# **Condensed Transcript**

# IN THE COURT OF COMMON PLEAS CUYAHOGA COUNTY, OHIO

Michelle R. Freeman,

## Plaintiff,

VS.

Case No. 490991

Cardiovascular Clinic, et al.,

Defendants.

### VIDEOTAPED DEPOSITION OF

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

November 1, 2004 5:45 p.m.

Knox Community Hospital 1330 Coshocton Avenue Mount Vernon, Ohio

Sharon T. Pontius, Registered Merit Reporter, Notary Public



Nationwide Scheduling

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#### 1 (Pages 1 to 4)

#### Videotaped Deposition of Barry S. George, M.D. - November 1, 2004

1			
	Page 1 IN THE COURT OF COMMON PLEAS	1	Page 3 APPEARANCES (continued)
	CUYAHOGA COUNTY, OHIO	2	
2		3	ALSO PRESENT:
3	Michelle R. Freeman,	4	KRISTEN MIELE, VIDEOGRAPHER
4	Plaintiff,	5	•
5	vs. Case No. 490991	6	
6		7	
7	Cardiovascular Clinic,	8	
8	et al.,	9	
9 10	Defendants.	10	
11		11	
12		12	
13	VIDEOTAPED DEPOSITION OF	13	•
14		14	
15	BARRY S. GEORGE, M.D.	15	
16		16	
-17	November 1, 2004	17	
18	5:45 p.m.	18	
19		19	<i>,</i>
20	Knox Community Hospital	20	
21	1330 Coshocton Avenue	21	• '
22 23	Mount Vernon, Ohio	22 23	•
23 24	Sharon T. Pontius, Registered Merit Reporter, Notary Public	23	•
24	Sharon 1. Fonnus, Registeren Merit Reporter, Notary Fublic	25	
		2	•
	Page 2		Page 4
1	APPEARANCES	1	STIPULATIONS
2		2	,
3	ON BEHALF OF THE PLAINTIFF	3	It is stipulated by and among
4	BECKER & MISHKIND CO., L.P.A.	4	counsel for the respective parties herein that
5	MR. JOHN BURNETT, ATTORNEY AT LAW	5	this deposition of BARRY S. GEORGE, M.D., a
6	134 Middle Avenue	6	Witness herein, called by the Defendants under
	Elyria, Ohio 44135		
7		7	the statute, may be taken at this time and
8		8	reduced to writing in stenotypy by the
8 9	ON BEHALF OF THE DEFENDANTS JAMES SECHLER, M.D.,	8 9	reduced to writing in stenotypy by the Notary, whose notes may thereafter be
8 9 10	ON BEHALF OF THE DEFENDANTS JAMES SECHLER, M.D., CHRISTINE ZIRAFI, M.D., AND THE CARDIOVASCULAR	8 9 10	reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the
8 9 10 11	ON BEHALF OF THE DEFENDANTS JAMES SECHLER, M.D., CHRISTINE ZIRAFI, M.D., AND THE CARDIOVASCULAR CLINIC	8 9 10 11	reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; and that proof of the official
8 9 10 11 12	ON BEHALF OF THE DEFENDANTS JAMES SECHLER, M.D., CHRISTINE ZIRAFI, M.D., AND THE CARDIOVASCULAR CLINIC BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP	8 9 10 11 12	reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; and that proof of the official character and qualifications of the Notary is
8 9 10 11 12 13	ON BEHALF OF THE DEFENDANTS JAMES SECHLER, M.D., CHRISTINE ZIRAFI, M.D., AND THE CARDIOVASCULAR CLINIC BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP MR. PAUL A. DZENITIS, ATTORNEY AT LAW	8 9 10 11 12 13	reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; and that proof of the official
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1 2	Page 5		Page 7
	Videotaped Deposition of Barry S. George, M.D.	1	A. That is correct.
	November 1, 2004	2	Q. Where did you go to medical
3	THE VIDEOGRAPHER: This is the	3	school?
4	videotape deposition of Barry S. George, M.D.,	4	A. I went to medical school at Ohio
5	taken in the matter of Michelle R. Freeman	5	State University.
6	versus Cardiovascular Clinic, et al., for the	6	Q. And you are a practicing
7	Court of Common Pleas, Cuyahoga County, Ohio,	7	cardiologist; is that correct, sir?
8	Case Number 490991. This deposition is being	8	A. That is correct.
9	held at 1330 Coshocton Avenue, in Mount	9	Q. Where did you do your training?
10	Vernon, Ohio, on November 1, 2004. My name	10	A. My training in cardiology was at
11	is Kristen Miele. I am the videographer.	11	Riverside Methodist Hospital and Ohio State
12	The court reporter is Susan (sic) Pontius.	12	University Hospitals in Columbus, as well as
13	Counsel will now introduce themselves.	13	at Seton Medical Center in Daly City,
13	MR. DZENITIS: Paul Dzenitis, for	13	California.
15	Dr. Zirafi, Dr. Sechler, and Cardiovascular	15	Q. Your training – let's see. You
15	Clinic.	15	
10	MR. TORGERSON: Ken Torgerson, for	10	did a fellowship in cardiology at, which you told us, Riverside and then the interventional
17 18	Parma Community General Hospital and Parma	17	,
18 19	Home Healthcare.	18 19	cardiology fellowship. That was in Daly City, California?
19 20	MR. BURNETT: John Burnett, for	20	
20 21	the Estate of Sally Huerster.	20	A. Yes. It was at the Seton Medical Center, which is affiliated with the
1	•	21	,
22	THE VIDEOGRAPHER: The reporter will now swear in the witness.	22	University of California at San Francisco.
23		1	Q. Are you board certified?
24 25	BARRY S. GEORGE, M.D., Being by me first duly sworn, as hereinafter certified,	24 25	A. Yes, I am.
23	first duty sworn, as nerematici certified,	25	Q. In what specialties?
	Page 6		Page 8
1	deposes and says as follows:	1	A. I am board certified in internal
2	DIRECT EXAMINATION	2	
		1	medicine and I'm board certified in
3	BY-MR.DZENITIS:	3	medicine and I'm board certified in cardiovascular diseases and I am board
3 4	BY-MR.DZENITIS: Q. Will you introduce yourself to the	3 4	cardiovascular diseases and I am board certified in interventional cardiology.
		3	cardiovascular diseases and I am board
4	Q. Will you introduce yourself to the	3 4	cardiovascular diseases and I am board certified in interventional cardiology.
4 5	Q. Will you introduce yourself to the jury, please.	3 4 5	cardiovascular diseases and I am board certified in interventional cardiology. Q. Doctor, could you take us through
4 5 6	<ul><li>Q. Will you introduce yourself to the jury, please.</li><li>A. My name is Barry S. George.</li></ul>	3 4 5 6	cardiovascular diseases and I am board certified in interventional cardiology. Q. Doctor, could you take us through a typical day or a typical week, what you do
