# **Original Transcript**

## IN THE COURT OF COMMON PLEAS CUYAHOGA COUNTY, OHIO

Michelle R. Freeman, et al.,

#### Plaintiffs,

vs.

Case No. 490991

Cardiovascular Clinic, et al.,

Defendants.

## **TELEPHONIC DEPOSITION OF**

#### BARRY S. GEORGE, M.D.

September 1, 2004 6:03 p.m.

1330 Coschocton Avenue Mount Vernon, Ohio

Laurie A. Braverman Professional Reporter





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1	APPEARANCES
2	ON BEHALF OF THE PLAINTIFFS MICHELLE R. FREEMAN, ET
3	AL.:
4	BECKER & MISHKIND CO., L.P.A.
5	JOHN W. BURNETT
6	ATTORNEY AT LAW
7	VIA TELEPHONE
8	134 Middle Avenue
9	Elyria, Ohio 44135
10	
11	ON BEHALF OF THE DEFENDANTS DR. JAMES SECHLER, DR.
12	RAJU MODI AND DR. CHRISTINE ZIRAFI:
13	BUCKINGHAM, DOOLITTLE & BURROUGHS, L.L.P.
14	CHRISTOPHER L. PARKER
15	ATTORNEY AT LAW
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1	APPEARANCES CONTINUED
2	ON BEHALF OF THE DEFENDANTS PARMA GENERAL
3	COMMUNITY HOSPITAL AND PARMA GENERAL COMMUNITY
4	HOSPITAL HOME HEALTH CARE.
5	WESTON, HURD, FALLON, PAISLEY & HOWLEY, L.L.P.
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1	STIPULATIONS
2	It is stipulated by and between counsel for the respective
3	parties herein that this deposition of BARRY S. GEORGE, M.D., a
4	Witness herein, called by the Defendants under the statute, may be
5	taken at this time and reduced to writing in stenotypy by the Notary,
6	whose notes may thereafter be transcribed out of the presence of the
7	witness; that proof of the official character and qualifications of the
8	Notary is waived.
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1	Telephonic Deposition of Barry S. George, M.D.
2	September 1, 2004
3	BARRY S. GEORGE, M.D., being by me
4	first duly sworn, as hereinafter certified,
5	deposes and says as follows:
6	EXAMINATION
7	BY-MR.BURNETT:
8	Q. Doctor, I'm John Burnett. I
9	represent the plaintiffs in this case. Would
10	you tell us your full name, please?
11	A. Barry Scott George.
12	Q. Sir, do you understand that this
13	is a question and answer session under oath?
14	A. Yes, I do.
15	Q. One of my goals here is to walk
16	away from this deposition with a full
17	understanding of your opinions in this case
18	as well as each and every basis for the
19	opinions. So as we go through this, if for
20	some reason I have cut you off and not let
21	you answer fully, will you tell me that so
22	you can go ahead and give me your full
23	answer?
24	A. Yes, I will.
25	Q. Also, if you have not understood



	6
1	one of my questions or I have not stated it
2	artfully, would you tell me? And I'll do my
3	best to rephrase it.
4	A. Yes, I will.
5	Q. Sir, if you answer my question,
6	I'm going to conclude that you have
7	understood it and have given me your best
8	answer. Is that fair?
9	A. Yes.
10	Q. Okay. You know, why don't you
11	just give me a quick thumbnail sketch of your
12	educational background starting with college
13	through medical school and residency?
14	A. I finished high school in 1972. I
15	received a bachelor of engineering degree with
16	a specialty in biomechanical and biomedical
17	engineering from Youngstown State University in
18	1976. I went on to Ohio State Medical
19	School, and I received a doctor of medicine
20	degree from Ohio State Medical School in
21	1979.
22	Q. Okay.
23	A. After I finished that, I did my
24	internship for one year at Riverside Methodist
25	Hospital in Columbus.



7 1 Then I did a two-year residency in 2 internal medicine at Riverside Hospital. This 3 was followed by a two-year fellowship in 4 cardiology at Riverside Hospital in Columbus 5 as well as Ohio State University Hospitals. 6 This was then followed by an additional vear 7 at the University of California of San 8 Francisco in interventional cardiovascular 9 medicine. 10 Ο. Tell me about your practice as it 11 Break it down for me. is today. Are you 12 an interventionalist? 13 My practice is primarily in Α. 14 clinical cardiology as well as interventional 15 cardiovascular medicine which basically 16 involves balloon angioplasty and staining of 17 coronary arteries, carotid arteries, leq 18 arteries, kidney arteries; pretty much anything 19 to do with clinical cardiovascular medicine. 20 How do you spend your 0. Okay. 21 professional time? Is more than 50 percent 22 of it involved in the clinical practice of 23 cardiology? 24 Α. Yes. 25 Q. When you say clinical cardiology



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1	and interventional cardiology, tell me what
2	the difference is.
3	A. Well, I look at interventional
4	cardiology as we sometimes refer to it in the
5	vernacular, a lab rat. We're in the
6	cardiovascular lab all the time doing
7	angioplasty-type procedures. That is what I
8	consider interventional cardiology. Clinical
9	cardiology is the care of patients on an
10	outpatient setting as well as in the hospital
11	outside of the cardiac cath lab for
12	cardiovascular disorders.
13	Q. With regard to your role as a lab
14	rat as you put it, what percentage of your
15	time is spent doing that?
16	A. I'm in the cardiac cath lab, I
17	would say, probably about 80 percent of my
18	time.
19	Q. Okay. And then how much, then,
20	percentage-wise do you spend in the clinical
21	practice?
22	A. Outside of the cardiac cath lab,
23	probably 20 percent to as high as 35 percent
24	is spent caring for patients on an outpatient
25	basis or in hospital consultations.

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1	Q.	Okay. Do you care for patients in
2	a capacity	as an internal medicine doctor?
3	Α.	Very little.
4	Q .	Can you give me a percentage?
5	Α.	Less than 5 percent.
6	Q.	Okay. You're licensed in Ohio?
7	Α.	Excuse me?
8	Q.	You're licensed in Ohio, sir?
9	Α.	Yes.
10	Q.	Anywhere else?
11	Α.	I'm also licensed in the state of
12	Florida.	
13	Q.	Okay. I take it in neither of
14	those state	es has your license ever been
15	suspended,	revoked, or called into question.
16	Α.	That is correct.
17	Q.	In both of those states with
18	regard to	your privileges, have any of those
19	privileges	ever been suspended, revoked, or
20	called into	o question?
21	Α.	No.
22	Q.	To your knowledge, has there been
23	a complaint	t filed with either of the medical
24	boards in	Florida or Ohio?
25	Α.	No.



