflate it
[13] inside the bladder, will still do the job, okay?

[14] Because imagine now that the balloon — can I do
[15] some more artistic work up here?

[16] **Q:** You know what, let me do — let's just do another
[17] page so we don't mess that up.

[18] **A:** You know, the bladder is here, you know, imagine
[19] here's a part of the catheter, tip of the
[20] catheter, okay, and there's the balloon, right?
[21] And the rest of the Foley here, right? As long
[22] as the balloon can prevent the catheter from
[23] slipping away, it should be okay. So if you
[24] inflate it here, that's appropriate.

[25] **Q:** So you can inflate it inside the bladder then?

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

[5] MR. MULVIHILL: We will mark this
[6] as Exhibit 4.

[7]
[8] (Thereupon, Plaintiff's Exhibit 4
[9] was marked for purposes of identification.)

[10]
[11] Q: Doctor, you also made a drawing which we have now
[12] marked as Exhibit 4 which I think shows the
[13] balloon being inflated really inside the bladder,
[14] correct?

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

[21] Q: Okay.

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

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

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

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

[5] Q: Yes.

[6] And what you're looking at is your report
[7] of —

[8] A: Page 2, sir.

[9] Q: — September 4th?

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

[13] Q: Does the standard of care require a nurse to
[14] measure that?

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

[19] Q: Why is that?

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

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

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

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

[11] A: Afterwards —

[12] MS. McGURK: Objection.

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

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

[22] MS. McGURK: Objection by Tracy
[23] McGurk.

[24] A: It depends what the patient is in the emergency
[25] room for.

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

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

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

[10] A: Not initially, because he had a more serious
[11] problem.

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

[15] A: Yes.

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

[19] A: Yes.

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

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

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

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

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[1] Q: What's the basis of your opinion that the urine
[2] was flowing easily?
[3] A: The fact that the Foley catheter was draining
[4] urine, according to Miss Verlei's record, and
[5] then later on she called the patient's wife to
[6] check on the patient. She put in the record that
[7] she asked the patient if the Foley was still
[8] draining, and Ms. Restivo assured the nurse it
[9] was draining.
[10] Q: Draining what?
[11] A: Fine, beautifully.
[12] Q: Have you read —
[13] A: That was the words.
[14] Q: Have you read Ms. Restivo's deposition?
[15] A: If I noted it in my records, I must have.
[16] Obviously she said something different.
[17] Q: Have you read Ms. Restivo's deposition?
[18] A: Yes, I did.
[19] Q: And what did she say with respect to that
[20] telephone call with the nurse?
[21] A: I have to look at it if I can.
[22] Q: Do you recall as you sit here?
[23] A: You know, I don't. I think, I think probably
[24] something different. I don't know. You tell me
[25] if you have it.

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

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

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

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

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

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

[21] Are you aware of any evidence that in prior
[22] catheterizations he had difficulty voiding?

[23] MS. HARRIS: Objection.

[24] MS. SFISCKO: That's right.

[25] MS. HARRIS: I think that's —

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[1] A: You know, there's really —

[2] MS. SFISCKO: You don't void in
[3] catheterization.

[4] MR. MULVIHILL: I beg your pardon?

[5] MS. SFISCKO: You don't void in
[6] catheterization.

[7] Q: Let me say it again. Getting rid of urine in
[8] catheterizations?

[9] MS. SFISCKO: Draining?

[10] Q: Draining?

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

[15] Q: I'm not worried about the difficulty right now.
[16] I'm worried about the amount that came through
[17] the catheter.

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

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

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[1] opposed to prior ones?

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

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

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

[11] Q: And one of those also is improper placement of
[12] the catheter, correct?

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

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

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

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[1] wrong place. It's not possible.

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

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

[5] Q: Right. So getting back to my original
[6] question —

[7] A: Yeah.

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

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

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

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

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[1] inserted properly, correct?

[2] A: When there's urine noted in the bag, urine
[3] flowing in the bag, the catheter is in the right
[4] place.