4 5 6 7	<ul> <li>Q. Will you introduce yourself to the jury, please.</li> <li>A. My name is Barry S. George.</li> <li>Q. You are a cardiologist, sir?</li> </ul>	3 4 5 6 7	cardiovascular diseases and I am board certified in interventional cardiology. Q. Doctor, could you take us through a typical day or a typical week, what you do in your practice of medicine.
4 5 6 7 8	<ul> <li>Q. Will you introduce yourself to the jury, please.</li> <li>A. My name is Barry S. George.</li> <li>Q. You are a cardiologist, sir?</li> <li>A. That is correct.</li> </ul>	3 4 5 6 7 8	cardiovascular diseases and I am board certified in interventional cardiology. Q. Doctor, could you take us through a typical day or a typical week, what you do in your practice of medicine. A. Well, today, I for example,
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4 5 6 7 8 9 10 11	<ul> <li>Q. Will you introduce yourself to the jury, please.</li> <li>A. My name is Barry S. George.</li> <li>Q. You are a cardiologist, sir?</li> <li>A. That is correct.</li> <li>Q. And you are going to be testifying in this case about Ms. Huerster's life expectancy and cause of death, correct, sir?</li> </ul>	3 4 5 6 7 8 9 10 11	<ul> <li>cardiovascular diseases and I am board</li> <li>certified in interventional cardiology.</li> <li>Q. Doctor, could you take us through</li> <li>a typical day or a typical week, what you do</li> <li>in your practice of medicine.</li> <li>A. Well, today, I for example,</li> <li>this morning, I did a procedure on a patient</li> <li>who had problems with varicose veins, which</li> <li>involved using laser treatment. Then this</li> </ul>
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	Page 9		Page 11
.1	interventional cardiologist in that patients	1	A. Yes, it is.
2	are seen in the office usually before	2	Q. And if we could mark that as
3	procedures or after procedures and inpatients	3	Exhibit Number 1, I'm going to move to have
4	are seen in the hospital when they have their	4	that introduced as an exhibit to the
5	procedures.	5	deposition.
6	Q. Now, I note that and you've told	6	And, thereupon, Deposition Exhibit-1
7	us that you are board certified in internal	7	was marked for purposes of identification.
8	medicine. Could you tell us what percent of	8	Q. Is there anything else in the CV
9	your time you spend in the practice of	9	and we've run through the medical school,
10	internal medicine, primary care.	10	the training, and how you spend your day.
11	A. Well, I think that all	11	Is there anything else in the CV that you
12	cardiologists to some extent do practice	12	think would be relevant to the opinions that
13	internal medicine. As a pathway to board	13	you're going to be giving in the case here
14	certification and cardiovascular diseases, one	14	today?
15	must first do a residency in internal	15	A. I don't believe so.
16	medicine and one must first pass the boards	16	Q. Okay.
17	in internal medicine, which is basically	17	MR. BURNETT: Objection to the
18	treating nonsurgical problems of adults. Most	18	curriculum vitae as hearsay.
19	who go into the subspecialty field then	19	Q. Doctor, let's get into your
20	practice very limited amount of internal	20	opinions. First, I want to talk about the
21	medicine. For example, in my particular	21	life expectancy, and then I want to talk
22	practice, probably percentagewise, internal	22	about cause of death. What materials were
23	medicine I'm practicing is 5 percent.	22	you provided in this case?
23	* * *	23	A. The materials that I was provided
25	Q. Are you going to be giving	24	with were the hospitalizations of this patient
23	opinions in this case about the standard of	23	with were the hospitalizations of this patient
	Page 10		Page 12
1	care as it applies to Dr. Zirafi, Dr.	1	in June of 1999 as well as July, the
2	Sechler, and the physicians at Cardiovascular	2	depositions of several nurses that would
3	Clinic?	3	include Mary Ann Ambrose, Denise Laux - the
4	A. No, I'm not.	4	deposition of plaintiff's expert, Dr. Crane,
5	Q. Why not?	5	the deposition of Carol Stem, an RN, the
6	A. I think that this is primarily an	6	deposition of Dr. Sechler, the initial
7	internal medicine type of situation, and	7	complaints, the deposition of Dr. Martin Raff.
8	because of my amount of time spent in	8	I believe that's pretty much it.
9	internal medicine, particularly at this point	9	Q. Have you received and reviewed a
10	in time in my career, I'm not sure that I	10	copy of the Cardiovascular Clinic records, the
11	have the expertise that I could really render	11	office records?
12	an opinion on the standard of care. I do	12	A. Yes, I have.
12	believe that I have the expertise to render	13	Q. And have you reviewed the autopsy
13	an opinion about this patient's cardiac	13	report?
	* -	14	A. Yes, I have.
15	prognosis and also about the potential cause	1	
16	of the patient's unfortunate demise.	16	Q. And the autopsy report being a
17	Q. I would assume, Doctor, that 75	17	document which is, I believe, ten pages long.
18	percent or higher of your time is spent in	18	You've reviewed that document?
19	the active practice of medicine or teaching	19	A. Yes, I did.
20	medicine?	20	Q. Based upon your review of this
21	A. Yes, it is.	21	material, have you been able to form an
22	Q. And, Doctor, I have sitting in	22	opinion, based on your experience and
23	front of you there, I believe, a copy of	23	training, what Ms. Huerster's life expectancy
24	your curriculum vitae to your right. Is that	24	was if she had not died on July 5, 1999?
25	CV current and up to date?	25	A. This patient, I believe, based on