10 1 Ο. Prior lawsuits, have you been a 2 defendant before? 3 MR. PARKER: Objection. Δ Go ahead. 5 Α. I have been a defendant before. 6 Yes. 7 ΒY MR. BURNETT: 8 Q. Can you please tell me how many 9 times? 10 Α. To my knowledge, two times. 11 0. Okay. Let's talk about the first 12 one. Can you tell me when that occurred, 13 what the general allegations were, sir? 14 MR. PARKER: Objection. 15 Α. It was, I believe, in 1988, aive 16 couple years; but I'm pretty sure take a or 17 it was 1988. It was in regards to a patient 18 who had aortic coarctation in which Ι 19 performed a balloon angioplasty procedure on 20 the aorta. 21 BY MR. BURNETT: 22 Q. Okay. Did the patient die? 23 Α. No. 24 Q. Okay. What was the result of that 25 suit? Did you pay any money? Did you qo

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	. 11
1	to trial? What happened?
2	MR. PARKER: Objection.
3	A. I was vindicated at trial.
4	BY MR. BURNETT:
5	Q. A defense verdict.
6	A. That is correct.
7	Q. Let's talk about the next one,
8	please, sir.
9	A. The next one was a patient that I
10	was involved in the care after my partner had
11	performed a coronary angioplasty who
12	subsequently developed a septic arthritis in
13	the knee about two weeks after the procedure
14	was performed. And allegedly, this was due
15	to the groin insertion site and infection
16	from there in that it was not adequately or
17	appropriately diagnosed and deviated from the
18	standard of care.
19	Q. What happened with the patient?
20	A. The patient had no long-term
21	sequelae, had to have a drainage procedure
22	performed on the septic arthritis of the
23	knee.
24	Q. Okay. Did that go to trial?
25	A. Yes.



12 1 Q. Okay. And what happened there? 2 Α. The defense was vindicated on that З as well. 4 So another defense verdict for you. Ο. 5 That is correct. Α. 6 Q. To your knowledge, are there any 7 suits outstanding against you now? 8 Α. To my knowledge, there are none. 9 Ο. You haven't received any 180-day 10 letters recently? 11 Α. No. 12 MR. PARKER: Objection. 13 MR. BURNETT: ΒY 14 Ο. Okay. Do you know what that is, 15 the 180-day letter? 16 I'll explain it. It's a letter 17 they send where they say we're contemplating 18 bringing an action against you. We're 19 extending the statute by 180 days. 20 Α. Yes, I have not -- To my 21 knowledge, I have not seen any of those 22 recently. 23 Ο. With regard to lawsuits, let me 24 ask the question a little bit differently. 25 To your knowledge, has any professional group



13 1 or hospital with which you've been associated 2 been sued and you not named but your conduct -3 nevertheless called into question? 4 MR. PARKER: Objection. 5 No. Α. 6 ΒY MR. BURNETT: 7 0. Okay. You do medical legal work 8 apparently. 9 Α. Yes, I do. 10 How long have you been doing it? 0. 11 Α. I've been doing medical legal work 12 would say, about 12 to 14 years. for, I 13 Q. Okay. How did you get involved in 14 it? 15 Α. asked by an attorney to I was 16 opine on a case. 17 0. Okav. And you started doing it, 18 take it you enjoy it on some level. and I 19 That's correct. Α. Yes. 20 Okav. What, if you can, Ο. looking 21 back over the years, what percentage of your 22 medical legal work is reviewing for the 23 defense; and what percentage is for the 24 plaintiffs? 25 Α. My review - -And I think it's 



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1	Sometimes, when the networking occurs, it
2	skews it somewhat. But I would say probably
3	75 to 80 percent of the cases that I have
4	reviewed are for the defense; and 20, 25
5	percent are for the plaintiff.
6	Q. All right. Do you advertise your
7	services as a medical legal expert?
8	A. No, I don't.
9	Q. So it's just pretty much word of
10	mouth.
11	A. Correct.
12	Q. Have you ever testified at trial
13	for a plaintiff?
14	A. No, I have not.
15	Q. Okay. Have you ever testified at
16	trial for a defendant?
17	A. Yes.
18	Q. How many times, please?
19	A. Three times.
20	Q. Okay. Now, by the way, in the
21	cases in which you reviewed over the years,
22	have any involved issues similar to the ones
23	in this case?
24	A. In regards to the cardiovascular
25	illnesses, yes. In regards to the other



	15
1	noncardiac illnesses, no.
2	Q. Okay. And I'll get into this in
3	more detail, but what was the likely cause of
4	death in this case?
5	A. Well, that's always up for
6	speculation. But my thoughts and opinions in
7	regards to the cause of death is that this
8	was not necessarily related to hyperkalemia
9	and was more than likely related to the
10	respiratory embarrassment from a mucous plug
11	coupled with the fact that I believe despite
12	appropriate therapy this patient succumbed to
13	sepsis.
14	Q. In any of the cases you've
15	reviewed, have you opined that the cause of
16	the patient's death was the same as this
17	patient's death?
18	A. No.
19	Q. Okay. By the way, have you done
20	medical legal review for Buckingham, Doolittle
21	in the past?
22	A. Yes, I have.
23	Q. How about Ron Wilt or Paul
24	Dzenitis? Have you worked with them in the
25	past as well?



16 1 Α. can't recall for sure whether Ι 2 I've done work for Paul or not. I know I've 3 done it for Buckingham, Doolittle; but Т 4 don't know if it was in particular for Paul. 5 Ο. Can we talk about what's in your 6 file, please? 7 Α. Yes. 8 Q. Did you bring it with you, sir? 9 No, I did not. Α. 10 Ο. Okav. Did you make any notes in 11 your review of this case? 12 Α. The only notes I made on my chart 13 is that basically on the cover sheet of 14 information that I was offered I iust had 15 scribbled a very short note that said didn't 16 die of hyperkalemia. 17 Ο. Okav. Do you remember what was in 18 your chart? Can you recite it to me from 19 I mean what was in your file. memory? 20 Α. You mean what all materials did I 21 review? 22 Q. Yes, sir. 23 I reviewed the hospital charts that Α. 24 were from Parma Hospital, the admission prior 25 to the patient's demise.