[5] Q: Okay. There's no way that it can be partially
[6] inserted properly and get some flow rather than
[7] complete flow, is that what you're telling me?

[8] A: It's unlikely. If you have enough urine in the
[9] bag, it's unlikely.

[10] Q: Well, how much is enough urine in the bag to know
[11] whether it's inserted properly?

[12] A: You have more than the few cc's I mentioned to
[13] you.

[14] Q: All right. What I want to try to do here is make
[15] a distinction between — let me strike that.

[16] On Exhibit 3 and 4, which are your, just
[17] general diagrams, particularly Exhibit 4, you had
[18] given that as an example of it can be inserted
[19] that way and you will get some drainage, but the
[20] concern is, is that the catheter may move up and
[21] down within the bladder, correct?

[22] A: Yeah. The best place for the balloon to be in
[23] and to be tucked in in the neck here, see.

[24] Q: Right.

[25] A: That's the best place. If the balloon's inflated

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[1] in the urethra, you still get some drainage, but
[2] the best place is to be tucked in right here,
[3] because there's a weight to the bag. So the
[4] weight to the bag pull this thing down. Here's
[5] the neck, the thing is tucked in here, there's
[6] the weight, the tube go down, everything's
[7] working beautifully.

[8] Now this can move also, I mean, you know, if
[9] you, when you put the Foley in, Foleys can move.
[10] The patient turn around the wrong way, if he
[11] shake or have any type of sudden movement, it can
[12] move inside the urinary tract and then you have
[13] problems.

[14] Q: How much can it move before you get a problem?

[15] A: Depends where it moved. If it moves downward,
[16] major problems because it can bleed. If it moves
[17] sideways, you may not get any problems, so —

[18] Q: All right. Can the Foley catheter be inserted
[19] and the balloon inflated in such a way that
[20] you're going to get partial drainage and not full
[21] drainage?

[22] A: Not usually. The nurse, as she put, especially
[23] an experienced nurse, as she put the Foley in,
[24] even though you may experience some resistance
[25] initially, you've done this hundred of times, you

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[1] see the urine's just coming out, you're in the
[2] bladder, case closed.

[3] Q: Do you know how many Nurse Verlei had done, an
[4] insertion of a Foley catheter in a male patient
[5] before?

[6] A: Well, she's been a nurse for many years, from
[7] what I understand. So any nurse who have number
[8] of years of experience, she must have put
[9] hundreds or even thousands of Foleys. This is
[10] part of the nursing duties in hospital, and
[11] usually it's a very important portion of their
[12] training because it's such a common procedure.

[13] Q: Doctor, can you define urosepsis for me, please?

[14] A: Urosepsis is infection of the blood via the
[15] urine.

[16] Q: Okay. And can you define — I'm probably going
[17] to mispronounce this, but pyelonephritis?

[18] A: Pyelonephritis is inflammation of the kidneys.

[19] Q: Due to what?

[20] A: Due to bacteria, virus, HIV, other things.

[21] Q: Is it an infection or an inflammation?

[22] A: Pyelonephritis is inflammation that usually
[23] accompany infection.

[24] Q: You had mentioned earlier, doctor, that Nurse
[25] Verlei said that the catheter was draining

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[1] beautifully. Do you know when she made that
[2] entry?

[3] A: I think it was made later on that she, as she was
[4] documenting her encounter.

[5] Q: Do you know how far later on, how far in the
[6] future?

[7] A: No, no.

[8] Q: Would it make a difference to you in relying on
[9] that account that it was draining beautifully to
[10] know exactly when that entry was made?

[11] A: Usually if somebody make a positive comment, it's
[12] not forgotten. So if somebody said to a nurse
[13] this was working beautifully, she'd remember it
[14] today or a few days later. So it doesn't really
[15] make a difference to me. And the best thing is
[16] to write it and then if you — oftentimes you're
[17] busy and you will do it later.