4 (Pages 13 to 16)

	Page 13		Page 15
1	the fact that she had very significant	1	measured by several different means. One
2	cardiovascular disease coupled with other	2	that is most commonly used is what's called
3	preexisting problems, including lung problems	3	an echocardiogram where we actually bounce
4	and what appeared to be chronic obstructive	4	sound waves off the heart muscle and we look
5	lung problems, that coupled with the fact	5	at and compare the dimensions of the main
6	that she had, what we call, depressed	6	pumping chamber of the heart, the left
7	ejection fraction what that is is	7	ventricle when it is fully filled with blood,
8	basically, in laypersons' terms, it's the	8	and then when all the blood that's going to
9	the horsepower, if you may, of the pump that	9	be ejected with that heartbeat is ejected.
10	pumps the blood throughout your body, was	10	Q. Did Ms. Huerster have one of these
11	significantly down. It was basically about	11	echocardiograms done on her on or about April
12	half of what a normal person's pump	12	12 of 1999?
13	horsepower is, if you may. And we know from	13	A. Yes, she did.
14	studies that have been done in the past and	14	Q. Okay. I'm going to turn your
15	have been well documented in many medical	15	attention to that visit, if I may, sir.
16	textbooks that when	16	MR. DZENITIS: And, gentlemen, this
17	MR. BURNETT: Objection.	17	is from the medical records of Cardiovascular
18	Q the ejection fraction is	18	Clinic. It's marked as Defendant's A and
19	MR. BURNETT: Hearsay. Foundation.	19	Bates stamped page 51.
20	Q. – depressed as this unfortunate	20	Q. I'll ask you, sir, if you could
21	lady had, prognosis is not very good and	21	tell us why Ms. Huerster was presenting to
22	highly unlikely whether she was going to live	22	her cardiologist on that day, what kinds of
23	another two years.	23	problems she was having.
23	MR. BURNETT: Move to strike.	24	A. This is basically in April 12,
25	Q. Doctor, you mentioned some terms	25	1999. And Ms. Huerster was presenting to her
2.5	Q. Doctor, you mentioned some terms	2.5	1999, And Mis. Hacister was presenting to her
	Page 14		Page 16
1	there, and I'd like to go back and explore	1	cardiologist because she had had increasing
2	your opinion a little bit more thoroughly.	2	dyspnea, or, as we laypeople call it,
3	Before we do that, can we have an agreement,	3	shortness of breath. She had also had some
4	sir, that unless you otherwise indicate, the	4	rib discomfort and also had a cough which had
5	opinions that you're going to be giving us	5	yellowish, intermittently bloody-tinged sputum.
6	are based upon a reasonable degree of medical	6	So she's short of breath, and it looks like
7	probability?	7	she may possibly have a lung infection.
8	A. That is correct.	8	Q. Based upon those presenting
9	Q. Now, you mentioned the ejection	9	problems, was an echocardiogram done by Dr.
10	fraction. What is an ejection fraction? What	10	Sechler?
11	does that mean?	10	A. Yes, it was.
12	A. Well, in $-$ to try to put it in	12	Q. And the echocardiogram measured,
13	laypersons' terms, or for the jury, the heart	12	among other things, the left ventricular
13	muscle, the main pumping chamber of the heart	13	ejection fraction?
14	is called the left ventricle. The left	14	A. Yes.
15		15 16	
	ventricle fills with blood and enlarges. The	1	-
17	muscle then contracts and squeezes down. And the ratio between the volume of blood in the	17	study?
18		18	A. The study that was performed
19	left ventricle when it is fully enlarged and	19	basically revealed that the the size of
20	filled up and how much is squeezed out is	20	the main pumping chamber of the heart, the
21	called the ejection fraction.	21	left ventricle, was normal in size but that
22	Q. Okay. And how is the ejection	22	it did not squeeze normally, that the
23	fraction measured by doctors?	23	ejection fraction was quantitated to be in
24	A. Well, ejection fraction is measured	24	the range of 35 to perhaps as high as 40
25	we measure it in percentages, but it is	25	percent. Normal ejection fraction in a healthy
1			



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5 (Pages 17 to 20)