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1	Q. All right.
2	A. I also reviewed the charts of the
3	hospitalization in which the patient expired.
4	I reviewed the medical records of the
5	cardiovascular clinic, Volume 1 and Volume 2.
6	I also reviewed the opinion letters of the
7	plaintiffs' expert, Dr. Crane.
8	Q. Okay.
9	A. I also had reviewed You know, I
10	can't tell you; but there were numerous
11	depositions.
12	Q. All right.
13	A. And I've reviewed quite a few of
14	those.
15	Q. Did you review any other defense
16	reports?
17	I understood Or maybe I'm
18	thinking of Dr. Armitage. Did you review his
19	report or his deposition?
20	A. Yes, I did.
21	Q. Okay. Can you think of anything
22	else you reviewed?
23	A. I reviewed the opinions of Dr.
24	Michael Yaffe.
25	Q. Okay. Anybody else?



18 1 Α. Not that I can recall off the top 2 of my head. 3 0. Okav. Did you do any research in 4 preparation for authoring your report in this 5 case? 6 Α. No. 7 0. How much do you charge an hour to 8 review? 9 Α. I charge \$500 an hour. 10 Ο. How about to testify? 11 Α. The same. 12 0. Even at trial? 13 Α. Yes. If I go to trial as an 14 expert witness, it's \$500 an hour, minimum 15 eight hours. 16 Q. All right. Are you planning on 17 testifying at this trial when it proceeds 18 later this year? 19 Α. If asked to do so, I will. 20 Ο. Okay. Would you please define 21 hyperkalemia for me? 22 Α. Hyperkalemia is an elevation of the 23 serum potassium above what the usual, 24 conventional laboratory numbers. They are 25 slightly different depending on which



	19
1	laboratory analysis and which lab is
2	conducting the test. But it's usually if the
3	serum potassium level was above 5.2 or 5.3 or
4	thereabouts.
5	Q. In this case was she above 5.2 or
6	5.3?
7	A. In the later part of her illness
8	in the second admission, her potassium was
9	elevated. Yes.
10	Q. Okay. And it was above 5.2,
11	wasn't it?
12	A. Yes, it was.
13	Q. Okay. By the way, the patients
14	you've treated over the years when you've
15	evaluated them, have you ever had C. diff
16	colitis on your differential?
17	A. Yes.
18	Q. Okay. In those circumstances, did
19	you treat the C. diff empirically? Did you
20	suspect the C. diff empirically, or did you
21	wait for the result of a stool sample?
22	A. The way my practice is, I
23	basically am more so a cardiologist than an
24	internist. And as I mentioned before, I
25	practice Only about 5 percent of what I



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1	do is internal medicine. And in a patient
2	such as this patient who perhaps was a
3	patient under my care for a cardiovascular
4	disorder that comes in with her signs and
5	symptoms, she would be very quickly referred
6	to an infectious disease specialist or a
7	gastroenterologist.
8	Q. What if the patient came in, you
9	know, in the evening like this patient did
10	and they couldn't see an ID specialist until
11	the next day? Would you have nevertheless
12	treated the suspected C. diff colitis
13	empirically?
14	A. Well, in my institution, that's not
15	the case. We just don't deal with this.
16	Like I say, if I had a patient who came in
17	that I had been, that had been a cardiac
18	patient of mine who came in with a main
19	complaint of diarrhea, nausea, vomiting, fever,
20	that type of thing, the communication with
21	the emergency room physician would be one
22	such that this patient would be referred to
23	either an internist or an infectious disease
24	specialist. And I then would be a consultant
25	for her cardiovascular situation during her

	. 21
1	hospitalization.
2	Q. Have you ever ordered Flagyl to
3	cover suspected C. diff empirically?
4	A. Not in the last 15 years.
5	Q. Okay. Did you do it before that?
6	A. Yes.
7	Q. Okay. Why the difference in the
8	15 years? Why do you say that?
9	A. Because where I practice, there are
10	enough specialists and primary care physicians,
11	what we call hospitalists who are internal
12	medicine specialists, basically, who take care
13	of people in the hospital full time that my
14	practice of internal medicine has become less
15	and less and less to the point where I
16	mentioned before that it's probably no more
17	than 5 percent of what I do.
18	Q. But if you saw a patient coming in
19	with a two or three-day history of diarrhea
20	with co-morbid conditions such as COPD and
21	some heart disorders and you have on your
22	differential C. diff colitis and it was in
23	the evening, can we agree more likely than
24	not you would treat that empirically until an
25	internist would be able to see the patient?



	22
1	MR. PARKER: Objection.
2	A. No. Quite frankly, I wouldn't.
3	BY MR. BURNETT:
4	Q. Okay. Tell me why.
5	A. Because I haven't treated C.
6	difficile colitis for well over 15 years.
7	And not that I'm not board certified internal
8	medicine which I am, but I have not treated
9	a case of C. difficile colitis for over 15
10	years; and I'm sure that there are things
11	that have changed over the last 15 years that
12	I really don't consider myself to have the
13	expertise to do so. In my cardiac patient's
14	best interest, I would refer them on to an
15	expert who does have that expertise.
16	Q. If this was your patient and she
17	was admitted under the same circumstances as
18	she was with Dr. Zirafi, can we agree that
19	you would have insisted that a internal
20	medicine specialist see the patient that
21	evening rather than waiting until the next
22	evening then?
23	MR. PARKER: Objection.
24	A. I'm not sure that I would
25	necessarily insist on an internal medicine