[18] Q: Do you know how long she stayed with the Restivos
[19] on the 19th?

[20] A: No. I know she stayed long enough to make sure
[21] that the Foley was working. As far as number of
[22] minutes, I don't know.

[23] Q: Okay. So in your report when you say on page,
[24] Page 5, the end of the first — actually, the end
[25] of the, the continued paragraph where it says,

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[1] "For urine to be flowing into the bag properly,
[2] the catheter has to be in the bladder."

[3] A: Yes.

[4] Q: That's if you're getting anything more than just
[5] a couple of cc's of urine in the bag?

[6] A: Few cc's, that's right.

[7] Q: But again, there is, there's just no way to
[8] quantify that, correct?

[9] A: It depends on how much the patients have urine in
[10] his system. So if he had drank a lot of fluids,
[11] he have a lot of urine. If he drank few, he had
[12] few.

[13] Q: Is it your opinion in this case that somehow
[14] Mr. Restivo, in his seizures or convulsions or
[15] whatever you want to call them, somehow dislodged
[16] the Foley catheter?

[17] A: It's a possibility, because seizure patients,
[18] usually they lose control and they have
[19] involuntary, jerky, violent like movements, their
[20] extremities and their body, and during the
[21] seizure episodes you can, you can lose a cath,
[22] you know, you can break a tube, you can get an IV
[23] out, you can get a Foley out.

[24] Q: I'm not talking about what's possible. I'm
[25] talking about is it your opinion. Is it your

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[1] opinion in this case that Mr. Restivo somehow,
[2] somehow dislodged or changed the location of the
[3] catheter due to a seizure in this case?

[4] A: My opinion was the catheter eventually was not in
[5] the right position later on; could be from
[6] seizure, could be from movement, it could be from
[7] other factors.

[8] Q: Do you know?

[9] A: Is it seizure for sure? I don't know if it's for
[10] sure or not.

[11] Q: Do you know when that took place?

[12] A: I do not know.

[13] Q: Do you know why it took place in that the
[14] position of the catheter had changed?

[15] A: The ideas, as I told you, it can change for
[16] variety of reasons. I don't know which one can
[17] do it, but I know it was working properly, and
[18] when he went to the emergency room it wasn't. So
[19] between that time and that time, something
[20] happened that moved the catheter.

[21] Q: Okay. When the catheter moves and the balloon is
[22] inflated, would you expect bleeding?

[23] A: Sometimes yes, sometimes no, depending how
[24] violent the movement is. If you rip it off, you
[25] know, some patients do, patient in the psych unit

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

[7]
[8] (Thereupon, a recess was had.)

[9]
[10] Q: Doctor, have you ever treated anyone with
[11] urosepsis or pyelonephritis?

[12] A: Yes, sir.

[13] Q: How frequently?

[14] A: You know, urosepsis, probably few times a month
[15] in the hospital; and pyelonephritis would be
[16] pretty much similar number can be related.

[17] Q: When you're saying the hospital, are you talking
[18] about Barberton or St. Vincent?

[19] A: Both. Mostly Barberton. There I see patients,
[20] lots of these people have complications and
[21] infections and so on.

[22] Q: How large is Barberton?

[23] A: Close to 200 beds, so medium size.

[24] Q: And it has intensive care unit?

[25] A: Oh, sure. Coronary care and intensive care.

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[1] It's a teaching hospital, so —

[2] Q: D.O.'s or M.D.'s?

[3] A: M.D.'s.

[4]
[5] (Thereupon, a discussion was had off
[6] the record.)

[7]
[8] Q: Is there any way to say what normal urine output
[9] for a 78-year-old male would be, or is it
[10] entirely dependent upon what he's drinking and
[11] how his kidneys are functioning?

[12] A: Yeah, yeah, so many factors. Does he have renal
[13] disease, does he have bladder obstruction
[14] problems like Miss Verlei had few times before —

[15] MS. HARRIS: Excuse me?