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1	Page 17 human heart is 50 to 70 percent.	1	Page 19 I believe you testified that you had reviewed
2	Q. What is the significance to you as	2	- and I can - this is going to be at -
3	a cardiologist of this left ventricular	3	Defendant's Exhibit E on page number 5, and
4	ejection fraction of 35 to 40 percent in Ms.	4	it's under description of the heart and major
5	Huerster in April of 1999? What does that	5	blood vessels. And, Doctor, I'll go ahead
6	mean?	6	and
7	A. Well, in any patient who has an	7	A. Oh, thank you.
8	ejection fraction that is under 40 percent,	8	Q hand you this document.
9	in and around or just slightly under 40	9	A. Okay.
10	percent, we know that the prognosis is	10	Q. What I was interested in, sir, is
11		11	in that description in the autopsy, was the
	somewhat guarded in that patient. Regardless	12	
12	of the cause, whether it was due to a valve	12	left ventricle commented upon or remarked
13	problem, as Ms. Huerster had, whether it was	13	upon?
14	due to blocked up arteries that supply the		A. There were comments made in the
15	heart muscle, whether it was due to a virus	15	autopsy about the left ventricle, and
16	infection to the heart muscle itself, whether	16	basically, it said that the heart weighed 600
17	it's due to long-standing high blood pressure	17	grams, the weight being complicated by the
18	and thickening of the heart muscle, the fact	18	the major blood vessel coming out of the
19	of the matter is when the ejection fraction	19	heart, the aorta, being attached to it.
20	is around 40 percent or under that, the	20	Pathologists, at autopsy, try to measure heart
21	prognosis becomes significantly more guarded	21	enlargement by how much the heart weighs
22	for survival.	22	after one expires. The the only thing
23	Q. And are you able to quantify her	23	really that I can say from the the
24	survivability and her life expectancy based	24	autopsy findings that is striking is two
25	upon that ejection fraction?	25	things. Number one is that she had an
	Page 18		Page 20
1	A. If you look in, actually, any of	1	artificial heart valve in the mitral valve
2	the common cardiovascular textbooks	2	position. That's the one between the upper
3	MR. BURNETT: Objection. Hearsay.	3	and lower left-hand chambers of the heart.
4	A in medicine and I don't care	4	And the other that was quite striking is the
5	which one you refer to they all	5	fact that she had a very thick heart muscle.
6	universally show, as studies have shown,	6	The main pumping chamber of the heart was
7	natural history studies, as we call it, where	7	quite thick, and it was twice the thickness
8	if you look at patients who have ejection	8	of normal, which is very unusual and, again,
9	fractions of 40 percent or under, at two	9	portrays a very guarded prognosis.
10	years' time, slightly more than half of those	10	Q. With we'll talk about the
11	patients are no longer alive.	11	mitral valve in a minute. So setting that
12	MR. BURNETT: Move to strike.	12	aside, what was the size of the wall of the
13	Q. Doctor, based upon your education	13	left ventricle based upon the autopsy study?
14	and experience in treating patients such as	13	A. Well, the thickness of the heart
15	Ms. Huerster for heart ailments, what is your	14	muscle in the main pumping chamber of the
		15	heart was 2 centimeters, which is a little
16	opinion regarding her life expectancy given	10	
17	her ejection fraction of 35 to 40 percent?		less than an inch. $\Omega$ And what is it ordinarily?
18	A. I would say based upon reasonable	18	Q. And what is it ordinarily?
19	degree of medical certainty and probability,	19	A. Normally, the upper limits of
0.0	there is a no greater than a 50 percent	20	normal is 1.1 centimeters.
20			O. And why does an enlarged ventricle
21	chance that this lady would be alive from	21	
21 22	chance that this lady would be alive from just purely a cardiac standpoint at two	22	wall, if I'm using those terms correctly,
21 22 23	chance that this lady would be alive from just purely a cardiac standpoint at two years.	22 23	wall, if I'm using those terms correctly, have any significance to you with regard to
21 22	chance that this lady would be alive from just purely a cardiac standpoint at two	22	wall, if I'm using those terms correctly,



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6 (Pages 21 to 24)

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	Page 21		Page 23
1	A. Well, again, the – the thickness	1	porcine mitral valve, which is basically
2	of the heart muscle is very disconcerting for	2	it's a valve, an animal valve, a mammalian
3	a couple of reasons. The first is her main	3	animal, porcine, that is prepared and treated
4	heart valve problem was mitral stenosis before	4	and then mounted on a framework. And then
5	she had the heart valve surgery, and that is	5	the surgeon cuts out the old valve, sews in
6	a a scarred-up, narrowed valve between the	6	the porcine valve, as we call it, or the
7	upper and lower left-hand chambers of the	7	artificial animal valve, to take the place of
8	heart. So when there is a thickness and	8	the diseased human valve.
9	stricture and narrowing of the mitral valve,	9	Q. How long does a porcine valve
10	the lower chamber of the left ventricle	10	last?
11	actually becomes somewhat protected against	11	A. It varies. Some studies have
12	high pressures. Therefore, it is most commonly	12	shown that they'll last as little as nine or
13	of normal thickness. In this patient, it was	13	ten years.
14	markedly thickened, which suggests that she	14	MR. BURNETT: Objection. Hearsay.
15	had not only one but two very serious cardiac	15	A. And some, they won't last 15
16	problems. She had one where the heart muscle	16	years.
17	had become thick. And when a heart muscle	17	Q. Based upon
18	becomes thick, it doesn't squeeze in properly,	18	MR. BURNETT: Move to strike.
19	it doesn't relax properly, and the electrical	19	
20	signal as it goes through that thick heart	20	Q. Based upon your experience and training, are you able to give us an opinion
20		20	
21	muscle can become disarrayed and can cause	21	about how long the typical mitral porcine
22	heart rhythm disturbances.	22	valve lasts in patients that you've treated?
1	Q. Let's talk about the mitral valve	1	A. Well, if this patient had it
24	replacement. You're aware that Mrs. Huerster	24	placed in 1986, she certainly has got a lot
25	had her mitral valve replaced in her heart in	25	of mileage, if you may, out of that valve.
	Page 22		
1	Page 22 May of 1986.	1	Page 24 My experience has been that the porcine
2	A. Correct.	2	valves, particularly those that were placed in
3	Q. What is the mitral valve?	3	the '80s, 10 to 12 years at best. That was
4	A. Well, the mitral valve is	4	the best that could be expected out of that
5	basically, it's – it almost looks like a	5	type of a valve.
6	fish mouth sort of appartus, if you may.	6	Q. In and just so we're clear,
7	That is the main valve between the upper and	7	this valve was placed in May of 1986. Ms.
8	lower left-hand chambers of the heart.	8	Huerster passed away in July of 1999. That
9	Unfortunately, this patient when she was much	9	would indicate, sir, that this valve had
10	younger had rheumatic fever. Rheumatic fever	10	lasted a little over 13 years. Would that
10	has a tendency to affect the heart valves and	10	be accurate?
12	•	11	
12	in — later on in life, then the heart valves become scarred. This fish mouth	12	
13		1	Q. Doctor, I'd like to talk about
14	valve, as we would look at it, left chamber	14	your opinion regarding cause of death. Have
1	upper, left chamber lower, the valve goes	15	you been able to form an opinion, based upon
16	like this, two leaflets. What happens is	16	your review of the materials and your
17	that when the rheumatic fever affects it and	17	experience and training, about the cause of
	it scars it down, it just barely opens. And	18	Ms. Huerster's death?
18		19	A. Yes, I have.
19	so then the blood getting from the upper	E	
19 20	chamber to the lower chamber's restricted.	20	Q. And what is that opinion, sir?
19 20 21	chamber to the lower chamber's restricted. Back pressure then goes into the lungs, which	20 21	A. My opinion is that this unfortunate
19 20 21 22	chamber to the lower chamber's restricted. Back pressure then goes into the lungs, which causes patients to be very short of breath.	20 21 22	A. My opinion is that this unfortunate individual had many coexisting medical
19 20 21 22 23	chamber to the lower chamber's restricted. Back pressure then goes into the lungs, which causes patients to be very short of breath. Q. What kind of valve replacement did	20 21 22 23	A. My opinion is that this unfortunate individual had many coexisting medical illnesses that eventually added up to her
19 20 21 22	chamber to the lower chamber's restricted. Back pressure then goes into the lungs, which causes patients to be very short of breath.	20 21 22	A. My opinion is that this unfortunate individual had many coexisting medical