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1	specialist seeing at that point in time. I
2	think probably if I felt comfortable with the
3	emergency room physician and I felt they were
4	competent, that sort of thing, that probably
5	would be sufficient for me. I would
6	certainly make sure that contact was made
7	with an internal medicine specialist that
8	evening and then pretty much leave it up to
9	them.
10	BY MR. BURNETT:
11	Q. And what would you tell the
12	internal medicine specialist that evening?
13	What would you convey in this case?
14	A. I would say: Look. This is a
15	patient of mine who has a, you know, chronic
16	cardiovascular disease, had a mitral valve
17	replacement, has a low ejection fraction, has
18	significant pulmonary disease, none of which
19	are the presenting problem. It's acute
20	diarrhea, leukocytosis. It appears to be
21	some sort of a GI or infectious problem which
22	I don't feel comfortable taking care of, and
23	I think you need to.
24	Q. Very good. And then you would
25	leave it up to that internal medicine

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	24
1	specialist to decide whether he or she needed
2	to see the patient that evening or the next
3	day; correct?
4	A. That's the way I would practice.
5	Yes.
6	Q. Was that done in this case?
7	A. It would be appear to me that the
8	patient was brought into the hospital, was
9	admitted under the care of a cardiologist
10	after correspondence with the emergency room
11	physician. The clinical cardiologist who
12	initially saw the patient, it would appear at
13	least to my perusal of the chart, practices a
14	lot more clinical cardiology and probably a
15	fair amount more internal medicine than I do
16	and felt comfortable with admitting to their
17	service and proceeding with appropriate care.
18	Q. Okay. You know, a lot of these
19	questions beg, my questions to you kind of
20	beg this question. Are you going to testify
21	as to standard of care in this case?
22	A. I am not going to testify in
23	regards to the standard of care of whether
24	appropriate antibiotic therapy was rendered.
25	I don't feel I have the expertise to do



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1	that. My main testimony is in regards to
2	the presumed cause of death as well as the
3	cardiovascular prognosis for this patient.
4	Q. Well, since you're a cardiologist
5	and you practice some internal medicine and
6	Dr. Zirafi's a cardiologist, I mean, we know
7	she did not call an internal medicine
8	specialist that evening and speak with them
9	about the presenting symptoms and the concern
10	about the C. diff colitis. Was that a
11	deviation from the standard of care in your
12	mind?
13	MR. PARKER: Objection.
14	A. I really do not feel that I have
15	the expertise to render an opinion on that
16	particular situation.
17	BY MR. BURNETT:
18	Q. Okay. By the way, were you asked
19	to review this with an eye toward whether
20	there was a standard of care violation or
21	not?
22	A. I was asked to review the chart in
23	regards to the cause of death and the future
24	cardiovascular prognosis primarily.
25	Q. Okay. Do you think, though, that



	26
1	she was more likely than not sick enough with
2	C. diff Friday evening to be treated
3	empirically?
4	MR. PARKER: Objection.
5	A. Again, I'm not sure I have the
6	expertise to render an opinion about that.
7	BY MR. BURNETT:
8	Q. All right. In your practice, have
9	you had patients who actually had
10	pseudomembranous colitis?
11	A. Yes.
12	Q. Okay. Have any of them ever had
13	a sudden cardiac arrest?
14	A. I don't think so; but it's, you
15	know, I hesitate to say that it's not
16	occurred because we take care of a lot of
17	heart patients and see a lot of cardiac
18	arrests. So it would be really hard for me
19	to say that it's not happened, but I don't
20	specifically recall a case where that has
21	occurred.
22	Q. Is it fair to say that high
23	potassium levels and bicarbonate levels can
24	cause a sudden cardiac arrest?
25	A. Well, high potassium levels can



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1	cause a cardiac arrest. As a general rule,
2	the high potassium level associated with a
3	low bicarbonate level and not a high
4	bicarbonate level, it is more common for a
5	low bicarbonate level to cause a cardiac
6	arrest than a high bicarbonate level.
7	Q. Did she have a low bicarbonate
8	level before her death in this case?
9	A. Yes, she did.
10	Q. And how low? Can you articulate
11	that for me, put a number on it?
12	A. Well, her tank was about two-thirds
13	full, shall we say; in other words, at the
14	lower limits of normal for bicarbonate levels.
15	She had about two-thirds of what you were
16	supposed to have
17	Q. Okay.
18	A if I can explain it in
19	layperson's terms.
20	Q. So it's fair to say that in
21	general the high potassium level you saw in
22	this patient and the low bicarbonate level
23	you saw in this patient can, in general,
24	cause a sudden cardiac arrest.
25	A. At the levels that she had of



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1	bicarbonate level and potassium, it is
2	unusual; but it can on occasion.
3	Q. Okay. Why do you say it's
4	unusual, though?
5	A. Well, in this patient, the
6	potassium level basically at the terminal
7	event was, I believe, 7.4, 7.5; thereabouts.
8	I'd have to double-check the charts to be
9	sure which I don't have in front of me right
10	now. But I'm pretty sure I'm close to the
11	right number there. The day before, I think
12	it was 6.0.
13	And those numbers and based on my
14	experience in cardiovascular medicine over the
15	last 24 years, that doesn't cause
16	cardiovascular arrest. Ordinarily, we would
17	see blood potassium levels above 8 where you
18	really start seeing changes to the
19	electrocardiogram and significant rhythm
20	disturbances.
21	Q. Okay. What about the bicarbonate
22	level? Was that sufficient, though?
23	A. The bicarbonate level of 19, if I
24	recall is about what it was, in and of
25	itself would be highly unusual for that to



	29
1	cause a cardiac arrest.
2	Q. Is it fair to say toxins from
3	sepsis syndrome can cause a cardiac arrest?
4	A. I think that's a fair assumption.
5	Q. Okay. By the way, on the patients
6	you've had over the years who had C.
7	difficile colitis, did any of them die?
8	A. Not of the C. difficile colitis.
9	Q. Yes. And I guess that was my
10	question. I'm sure a lot of them die,
11	but
12	A. Well, thanks a lot.
13	Q. And I didn't mean it like that.
14	A. I know.
15	Q. Did any of them die from the
16	complications of the C. diff colitis, though,
17	such as And I may have asked this
18	earlier. If I did, I hope you'll excuse me
19	such as a cardiac arrest from the sepsis
20	syndrome?
21	A. Well, as you're aware, C. difficile
22	colitis can cause diarrhea, nausea, vomiting,
23	dehydration. All of those things when
24	coupled with any patient who has
25	cardiovascular disorders or any other chronic



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30 1 cardiopulmonary diseases certainly can 2 contribute to a sudden death event. 3 All right. Did you read Dr. Q. 4 Modi's deposition transcript? 5 Α. I believe I did, but it's been a 6 long time since I've read it. 7 Ο. I'm going to read to you from Page 8 24 and ask if you agree with this or not. 9 And I'm starting at Line 7. I asked Dr. 10 Modi: More than likely than not, her death 11 result of sepsis? was a 12 Answer: As we had suspected. 13 Right. 14 Question: And more likely than 15 sepsis results from the C. diff not, the 16 colitis; correct? 17 Answer: Probably. 18 Do you agree with that? 19 Α. Within my realm of expertise as an 20 internal medicine specialist who has not been 21 practicing internal medicine for a long time 22 and a cardiologist, I would agree with it. 23 Ο. Okay. But you don't agree with 24 Dr. Crane's opinion as to the cause of death; 25 correct?