[16] A: Mr. Restivo, pardon me. Mr. Restivo. How much,
[17] how much, how large the prostate is, does he have
[18] infection, how much fluids has he taken, is the
[19] heart okay, because the heart can affect that,
[20] too. Is the liver okay.

[21] Q: Did Mr. Restivo have any heart problems?

[22] A: Very severe, very severe coronary disease, yeah.

[23] Q: So I think what we have pretty much discussed
[24] here at length is the fact that we know that it's
[25] your opinion, pardon me, that Nurse Verlei

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[1] properly inserted the catheter when she was there
[2] the 19th as evidenced by the fact there was
[3] drainage into the bag, is that —
[4] **A:** Yes, and also the follow-up call that she made to
[5] ensure that there was enough drainage in the bag,
[6] that's correct.
[7] **Q:** Do you know whether or not Mrs. Restivo asked for
[8] another nurse to come out and check it that day?
[9] **A:** I think she made a phone call, I think, later on.
[10] **Q:** Do you know whether a nurse ever came out to
[11] check it?
[12] **A:** I don't think somebody came that night.
[13] **Q:** Okay. And is there any way to know exactly when
[14] the catheter became malpositioned before he got
[15] to the emergency room?
[16] **A:** No.
[17] **MS. HARRIS:** Objection.
[18] **MS. SFISCKO:** What, he said it was
[19] malpositioned in the emergency room?
[20] **MR. MULVIHILL:** I said before he
[21] got to the emergency room, and he says it
[22] in his report.
[23] **MS. HARRIS:** Wait a minute. What
[24] does he say? Can we have the question
[25] back?

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[1] **MR. MULVIHILL:** All right.
[2] **MS. HARRIS:** Are you saying it was
[3] malpositioned at the time he went into the
[4] emergency room? That's the question? I'm
[5] not sure.
[6] **MR. MULVIHILL:** That's what he
[7] said earlier, so I'm just, it's a
[8] follow-up. All right. Let's back up. Let
[9] me just start it all over again.
[10] **Q:** Doctor, I think you said earlier that by the time
[11] he got into the emergency room, the catheter was
[12] malpositioned, correct?
[13] **A:** It was not draining properly is what I'm saying.
[14] **MS. HARRIS:** In the emergency
[15] room?
[16] **A:** Yeah. It was not draining properly.
[17] **Q:** Right. Therefore, it was malpositioned, correct?
[18] **A:** That's a possibility.
[19] **Q:** Okay.
[20] **A:** It may not be draining because there's no urine
[21] to drain. So, so that's a possibility, you know,
[22] that it wasn't draining because it moved or it
[23] was not enough urine to drain.
[24] **Q:** All right. Well, then, let me make sure I
[25] understand what you're saying here. You would

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[1] agree that by the time he got to the emergency
[2] room there was no drainage, correct?
[3] **A:** That's correct.
[4] **Q:** Okay. You're not saying, and maybe this is where
[5] the confusion was, you're not saying it was
[6] malpositioned by the time he got to the emergency
[7] room, just that there was no drainage?
[8] **A:** Yes, I wasn't there.
[9] **Q:** It could have been that he simply had no urine to
[10] pass, correct?
[11] **A:** Yes.
[12] **Q:** Okay. At some point during his hospital stay,
[13] though, can you say that the catheter was
[14] malpositioned?
[15] **A:** He was admitted to the unit, the intensive care
[16] unit because he had the seizures and other
[17] medical problems, and on the 21st, sometime on
[18] the 21st it was noted that the urine output was
[19] poor. And that's when a nurse asked the
[20] urologist, you know, to look at it. And the
[21] urologist was asked to check the catheter. He
[22] deflated the balloon and pushed it little bit
[23] further and then a large amount of urine was
[24] drained.
[25] **Q:** How much?