7 (Pages 25 to 28)

	Page 25		Page 27
.1	due to the fact that because she was so ill,	1	Hospital, did Ms. Huerster have a history of
2	she was unable to mobilize or move secretions	2	mucus plug developing?
3	out of her bronchial tubes to the point where	3	A. It's of interest to note that this
4	she actually developed a blockage in the	4	patient, I believe, has had problems with
5	bronchial tubes that prevented adequate	5	mobilizing her secretions because of her
6	oxygenation of her bloodstream. When you	6	chronic lung disease. On her admission in
7	take that final event coupled with the fact	7	July when she came into the hospital and had
8	that she had had preexisting vascular problems	8	a – what appeared to be a bronchitis-type
9	in her lungs, preexisting bronchial problems,	9	infection, it was noted that she had a
10	preexisting cardiac problems, a recent GI	10	similar type of an episode where she had some
11	infection with C. difficile colitis, I think	11	difficulty. But at that time, she was able
12	this is what finally added up to her ultimate	12	to produce a strong, forceful cough in order
13	demise.	13	to get those secretions out of her lungs in
14	Q. I want to take you to the day of	14	order to better oxygenate her bloodstream.
15	her death, which was July 5 of 1999, and ask	15	Q. You said July. I think you might
16	you, sir, if you can go through the clinical	16	have meant June. You meant the earlier
17	description that was given by Dr. Modi –	17	hospitalization?
18	this is going to be from Exhibit D, the	18	A. The earlier hospitalization, yeah,
19	Parma Community Hospital records from July 2	19	whatever that was. I think it was June.
20	to July 5, 1999 – and ask you if you could	20	Q. That's fine.
21	review with us the description of the events	20	I'll direct you to Defendant's
22	immediately leading up to Ms. Huerster's death	21	Exhibit Number B, page 28 in the progress
23	according to that bottom note.	22	notes. And I believe it's dated 6/20/99,
23	A. Well, as most doctors are not very	23	
25	good cursive writers, it makes it a little	24	with some more doctors' writing at the bottom there. Can you describe for us what is
			· · · · · · · · · · · · · · · · · · ·
1	Page 26	4	Page 28
1 2	tough. But I'll do the best I can here.	1	
• /	TV	1	documented on that day, June 20, 1999.
3	It says on 7/5, July 5, events noticed. The	2	A. This was what I was referring to.
3	nurse went in to see how patient was doing.	23	A. This was what I was referring to. It was a June, not a July, admission. Able
3 4	nurse went in to see how patient was doing. No changes in status. She suddenly coughed	2 3 4	A. This was what I was referring to. It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug.
3 4 5	nurse went in to see how patient was doing. No changes in status. She suddenly coughed up excessive mucus with blood. Immediately	2 3 4 5	A. This was what I was referring to. It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug. Now much improved. Blood pressure 140/80,
3 4 5 6	nurse went in to see how patient was doing. No changes in status. She suddenly coughed up excessive mucus with blood. Immediately after that, she expired. No preceding chest	2 3 4 5 6	<ul> <li>A. This was what I was referring to.</li> <li>It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug.</li> <li>Now much improved. Blood pressure 140/80, pulse 80. Lung exam I believe this says</li> </ul>
3 4 5 6 7	nurse went in to see how patient was doing. No changes in status. She suddenly coughed up excessive mucus with blood. Immediately after that, she expired. No preceding chest pain or shortness of breath, no arrhythmia	2 3 4 5 6 7	<ul> <li>A. This was what I was referring to.</li> <li>It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug.</li> <li>Now much improved. Blood pressure 140/80, pulse 80. Lung exam I believe this says bilateral wheezing. Labs: PT, INR that's</li> </ul>
3 4 5 6 7 8	nurse went in to see how patient was doing. No changes in status. She suddenly coughed up excessive mucus with blood. Immediately after that, she expired. No preceding chest pain or shortness of breath, no arrhythmia before event. No bradycardia that means	2 3 4 5 6 7 8	A. This was what I was referring to. It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug. Now much improved. Blood pressure 140/80, pulse 80. Lung exam I believe this says bilateral wheezing. Labs: PT, INR that's the blood thinning test 4.5, which is a
3 4 5 6 7 8 9	nurse went in to see how patient was doing. No changes in status. She suddenly coughed up excessive mucus with blood. Immediately after that, she expired. No preceding chest pain or shortness of breath, no arrhythmia before event. No bradycardia that means slow heartbeat with the event. No changes	2 3 4 5 6 7 8 9	A. This was what I was referring to. It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug. Now much improved. Blood pressure 140/80, pulse 80. Lung exam I believe this says bilateral wheezing. Labs: PT, INR that's the blood thinning test 4.5, which is a little higher than we'd like. And it says,
3 4 5 6 7 8 9 10	nurse went in to see how patient was doing. No changes in status. She suddenly coughed up excessive mucus with blood. Immediately after that, she expired. No preceding chest pain or shortness of breath, no arrhythmia before event. No bradycardia that means slow heartbeat with the event. No changes in abdominal pain. No pulse regained during	2 3 4 5 6 7 8 9 10	A. This was what I was referring to. It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug. Now much improved. Blood pressure 140/80, pulse 80. Lung exam I believe this says bilateral wheezing. Labs: PT, INR that's the blood thinning test 4.5, which is a little higher than we'd like. And it says, Plan: Hold Coumadin, which is the blood
3 4 5 6 7 8 9 10 11	nurse went in to see how patient was doing. No changes in status. She suddenly coughed up excessive mucus with blood. Immediately after that, she expired. No preceding chest pain or shortness of breath, no arrhythmia before event. No bradycardia that means slow heartbeat with the event. No changes in abdominal pain. No pulse regained during CPR. Bowel sounds did become more hypoactive	2 3 4 5 6 7 8 9 10 11	A. This was what I was referring to. It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug. Now much improved. Blood pressure 140/80, pulse 80. Lung exam I believe this says bilateral wheezing. Labs: PT, INR that's the blood thinning test 4.5, which is a little higher than we'd like. And it says, Plan: Hold Coumadin, which is the blood thinner, so that the blood will thicken up
3 4 5 6 7 8 9 10 11 12	nurse went in to see how patient was doing. No changes in status. She suddenly coughed up excessive mucus with blood. Immediately after that, she expired. No preceding chest pain or shortness of breath, no arrhythmia before event. No bradycardia that means slow heartbeat with the event. No changes in abdominal pain. No pulse regained during CPR. Bowel sounds did become more hypoactive through night. Negative bowel movement,	2 3 4 5 6 7 8 9 10 11 12	A. This was what I was referring to. It was a June, not a July, admission. Able to mobilize sputum and cough up mucus plug. Now much improved. Blood pressure 140/80, pulse 80. Lung exam I believe this says bilateral wheezing. Labs: PT, INR that's the blood thinning test 4.5, which is a little higher than we'd like. And it says, Plan: Hold Coumadin, which is the blood thinner, so that the blood will thicken up some.
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8 (Pages 29 to 32)