	31
1	A. I would have to have his letter,
2	opinion letter here. Bear with me a second
3	here. I think we have it. If I could
4	review it or if you could paraphrase his
5	opinion, I could more accurately answer that
6	question.
7	Q. You wanted to put me on the spot,
8	didn't you?
9	A. No. Hang on a minute. I've got
10	the letter in front of me. Just bear with
11	me 30 seconds here.
12	Q. Okay. I moved to the front of
13	the office where our phone is. I'm at the
14	front desk rather than at my desk. And if
15	you need me to, I'll go back and get it if
16	you can't find it.
17	A. No. I have the letter in front
18	of me. I'm looking at it right now.
19	Q. Okay. Take a moment to read it.
20	A. As best I can gather from Dr.
21	Crane's letter, it doesn't specifically address
22	it. But his opinion basically is that the
23	cause of the patient's demise was due to
24	delayed appropriate antibiotic therapy for the
25	C. difficile colitis.



32 1 Q. And I think additionally if you 2 look at his deposition transcript, he says 3 that a combination of the high potassium 4 levels, the bicarbonate levels, and the toxins 5 from the sepsis syndrome caused an arrhythmia 6 from which she expired. 7 Do you agree with that? 8 Α. Not necessarily so. 9 Ο. Okav. That's what we need to get 10 to. 11 Α. Yes. 12 Q. Can you please tell me each and 13 every reason why you don't agree with that? 14 Well, everybody dies of a cardiac Α. 15 arrhythmia. 16 Ο. Okay. 17 Α. I mean, let's get that right out 18 in the open to begin with. I mean, your 19 heart stops beating. Either ít just ceases 20 to beat and have rhythm, or you develop a 21 rapid rhythm that then degenerates to what we 22 call a fibrillatory rhythm; and the heart 23 ceases to function as a pump. 24 Basically, that's pretty much how 25 everybody dies, even a person who, say, is in



	33
1	a multiple-trauma accident who bleeds to
2	death. What happens is is that by losing
3	all their blood, finally they develop eventual
4	lack of oxygen-carrying capacity to the vital
5	organs, most particular the heart. And the
6	heart develops a rhythm disturbance, and you
7	die.
8	Q. All right.
9	A. So it's really kind of difficult
10	for me to I don't know exactly how I can
11	be any clearer than that. Everybody dies of
12	a heart rhythm disturbance. Your heart
13	stops.
14	Q. Okay. But I think that what I
15	was pressing you on was how is it that your
16	opinion as to the cause of death differs from
17	Dr. Crane's if, in fact, I've articulated it
18	correctly?
19	A. I do not believe that the high
20	potassium levels, the low bicarbonate levels
21	in and of themselves caused the cardiac
22	arrest and the demise. What caused her
23	demise, I think, probably was a combination
24	of the mucous plug which was documented on
25	autopsy which most likely created lack of air



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	34
1	exchange, if you may, in this patient which
2	subsequently led to low oxygen levels that in
3	the face of probably sepsis, that was not
4	fully under control the antibiotic hadn't
5	controlled the problem coupled with
6	abnormal potassium and bicarbonate levels, they
7	all added up to her demise.
8	But I can tell you that in
9	patients who die strictly of hyperkalemia, it
10	is that they have very dramatic changes on
11	their EKG rhythm strips which this patient
12	did not have.
13	There are, I guess I would put it,
14	warning signs, changes on the EKG, the P
15	wave, the QRS intervals, the T waves such
16	that you know hyperkalemia's coming and you
17	know that that's going to cause the demise.
18	We didn't see that in this patient.
19	Q. Would the hyperkalemia be a result
20	of what? I mean, she had hyperkalemia.
21	What was the result of that?
22	A. I think the hyperkalemia most
23	likely was due to insidious and progressive
24	kidney failure coupled with dehydration coupled
25	with the sepsis picture.



	35
1	Q. Did the sepsis cause the kidney
2	failure?
3	A. I think the sepsis probably caused
4	pretty much organ, total body shutdown towards
5	the end in the last 24, 36 hours of this
6	patient's illness. The sepsis basically
7	hampered the kidney function such that she
8	was less capable to rid her body of the
9	poisons we all need to get rid of every day
10	as well as Because of her chronic
11	cardiovascular problems and her chronic
12	pulmonary problems, her immune resistance was
13	down; and despite using the appropriate
14	antibiotics, they weren't working.
15	Q. Was the sepsis more than likely
16	than not caused by the C. difficile disease?
17	MR. PARKER: Objection.
18	A. Again, it's a little difficult for
19	me to render an opinion on that. But I
20	think that if it wasn't the C. difficile
21	infection, I don't know what else it could
22	be. But I would certainly defer to an
23	internist or an infectious disease person
24	about that.
25	BY MR. BURNETT:



36 1 Q. Okay. Now, when we talk in terms 2 of a mucous plug and you talk about a lack 3 air exchange, does a mucous plug of have to 4 Tell me what a mucous plug is. I suppose 5 Ι should ask you to define that first. 6 Α. Well, ίn layperson's terms, it's 7 like somebody put a cork down your lungs and 8 now you're trying to breathe. 9 Where does the mucous plug 0. 10 physically have to be located for it to cause 11 this lack of air exchange that you've 12 described? 13 Α. Well, the pulmonary, the lungs, the 14 windpipe is connected to the lung tissue by a 15 series of tubes which is not unlike the 16 branches of a tree. And the closer to the 17 trunk of the tree the mucous plug occurs, the 18 more it compromises exchange of air and the 19 surface area to exchange. 20 If you consider the fact that she 21 had a mucous plug that was more on the left 22 side in the left, upper lung, that in and of 23 itself -- If you or I had a mucous plug in 24 left, upper lung, we would cough and our 25 choke and get short of breath; but it