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[1] **A:** I don't know the exact amount, but it was a large
[2] amount, so I'm assuming, usually more than 200
[3] cc's, you know.
[4] **Q:** Based on that, the doctor repositioning the Foley
[5] catheter, can we say with some certainty that at
[6] some point the catheter was malpositioned?
[7] **A:** The catheter, yes. Probably catheter moved,
[8] that's why it was not draining, that's correct.
[9] **Q:** Do you know when that catheter moved?
[10] **A:** No.
[11] **Q:** Would, and I think I asked this earlier, but
[12] would you expect blood when the catheter moved,
[13] or not necessarily?
[14] **A:** Not necessarily.
[15] **Q:** But your opinion is that Nurse Verlei put it in
[16] properly and then ultimately the doctor, the
[17] urologist had to reposition it. Sometime, in
[18] your opinion, between the point where Nurse
[19] Verlei put the catheter in and it was
[20] repositioned, somehow it had come out of
[21] position, correct?
[22] **A:** It moved, yes.
[23] **Q:** But you just don't know when, correct?
[24] **A:** Yes.
[25] **Q:** And you don't know how much, correct?

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

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- [1] Q: Why is that?
- [2] A: Because the outside portion of the catheter
- [3] beyond the tip of the penis to the bag is
- [4] contaminated. I mean it's open in the air. So
- [5] when you deflate the balloon and you put this
- [6] contaminated portion back in, you bring infection
- [7] right in.
- [8] Q: Did Mr. Restivo have any sort of urine infection
- [9] or bladder infection prior to Dr. Larchian doing
- [10] that?
- [11] A: It was some positive urine cultures, which is not
- [12] surprising because anybody who have a, have a
- [13] chronic and indwelling catheter would have some
- [14] bacteria in the urine. It's almost hundred
- [15] percent of patients who have that.
- [16] Q: Prior to Dr. Larchian inserting the catheter
- [17] further into the bladder, what did the lab at
- [18] Elyria Memorial say was growing?
- [19] A: There was some pseudomonas infection.
- [20] Q: And what is that?
- [21] A: It's a bacteria infection.
- [22] Q: Anything else?
- [23] A: There was other organisms later on, including
- [24] staph, staphylococci gram positive.
- [25] Q: I'm going to stop you. I'm talking about prior

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- [1] to Dr. Larchian inserting it further.
- [2] A: I think pseudomonas was the predominant organism.
- [3] Q: And my question is was there anything else other
- [4] than the pseudomonas?
- [5] A: I have to look at the urine culture to tell you
- [6] that.
- [7] Q: You don't recall as you sit here?
- [8] A: No.
- [9] Q: What about MRSA?
- [10] A: There was MRSA.
- [11] Q: When?
- [12] A: Before.
- [13] Q: Before what?
- [14] A: There was two cultures for MRSA. There would
- [15] have been for the sputum and one for the urine,
- [16] and they were both positive for MRSA. I think I
- [17] can tell you the date, I have it here somewhere.
- [18] MS. SFISCKO: Page 6.
- [19] A: I don't have the exact date, but probably was the
- [20] 21st.
- [21] Q: Well, was it before Dr. Larchian —
- [22] A: It was after.
- [23] Q: — pushed the catheter in?
- [24] A: I think it was after, but I'm not hundred percent
- [25] sure. I have to look at the dates and all that.

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

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[1] Dilantin, if I'm not mistaken, but I don't have
[2] all, the list of the medication names in the
[3] record.

[4] Q: Did he get Activan?

[5] A: Ativan.

[6] Q: Ativan?

[7] A: Yeah. Ativan is not really a seizure medicine,
[8] per se. It's used when people are really hyper
[9] in the, in the acute setting. If somebody's very
[10] wild or, or having a lot of emotion and just
[11] anxious and so on, they use Ativan to calm them
[12] down a little bit. It's not really a long-term
[13] seizure medicine. It's more for acute problem.

[14] Q: Is there any relationship between the medicine he
[15] got and the getting the pneumonia from the
[16] sputum?