1			
1	Page 29	1	Page 31
.1	occurred, she developed a lot of diarrhea,	1	related to the potassium. Her eventual
2	had some, I believe, nausea and some	2	demise, she had a heart rhythm disturbance.
3	vomiting, and she became dehydrated. Well, in	3	But when we all die, we have a heart rhythm
4	order to effectively mobilize or get the	4	disturbance. Our heart just stops beating.
5	secretions out of your lungs when you have an	5	But to say that a high potassium caused her
6	infection, your mucus has to be moist. If	6	heart rhythm disturbance or that that was the
7	it's not moist, it literally can turn to	7	primary inciting event that caused her death,
8	almost concrete in your bronchial tubes and	8	I see nothing in the chart that would lead
9	become extremely difficult to - to get out	9	me to believe that that's the case.
10	of your lungs to effectively oxygenate. So I	10	Q. And that would include review of
11	think that the the lung infection was	11	those EKG strips?
12	compounded then by the the gastrointestinal	12	A. That is correct.
13	infection, which which then caused her to	13	Q. Do you find evidence in the
14	become dehydrated, which then further	14	autopsy report that was done I think you
15	aggravated her lung problems and her ability	15	may have it over there to your right. Is
16	to oxygenate.	16	that it there, ten-page document?
17	Q. All right. The opinion has been	17	A. This is it, yes.
18	expressed in this case that Ms. Huerster had	18	Q. Do you find evidence in the
19	high potassium, which led to cardiac problems	19	autopsy report or support for your opinion
20	and cardiac arrhythmia. I want to explore	20	
20	that with you for a minute.	20	that this was a pulmonary or lung problem
	-		leading to Ms. Huerster's death as opposed to
22	Can high potassium cause heart	22	a metabolic or heart problem?
23	problems?	23	A. Yes, I do.
24	A. Elevated potassium levels can	24	Q. What is that support?
25	indeed cause heart problems, heart rhythm	25	A. Well, I can quote from the autopsy
	Page 30		Page 32
1	problems, and disturbances as such.	1	findings as described by the pathologist,
2	Q. Okay. And why is that, sir?	2	which shows there is a mucus plug in the
3	A. What happens is is the the	3	left upper lobe bronchus, and bilaterally,
4	when the levels of potassium increase in the	4	there is red discoloration, with suggestion of
5	heart muscle and in the electrical tissue in	5	granularity of the mucosa of the bronchi.
6	the heart muscle, it can cause the electrical		
4		6	Basically, what that means is that she had
17		6 7	Basically, what that means is that she had plugs in her bronchial tubes as well as
7	signal to become distorted or disarrayed to	7	plugs in her bronchial tubes as well as
8	signal to become distorted or disarrayed to the point where it can cause very rapid	7 8	plugs in her bronchial tubes as well as inflammation in the lung tissue itself.
8 9	signal to become distorted or disarrayed to the point where it can cause very rapid heartbeats or very slow heartbeats.	7 8 9	plugs in her bronchial tubes as well as inflammation in the lung tissue itself. Now granted, it was not the whole
8 9 10	signal to become distorted or disarrayed to the point where it can cause very rapid heartbeats or very slow heartbeats. Q. In this case, have you well,	7 8 9 10	plugs in her bronchial tubes as well as inflammation in the lung tissue itself. Now granted, it was not the whole lung. It's not like the main windpipe had a
8 9 10 11	signal to become distorted or disarrayed to the point where it can cause very rapid heartbeats or very slow heartbeats. Q. In this case, have you well, how do we measure heartbeat and heart	7 8 9 10 11	plugs in her bronchial tubes as well as inflammation in the lung tissue itself. Now granted, it was not the whole lung. It's not like the main windpipe had a cork in it. This was just a substantial
8 9 10 11 12	signal to become distorted or disarrayed to the point where it can cause very rapid heartbeats or very slow heartbeats. Q. In this case, have you well, how do we measure heartbeat and heart disturbance?	7 8 9 10 11 12	plugs in her bronchial tubes as well as inflammation in the lung tissue itself. Now granted, it was not the whole lung. It's not like the main windpipe had a cork in it. This was just a substantial portion of the left upper portion of the
8 9 10 11 12 13	signal to become distorted or disarrayed to the point where it can cause very rapid heartbeats or very slow heartbeats. Q. In this case, have you well, how do we measure heartbeat and heart disturbance? A. Well, we measure heartbeats and	7 8 9 10 11 12 13	plugs in her bronchial tubes as well as inflammation in the lung tissue itself. Now granted, it was not the whole lung. It's not like the main windpipe had a cork in it. This was just a substantial portion of the left upper portion of the lung. But if you add that to the other
8 9 10 11 12 13 14	signal to become distorted or disarrayed to the point where it can cause very rapid heartbeats or very slow heartbeats. Q. In this case, have you well, how do we measure heartbeat and heart disturbance? A. Well, we measure heartbeats and heart disturbance by putting patients on	7 8 9 10 11 12 13 14	plugs in her bronchial tubes as well as inflammation in the lung tissue itself. Now granted, it was not the whole lung. It's not like the main windpipe had a cork in it. This was just a substantial portion of the left upper portion of the lung. But if you add that to the other problems that she had, this certainly could
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9 (Pages 33 to 36)