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1 wouldn't	
	kill us per se. In a patient who
2 has all t	the other cardiorespiratory infectious,
3 bedridden	illnesses that this lady was dealing
4 with, yea	h, it could kill you.
5 Q.	Is that where it was found on
6 autopsy,	the left, upper part of the lung?
7 A.	I believe that was correct. I'd
8 have to :	refer to the chart again here.
9 Q.	Yes. Please take a look and see
10 so that	we know.
11 A.	Okay. Bear with me here just a
12 second.	
13 Q.	Sure.
14 A.	Yes. It was Finding Number 4 on
15 the autop	esy report; mucous plug left, upper
16 lobe bron	chus.
17 Q.	Does it say how big it was?
18 Doesn't i	t have to be a certain size?
19 A.	Not really.
20 Q.	How big does it have to be to
21 cause thi	s lack of air exchange that we've
22 discussed	?
23 A.	It depends on how sick the patient
24 is, that	I think this patient had compromised
25 air excha	ange to begin with because of the



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	38
1	chronic pulmonary disorder coupled with acute
2	issues of Patients get what's called
3	atelectasis where they get mini-lung collapse
4	just from being acutely ill.
5	And all of this is an additive
6	effect. And, yes, if you were to say this
7	patient just had a left, upper lobe mucous
8	plug and that's it, that's not going to kill
9	the patient. But when you add it up to all
10	the other issues surrounding this patient's
11	acute illness, it could easily tip the
12	patient over the edge.
13	Q. I'm going to just restate what I
14	think your opinion is, and please tell me if
15	I'm right or wrong. The cause of death was
16	a combination of the mucous plus, the sepsis
17	which was not fully under control, and the
18	increased bicarb levels. Is that fair?
19	A. No. It's not increased bicarb
20	levels.
21	Q. I'm sorry. The decreased bicarb
22	levels.
23	A. Well, the decreased bicarb levels
24	are basically a manifestation of acidosis
25	which is again due to sepsis that's not being



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[	39
1	adequately treated with the appropriate
2	antibiotics due to the patient's compromised
3	immune situation.
4	Q. Okay. So really, then, the cause
5	of death is actually a combination of the
6	mucous plug and the sepsis which was not
7	fully under control. Is that fair?
8	A. I would say that would be in my
9	opinion the best guess.
10	Q. Okay. Would you hold that opinion
11	to a reasonable degree of medical probability?
12	A. Yes, I would.
13	Q. Okay. Then is it fair to say
14	that the sepsis not fully under control was
15	certainly a substantial contributing factor to
16	this patient's death?
17	MR. PARKER: Objection.
18	A. Yes. Despite appropriate
19	antibiotic therapy, it appeared as if it was
20	not doing its job. The antibiotics weren't
21	doing its job due to the patient's
22	preexisting, compromised immune status.
23	BY MR. BURNETT:
24	Q. What do you mean by her
25	preexisting, comprised immune status?



	40
1	A. Well, we know for a medical fact
2	that patients who have preexisting cardiac
3	disorders and/or pulmonary disorders or kidney
4	failure or anemia, or these types of things,
5	that these patients do not have near the
6	ability to fight off infections that a
7	normal, healthy individual who does not have
8	chronic illnesses has.
9	So the You know, I guess a
10	layperson would think, okay, I take
11	antibiotics and it will make everything
12	better. What antibiotics do is they have the
13	ability to kill bacteria in most situations.
14	But without an intact, robust immune system,
15	antibiotics aren't going to work.
16	Q. Okay. All right. So describe if
17	you will for me, then, the mechanism of the
18	death. I mean, I take it there was, then,
19	an arrhythmia.
20	A. Well, it's a little difficult to
21	say from looking at the charts. But
22	obviously, she had arrhythmia; or she wouldn't
23	be dead.
24	Q. Right. I know that from what we
25	discussed. So we know that happened.

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	41
1	A. Right. What I The best I can
2	glean from the chart is that the patient
3	developed what we refer to asystole which is
4	basically the spark plugs cease to fire for
5	the automobile engine, if you may, to use the
6	analogy. The pacing mechanism of the heart
7	just gave up and stopped.
8	Q. Okay. Well, you say in your
9	report with regard to the hyperkalemia this
10	metabolic disorder did not cause an arrhythmia
11	and subsequent death. I want to make sure
12	that I understand that fully. Would you
13	flush that out for me, please?
14	A. Well, there's several reasons why I
15	opined that the hyperkalemia was not a
16	significant contributing factor to her demise.
17	The two things, number one, is again I had
18	previously mentioned that when you look at
19	her EKG, the P wave, the QRS complex, the T
20	wave soon, or prior to her demise, there were
21	no warning signs on the EKG which is seen
22	probably 90 percent of the time if
23	hyperkalemia is the problem.
24	We do have time to react the
25	majority of the time to hyperkalemia. That



	42
1	coupled with the fact during her cardiac
2	arrest she received not only epinephrine but
3	she received calcium chloride. Calcium
4	chloride is for cardiac rhythm disturbances
5	due to hyperkalemia, is almost an instant
6	antidote that will correct the rhythm
7	disturbance in a cardiac arrest situation.
8	And needless to say, it didn't correct
9	anything in this situation.
10	Q. All right. Have you given me all
11	the reasons why you state hyperkalemia did
12	not cause an arrhythmia and subsequent death?
13	A. I'm not sure I understand your
14	question. I thought I just did.
15	Q. Yes. That's what I'm saying. Is
16	there anything else that you haven't told me?
17	A. No.
18	Q. Okay. That's what I'm trying to
19	get at.
20	A. Okay.
21	Q. All right. Let's talk for a
22	moment about your prognosis for her, her
23	two-year survival to be no higher than 50
24	percent. What's your basis for that?
25	A. My basis for that is primarily



	43
1	related to the fact that she had very
2	significant cardiac disease that had been
3	cared for for, gee, 15 years and that recent
4	evaluation by Dr. Sechler and his colleagues
5	had shown that she had a rather substantial
6	depressed, left ventricular ejection fraction
7	that was in the range of 30 to 35 percent.
8	This was coupled with the fact
9	that prior to her demise she had been treated
10	for the prior four to six months for bouts
11	of congestive heart failure. When you
12	combine those two things, study after study
13	after study, text book after text book after
14	text book in cardiovascular diseases will
15	confirm that the patient's prognosis is very
16	poor when they have a depressed ejection
17	fraction under 40 percent coupled with
18	recurrent congestive heart failure despite
19	medical therapy.
20	Q. I'm sorry. Did you reference
21	studies or texts?
22	A. I didn't reference any particular
23	cardiovascular textbook or any particular
24	article. This is almost general knowledge, I
25	guess I should say, in cardiology.