[17] A: Anytime you worry about aspiration pneumonia you
[18] have to worry about medications, because if
[19] somebody's out of it, like have a stroke or have
[20] the tube in or is not able to swallow his saliva
[21] properly, you can aspirate, and if you aspirate,
[22] you can get the wrong bacteria in the lungs and
[23] they get infection.

[24] Q: And is there a causal link between the medication
[25] he got at the hospital and the bronchial

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[1] pneumonia?

[2] A: There's no evidence that there was. You know,
[3] people get pneumonia in hospitals all the time,
[4] especially ill people who have multiple chronic
[5] medical problems such as Mr. Restivo.

[6] Q: We talked a minute ago about what his cause of
[7] death was, and what was the cause of death,
[8] doctor?

[9] A: Can I borrow the coroner's report?

[10] MS. SFISCKO: Yeah.

[11] THE WITNESS: Thank you.

[12] MS. SFISCKO: And here's the death
[13] certificate.

[14] Q: And what are you referring to now, doctor?

[15] A: This is the death certificate, and number one
[16] says CVA, which stands for cerebral vascular
[17] accident, the central nervous system disease,
[18] respiratory failure, which is in relationship to
[19] his pneumonia and his failing lungs and his
[20] emphysema, and then the third one, which is CAD,
[21] which stands for coronary artery disease.

[22] Q: Was there an autopsy done?

[23] A: Yes.

[24] Q: And what does the autopsy say?

[25] A: In the autopsy there are seven clinical

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[1] diagnoses. The first one is status post seizure
[2] disorder. Remember, this is diagnosis.
[3] Hypertension, diabetes, respiratory failure,
[4] kidney failure, possible multiple myeloma.

[5] Q: Wasn't that the clinical diagnosis, doctor?

[6] A: Yes, sir.

[7] Q: Why don't you look at Page 4 of the autopsy
[8] report.

[9] A: Sure.

[10] Q: The one sentence paragraph right above the gross
[11] description, you see that? The cause of death is
[12] the result of multisystem organ failure and
[13] sepsis?

[14] A: That's correct.

[15] Q: Okay. So what's the cause of death in
[16] Mr. Restivo?

[17] A: Multisystem organ failure and sepsis. Sepsis was
[18] a clinical diagnosis. There was no positive
[19] blood cultures here, that I'm aware of. So when
[20] I reviewed the records, there was no positive
[21] blood cultures, so the sepsis was clinical
[22] diagnosis.

[23] Q: Were there negative blood cultures?

[24] A: Yes.

[25] Q: What does that indicate to you about sepsis?

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[1] A: It indicated that there was no bacteria in the
[2] blood. It was negative. Took some blood
[3] samples, tested it, and it was negative. The
[4] cultures that I reviewed was negative blood
[5] cultures. So when people make a diagnosis of
[6] sepsis, it's a clinical diagnosis, not definitive
[7] diagnosis.

[8] Q: Is it always a clinical diagnosis?

[9] A: No.

[10] Q: Can you not diagnose sepsis based on cultures?

[11] A: Well, it's unlikely. I mean usually people, when
[12] they use the term sepsis, they refer to a blood
[13] infection, and I did not see records here of
[14] evidence of positive blood cultures. I saw
[15] evidence of sputum from the lungs that was
[16] positive and from the urinary tract, in the
[17] urine.

[18] Q: Okay. Are you telling me that the autopsy report
[19] that says the cause of death is a result of
[20] sepsis is incorrect?

[21] A: I didn't say it is, I didn't say that at all. I
[22] did not.

[23] Q: That's what I'm trying to get you to reconcile
[24] the position there was no positive blood —

[25] A: No.