	D. 12		D 35
1	Page 33 CROSS-EXAMINATION	1	Page 35 they are maybe initially, the
2	BY-MR.BURNETT:	2	receptionist may answer the phone, but then
3	Q. Doctor, I'm John Burnett. We met	3	when it becomes a medical thing, then they
4	before the deposition. How are you, sir?	4	are referred to our nurse. And our nurse
5	A. Okay, John.	5	then triages the situation, if you may, and
6	Q. Sir, is it fair to say that you,	6	then determines whether or not it's something
7	as a practicing physician, have a duty to	7	that requires my attention.
8	each of your patients to render prudent and	8	Q. I see. And if it's not something
o 9	safe care? Is that fair?	9	that requires your attention, then the nurse
10	A. That is correct.	10	may get back to the person and refer the
		10	
11	Q. They rely on you to help them with	12	person to a physician appropriate to care for that purchases in that fair?
12	their medical problems. Is that a fair		that problem; is that fair?
13	characterization of how they come to you?	13	A. It may be a situation where the
14	A. Yes, that's true.	14	nurse may say, well, this certainly doesn't
15	Q. If you don't feel qualified to	15	sound like it's related to your heart or some
16	handle a problem they present to you with,	16	cardiac problem. I would suggest that you
17	you refer them to a doctor who can help	17	call your family practitioner or your
18	them, don't you?	18	internist and get his opinion on what to do
19	A. That is correct.	19	with this.
20	Q. And that's your duty to do that;	20	Q. Okay. And that's part of your job
21	isn't it, sir?	21	as a physician, to make sure your nurses
22	A. Yes, it is.	22	field a call like that and communicate back
23	Q. And, in fact, it's incumbent upon	23	with the patient; is that fair?
24	you that in the course of referring these	24	A. I would agree with that, yes.
25	folks to a doctor who can help them, you've	25	Q. Okay. Now, you mentioned something
	Page 34		Page 36
1	got to contact them back. If they've called	1	on direct examination about Mrs. Huerster,
2	and all the state of the state		
1	your office with a complaint, you contact	2	Sally Huerster, having a lung infection and
3	your office with a complaint, you contact them back, you talk to them, you find out	2 3	
1			Sally Huerster, having a lung infection and
3	them back, you talk to them, you find out	3	Sally Huerster, having a lung infection and there were antibiotics used to treat the lung
3 4	them back, you talk to them, you find out what the problem is, and you refer them on	34	Sally Huerster, having a lung infection and there were antibiotics used to treat the lung infection, which created a GI infection.
3 4 5	them back, you talk to them, you find out what the problem is, and you refer them on if appropriate. Is that fair, sir?	3 4 5	Sally Huerster, having a lung infection and there were antibiotics used to treat the lung infection, which created a GI infection. Does that kind of fairly restate what you
3 4 5 6	them back, you talk to them, you find out what the problem is, and you refer them on if appropriate. Is that fair, sir? A. If a patient comes to me with a	3 4 5 6	Sally Huerster, having a lung infection and there were antibiotics used to treat the lung infection, which created a GI infection. Does that kind of fairly restate what you told us?
3 4 5 6 7	them back, you talk to them, you find out what the problem is, and you refer them on if appropriate. Is that fair, sir? A. If a patient comes to me with a complaint and I see them in the office or	3 4 5 6 7	Sally Huerster, having a lung infection and there were antibiotics used to treat the lung infection, which created a GI infection. Does that kind of fairly restate what you told us? A. Right.
3 4 5 6 7 8	<ul><li>them back, you talk to them, you find out what the problem is, and you refer them on if appropriate. Is that fair, sir?</li><li>A. If a patient comes to me with a complaint and I see them in the office or they call the office and perhaps talk to my</li></ul>	3 4 5 6 7 8	<ul> <li>Sally Huerster, having a lung infection and there were antibiotics used to treat the lung infection, which created a GI infection.</li> <li>Does that kind of fairly restate what you told us?</li> <li>A. Right.</li> <li>Q. Okay. And this would be between the July or the June 25 discharge from</li> </ul>
3 4 5 6 7 8 9	them back, you talk to them, you find out what the problem is, and you refer them on if appropriate. Is that fair, sir? A. If a patient comes to me with a complaint and I see them in the office or they call the office and perhaps talk to my nurse and that sort of thing and they have a particular medical problem, I, if you may,	3 4 5 6 7 8 9	<ul> <li>Sally Huerster, having a lung infection and there were antibiotics used to treat the lung infection, which created a GI infection.</li> <li>Does that kind of fairly restate what you told us?</li> <li>A. Right.</li> <li>Q. Okay. And this would be between the July or the June 25 discharge from Parma Hospital and before the July 2</li> </ul>
3 4 5 6 7 8 9 10 11	them back, you talk to them, you find out what the problem is, and you refer them on if appropriate. Is that fair, sir? A. If a patient comes to me with a complaint and I see them in the office or they call the office and perhaps talk to my nurse and that sort of thing and they have a particular medical problem, I, if you may, triage that problem and then decide whether	3 4 5 6 7 8 9 10 11	<ul> <li>Sally Huerster, having a lung infection and there were antibiotics used to treat the lung infection, which created a GI infection.</li> <li>Does that kind of fairly restate what you told us?</li> <li>A. Right.</li> <li>Q. Okay. And this would be between the July or the June 25 discharge from Parma Hospital and before the July 2 admission to Parma Hospital; is that fair?</li> </ul>
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3 4 5 6 7 8 9 10 11 12 13 14 15 16	them back, you talk to them, you find out what the problem is, and you refer them on if appropriate. Is that fair, sir? A. If a patient comes to me with a complaint and I see them in the office or they call the office and perhaps talk to my nurse and that sort of thing and they have a particular medical problem, I, if you may, triage that problem and then decide whether that's something which is in my realm of expertise or whether that's something that should be referred to a more appropriate physician who has expertise in with that particular problem.	3 4 5 6 7 8 9 10 11 12 13 14 15 16	<ul> <li>Sally Huerster, having a lung infection and there were antibiotics used to treat the lung infection, which created a GI infection. Does that kind of fairly restate what you told us?</li> <li>A. Right.</li> <li>Q. Okay. And this would be between the July or the June 25 discharge from Parma Hospital and before the July 2 admission to Parma Hospital; is that fair?</li> <li>A. That's correct.</li> <li>Q. And that GI infection was C. difficile disease; is that fair?</li> <li>A. It was ultimately found to be that, yes.</li> </ul>
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10 (Pages 37 to 40)