1

	44
1	Q. Okay. I want to talk to you
2	about the mucous plug again. I'm looking at
3	Dr. Crane's deposition at Page 94. And he
4	says And I'll quote:
5	I just think that if it's a mucous
6	plug it would have to be the trachea because
7	this has to be a total asphyxiation in order
8	for her to die like that. And that would be
9	a major blockage of the trachea.
10	And that's the end of the quote.
11	Do you agree or disagree with that statement?
12	A. I disagree with the statement.
13	Q. And that's because where you
14	believe it was found on autopsy combined with
15	the sepsis and the organ shutdown, it was
16	sufficient to cause the death?
17	A. As I mentioned before, I would
18	agree with Dr. Crane's assessment if you or I
19	had a left, upper lobe mucous plug. It
20	would be pretty difficult for that to cause
21	death in either you or I who I presume
22	you're a healthy individual, also.
23	Q. I think so, once in a while
24	anyway.
25	A. But in a patient who has



	45
1	preexisting cardiopulmonary compromise and
2	embarrassed cardiopulmonary reserve, I would
3	easily be able to see this happening. As a
4	matter of fact, it happened to one of my
5	patients just less than two weeks ago.
6	Q. What? A mucous plug caused what
7	was the triggering event to a death?
8	A. It was an 84-year-old gentleman who
9	had undergone mitral valve surgery, had
10	preexisting liver problems but required the
11	mitral valve surgery because his valve was
12	leaking very badly because of his advanced
13	age which compromised his immune status
14	coupled with the fact he had smoked for years
15	and had pulmonary compromise coupled with the
16	fact that he was just soon after major open
17	heart surgery. He ended up, was doing fairly
18	well and wound up with the same situation, a
19	mucous plug that just put him over the edge,
20	exhausted his reserve.
21	Q. What causes these mucous plugs?
22	A. Mucous plugs are caused primarily
23	due to any patient who has an acute illness
24	and particularly if there is problems with
25	the lungs. Anytime that the lungs are not



	46
1	fully aerated or expanded or if they have
2	been compromised in any way by an infectious
3	process or if their chest wall has been
4	compromised, the lungs' response is to
5	manufacture more mucous as part of the
6	fighting off infection.
7	If too much mucous is produced and
8	it is not mobilized with coughing, deep
9	breathing, that type of thing, it can become
10	dehydrated, harden, and act like a cork in a
11	bronchus.
12	Q. When you say acute illness, in
13	this patient, was the acute illness which led
14	to the mucous likely the C. difficile leading
15	to the sepsis?
16	A. I think the C. difficile and the
17	sepsis and the surrounding diarrhea,
18	dehydration, all of those things added up to
19	mucous plug.
20	Q. Okay. So basically, more likely
21	than not, if this patient's C. difficile
22	colitis had been brought under control, we
23	wouldn't have let the sepsis and, we wouldn't
24	have had a mucous plug more likely than not.
25	Fair?



	47
1	MR. PARKER: Objection.
2	A. Well, I think if the patient would
3	have responded to antibiotics like most
4	patients do to C. difficile colitis, there
5	was a much greater chance that she would have
6	survived the event; and there is probably a
7	much greater chance that she would not have
8	had a mucous plug.
9	BY MR. BURNETT:
10	Q. Okay. And you say most patients
11	do respond to the antibiotics. Fair?
12	A. In my experience, yes.
13	Q. Okay. Is it in your experience,
14	too, that the sooner the C. difficile colitis
15	is treated by an appropriate antibiotic, the
16	better the chance of the patient for
17	survival? Fair?
18	MR. PARKER: Objection.
19	A. Well, I can just tell you as a
20	practicing physician that when an infectious
21	process is diagnosed or entertained, the
22	sooner antibiotic therapy of any sort is
23	started, as a general rule, that would lead
24	to a better prognosis.
25	BY MR. BURNETT:



	48
1	Q. In this patient more likely than
2	not, had the Flagyl been started 24 hours
3	earlier, would we have had a more favorable
4	outcome?
5	MR. PARKER: Objection.
6	A. I'm really not in a position to
7	render an expert opinion on that because I'm
8	not an infectious disease specialist. So I
9	just don't think it's probably worthwhile me
10	answering one way or the other.
11	BY MR. BURNETT:
12	Q. Okay. And the reason I asked that
13	is because you say that most patients respond
14	to the Flagyl.
15	A. Right.
16	Q. And in my mind, that was the next
17	logical question because it seems that you do
18	have some experience with patients with C.
19	diff and Flagyl and how they respond.
20	A. That's true. But it's usually
21	My experience is caring for patients from,
22	like I say, 15 years ago. And my experience
23	is caring for my cardiac patients watching
24	after the cardiac problems as they're being
25	treated for their C. difficile colitis by an



	49
1	infectious disease specialist.
2	Q. Okay. And I probably asked you
3	this; and if I did, forgive me.
4	Have any of your patients gone on
5	to develop sepsis and die from either the
6	sepsis or a combination of sepsis and a
7	mucous plug if they had C. difficile colitis?
8	MR. PARKER: Objection.
9	A. In my experience, I have not seen
10	that happen.
11	BY MR. BURNETT:
12	Q. Okay. Sir, have I covered all
13	your opinions in this case?
14	A. Yes, you have.
15	MR. BURNETT: Ken, while I review
16	my notes, do you have any questions of the
17	doctor?
18	MR. TORGERSON: I have no
19	questions of Dr. George.
20	BY MR. BURNETT:
21	Q. By the way, in your experience
22	either in the last 15 years watching your
23	patients being treated by an internist or an
24	infectious disease specialist or, you know,
25	prior to 15 years ago, have you ever seen