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

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[1] that killed him?
[2] MS. HARRIS: Objection.
[3] MS. SFISCKO: Yeah.
[4] A: I do not have an opinion.
[5] Q: Is it improper to inflate the Foley catheter in
[6] the prostatic urethra?
[7] A: Is it improper to inflate it there?
[8] Q: Yeah.
[9] A: Yeah, it's improper.
[10] Q: It has to be above the urethra?
[11] A: Yes.
[12] Q: Pardon me. It has to be above the prostate?
[13] A: Yes, has to go through this area, then you can
[14] inflate it and have it positioned.
[15] Q: I want you to assume just for a second that Nurse
[16] Verlei inflated the catheter in the prostatic
[17] urethra. If she did that and he wasn't drained
[18] for about another 53 hours, you know, two days
[19] and five hours, what impact would that have on a
[20] patient like Mr. Restivo?
[21] MS. SFISCKO: Objection.
[22] MS. McGURK: Objection.
[23] A: You ask me to assume — again, it's a fact, the
[24] fact that she drained urine. How can I assume
[25] that? I mean, she's writing that the patient,

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

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

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[1] cultured and they found the pseudomonas and the
[2] MRSA's. Can you tell me whether or not that urine
[3] backed up into the kidney to create the condition
[4] of pyelonephritis?

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

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

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

[18] Q: Okay.

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

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

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

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

[3] MS. HARRIS: Objection to the term
[4] urosepsis.

[5] A: Sir —

[6] MS. SFISCKO: Yeah, I object.

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

[9] Q: Okay.

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

[14] Q: I beg your pardon?

[15] A: I mean, I answered you five times the same
[16] question, so —

[17] Q: What do you mean you have things to attend to?

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

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

[25] MS. SFISCKO: The time was 5:30.

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[1] A: I answered the question there was no positive
[2] blood cultures. There was no, there was no
[3] positive blood cultures, so the diagnosis of
[4] urosepsis was based on clinical diagnosis.
[5] That's all I said.

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

[8] A: There was no objective evidence that there was
[9] infection in the blood.

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

[12] A: Yes. Yes, you can.

[13] Q: Okay. And I just have a couple more questions,
[14] doctor.

[15] A: Sure.

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

[18] A: Yes.

[19] Q: What specifically, what difficulty did she have?

[20] A: Insertion, advancing the catheter.

[21] Q: How about expanding the balloon?

[22] A: Usually you don't get difficulty with that.

[23] Usually the most difficulty you get is when you

[24] insert it because the catheter is elastic, you

[25] know, structure and it goes through the penis.

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[1] It, if there's something inside that's making the
[2] lumen or the hole narrow, it doesn't go as
[3] smooth, so you have to work your way through it.

[4] Now, once you, once you get to the right
[5] place and urine drains, then you inflate the
[6] balloon. So most likely, you know, she had
[7] difficulty with insertion.

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

[10] A: I don't believe she did.

[11] Q: Okay. Do you believe that Mr. Restivo had the
[12] infection that, of the pseudomonas and MRSA's
[13] prior to Nurse Verlei coming out to see
[14] Mr. Restivo on the 19th?

[15] A: I do not know the answer to that.

[16] MR. MULVIHILL: Okay. I don't
[17] have any other questions. Thank you,
[18] doctor.

[19] MS. HARRIS: Doctor, do you have a
[20] couple minutes?

[21] THE WITNESS: Sure. Absolutely.

[22] MS. HARRIS: I only have a couple
[23] questions.

[24]

[25]

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CROSS-EXAMINATION OF AHMED ELGHAZAWI

BY MS. HARRIS:

- [1] **Q:** I only have a few questions for you. I
[2] represent, as you know, the emergency medicine
[3] physicians —
[4] **A:** Sure.
[5] **Q:** — at EMH, and as I understand it, you have no
[6] criticisms of the care rendered or the treatment
[7] rendered by the emergency medicine physicians
[8] when he was taken to the hospital, is that
[9] correct?
[10] **A:** Yes, ma'am.
[11] **Q:** You have no criticism?
[12] **A:** No, ma'am.
[13] **Q:** Okay. Doctor, just so I'm clear, when, after he
[14] was admitted, Mr. Restivo was admitted to the
[15] hospital and placed on a regular floor, he had
[16] urine drainage for at least the first shift on
[17] the regular floor?
[18] **A:** Yes.
[19] **Q:** Do you agree with that?
[20] **A:** Yes.
[21] **Q:** Okay. Can we then agree that if it was draining
[22] on the floor, the catheter was, had not been
[23] dislodged previously during the time he was in

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- [1] the emergency room?
[2] **A:** Most probably not.
[3] **Q:** Okay. And there's nothing that you saw in the
[4] emergency medicine room report that the catheter
[5] was dislodged, correct?
[6] **A:** No, there was no, there was no evidence of that.
[7] **Q:** And can we agree that if the emergency medicine
[8] doctor, Dr. Carroll, is examining this patient
[9] and touching the abdomen, that she would be able
[10] to observe if the catheter is out too far or
[11] inserted, not inserted far enough in?
[12] **MR. MULVIHILL:** Objection.
[13] **A:** We can agree to that.
[14] **MS. HARRIS:** Thank you. Nothing
[15] further.
[16] **MS. SFISCKO:** Anything on the
[17] phone?
[18] **MS. MCGURK:** No, I have no
[19] questions, but I would like a copy of the
[20] transcript.
[21] **MS. SFISCKO:** Okay. Anything
[22] else?
[23] **MR. MULVIHILL:** Just one question,
[24] doctor.
[25] **THE WITNESS:** Yes.

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FURTHER CROSS-EXAMINATION OF

AHMED ELGHAZAWI, M.D.

BY MR. MULVIHILL:

- [1] **Q:** I thought we covered it, but I got a little
[2] confused, so I apologize for the repetition.
[3] **A:** That's all right.
[4] **Q:** Can you tell me when the Foley catheter became
[5] malplaced or maladjusted or dislodged?
[6] **A:** It's sometime between the 19th and the 21st.
[7] **Q:** And you can't be any more specific than that?
[8] **A:** I cannot.
[9] **Q:** Okay.

FURTHER CROSS-EXAMINATION OF

AHMED ELGHAZAWI, M.D.

BY MS. HARRIS:

- [1] **Q:** But, doctor, there's nothing to suggest if the
[2] catheter was viewed that this catheter was
[3] dislodged at the time of the emergency room
[4] department visit, correct?
[5] **A:** No.
[6] **Q:** So most probably, more probably than not, it
[7] wasn't dislodged at the time she was in the, he
[8] was in the emergency room?

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MR. MULVIHILL: Objection.

A: Yes.

MS. HARRIS: Thank you.

THE WITNESS: Thank you.

AHMED ELGHAZAWI

[1]

[2]

CERTIFICATE

[3]

[4] The State of Ohio,) SS:

County of Cuyahoga.)

[5]

[6]

I, Katherine A. Koczan, a Notary Public

[7] within and for the State of Ohio, authorized to

administer oaths and to take and certify

[8] depositions, do hereby certify that the

above-named witness was by me, before the giving

[9] of their deposition, first duly sworn to testify

the truth, the whole truth, and nothing but the

[10] truth; that the deposition as above-set forth was

reduced to writing by me by means of stenotypy,

[11] and was later transcribed into typewriting under

my direction; that this is a true record of the

[12] testimony given by the witness; that said

deposition was taken at the aforementioned time,

[13] date and place, pursuant to notice or

stipulations of counsel; that I am not a relative

[14] or employee or attorney of any of the parties, or

a relative or employee of such attorney or

[15] financially interested in this action; that I am

not, nor is the court reporting firm with which I

[16] am affiliated, under a contract as defined in

Civil Rule 28(D).

[17]

IN WITNESS WHEREOF, I have hereunto set my

[18] hand and seal of office, at Cleveland, Ohio, this

____ day of _____, A.D. 20____.

[19]

[20]

[21] Katherine A. Koczan

Notary Public, State of Ohio

[22] 1750 Midland Building, Cleveland, Ohio 44115

My commission expires August 27, 2006

[23]

[24]

[25]

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