	50				
1	anyone prescribe Clindamycin when C. diff				
2	colitis was on the differential?				
3	A. I've not seen it prescribed, but				
4	my understanding is that it is an alternative				
5	antibiotic for C. difficile colitis.				
6	Q. Do you have any opinion relative				
7	to the heart size in this case as to whether				
8	it was at all abnormal and/or contributory to				
9	the death?				
10	A. Her heart size was enlarged.				
11	Q. Okay. I think it was 600 grams;				
12	right?				
13	A. I'd have to refer back to the				
14	autopsy to confirm that.				
15	Q. Yes. Do you have that at your				
16	fingertips?				
17	A. I'm looking ay it right now.				
18	Correct. It was 600 grams.				
19	Q. Okay. What would the normal				
20	weight, you know, likely have been for				
21	someone this age?				
22	A. You know, I really don't know.				
23	Q. Okay.				
24	A. I don't You know, it's a little				
25	tough when people are alive to weigh their				



	51
1	hearts. That's sort of a pathologist's
2	assessment of heart enlargement. When we
3	deal with living patients, the way we assess
4	heart enlargement is primarily by chest x-ray
5	and echocardiogram.
6	Q. Okay. If this is a large heart,
7	if the pathologist describes it as a large
8	heart, what's the likely cause of that if you
9	know?
10	A. The enlarged heart was due to her
11	preexisting valvular heart disease and the
12	long-term ramifications of the preexisting
13	heart valve disease.
14	Q. Okay. Are you critical of any of
15	the care provided in this case?
16	A. No, I'm not.
17	Q. Now, you say she had severe COPD.
18	What's the basis for that, please?
19	A. She didn't have COPD per se. My
20	impression was from reading Dr. Sechler's
21	evaluation that she had had past bouts of
22	asthma and bronchitis, and this is not at all
23	uncommon in patients who have mitral valve
24	disorders such as this lady who had mitral
25	stenosis and rheumatic heart disease prior to



	52
1	her valve replacement.
2	Q. Okay. So is it fair to say,
3	though, that she did not have severe COPD?
4	A. Well, she clearly had some degree
5	of pulmonary compromise. I really in
6	reviewing the chart could not say to what
7	degree of severity it was. It was certainly
8	clinically significant.
9	Q. I mean, you use the word severe.
10	Is that accurate or is that inaccurate?
11	A. I think that it may not be totally
12	accurate, severe COPD, because I don't have
13	any objective parameters in the chart that I
14	could, you know, support that.
15	Q. Having talked to me about this
16	case right now and you're looking at your
17	report is there anything in your report
18	that you wish to change or that you think
19	you should add to the report?
20	A. No, I don't.
21	Q. Okay. And you've conveyed to me
22	all of your opinions in this case, sir?
23	A. Yes, I have.
24	Q. Okay. And the bases for these
25	opinions?

53 1 The basis for these opinions? Α. 2 Q. Yes, sir. 3 Α. The basis for these opinions is 4 based on my experience and training coupled 5 with my review of the chart. 6 MR. BURNETT: Okay. Gentlemen, I 7 think that's all I have. 8 MR. PARKER: Okay. John. I'm 9 Is 30 days okay? going to have him read. 10 MR. BURNETT: Take as much time as 11 vou want. We're still a couple of months 12 out from trial. 13 MR. PARKER: Right. 14 MR. BURNETT: That's fine. 15 (Signature not waived.) 16 And, thereupon, the deposition was concluded 17 at approximately 7:01 p.m. 18 19 20 21 22 23 24 25

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1	CERTIFICATE
2	State of Ohio :
3	SS :
4	County of Franklin :
5	I, Laurie A. Braverman, Notary
6	Public in and for the State of Ohio, duly
7	commissioned and qualified, certify that the
8	within named BARRY S. GEORGE, M.D., was by
9	me duly sworn to testify to the whole truth
10	in the cause aforesaid; that the testimony
11	was taken down by me in stenotypy in the
12	presence of said witness, afterwards
13	transcribed upon a computer; that the
14	foregoing is a true and correct transcript of
15	the testimony given by said witness taken at
16	the time and place in the foregoing caption
17	specified.
18	I certify that I am not a
19	relative, employee, or attorney of any of the
20	parties hereto, or of any attorney or counsel
21	employed by the parties, or financially
22	interested in the action.
23	IN WITNESS WHEREOF, I have set my
24	hand and affixed my seal of office at
25	Columbus, Ohio, on this 15th day of



1

55 September, 1 2004. 2 a fels man aur 3 LAURIE Α. BRAVERMAN, Notary 4 in and for the State of Public 5 Ohio and Professional Reporter 6 My Commission expires January 16, 7 2006. 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25



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	56				
1	CAPTION				
2	The Deposition of Barry S. George,				
3	M.D., taken in the matter, on the date, and				
4	at the time and place set out on the title				
5	page hereof.				
6	It was requested that the deposition				
7	be taken by the reporter and that same be				
8	reduced to typewritten form.				
9	It was agreed by and between counsel				
10	and the parties that the Deponent will read				
11	and sign the transcript of said deposition.				
12					
13					
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25					



	57				
1	CERTIFICATE				
2	STATE OF:				
3	COUNTY/CITY OF:				
4	Before me, this day, personally				
5	appeared, Barry S. George, M.D., who, being				
6	duly sworn, states that the foregoing				
7	transcript of his/her Deposition, taken in				
8	the matter, on the date, and at the time and				
9	place set out on the title page hereof,				
10	constitutes a true and accurate transcript of				
11	said deposition.				
12					
13	Barry S. George, M.D.				
14					
15	SUBSCRIBED and SWORN to before me this				
16	day of, 2004 in the				
17	jurisdiction aforesaid.				
18					
19	My Commission Expires Notary Public				
20					
21					
22					
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# **Nationwide Scheduling**

Telephonic Deposition of Barry S. George, M.D. - September 1, 2004

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Streamlined • Centralized • Standardized The Evolution of Deposition Management

## **Nationwide Scheduling**

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