	Page 37		Page 39
.1	Q. All right. You've taken care of a	1	absorb and endure an insult to the system
2	whole bunch of patients who have been	2	from an infection such as C. difficile
3	admitted to the hospital and you've seen them	3	disease; is that fair?
4	in the hospital and then they've been	4	A. Well, I think – in an elderly
5	discharged from the hospital; is that fair?	5	patient, a patient with a lot of other
6	A. That's pretty accurate, yes.	6	coexisting medical problems, I think it's more
7	Q. Okay. And then you'll follow them	7	important that you make an accurate diagnosis
8	after they're outside the hospital, after	8	before you, as we call it in the vernacular,
9	they've been discharged; is that fair?	9	start shotgunning with other medications. But
10	A. Primarily for their cardiac	10	you want to make a prompt diagnosis, if you
11	problems, but yes, I do.	11	can, of that patient's problem so you treat
12	Q. Okay. Now, Doctor, if one of your	12	it effectively and appropriately.
13	patients has been recently hospitalized, the	12	
13	patients has been recently hospitalized, the patient is over 60, the patient's been given	13	
14		15	you should diagnose it as a as a
í	antibiotics and calls your office complaining		cardiologist, but certainly, you want to get
16	of severe diarrhea, is it fair to say that	16	that have communication with that patient
17	either you or your nurse would tell that	17	to tell the patient to get to somewhere where
18	patient to either get to an internal medicine	18	a proper diagnosis can be had as soon as
19	physician or to an emergency room as soon as	19	possible; is that fair?
20	possible? Is that fair?	20	A. I think it's very important in
21	A. I would say probably, depending on	21	patients that there is a phone treatment
22	the length of duration of the diarrhea. I	22	plan, if you may, what to do if things get
23	mean, if it's if it's something that's	23	worse, what to do if things get better, and
24	been going on less than 24 hours, I may say,	24	and a follow-through to make sure that the
25	you know, if this thing's not heading the	25	patient's particular problem is appropriately
	Page 38		Page 40
1	right direction in the next 24 hours, then	1	addressed and and seen to.
2	you should give your your family	2	Q. Now, hypothetically, sir, if
3	practitioner or your internist a call because	3	Christine Huerster contacted Dr. Sechler's
4	it may be more than just a bug or a virus,	4	office on June 26 with complaints of severe
5	gastroenteral virus.	5	diarrhea on the part of Sally Huerster, that
6	Q. And, in fact and I know you	6	Sally was suffering from severe diarrhea,
7	don't practice primarily in internal medicine	7	hypothetically, it was certainly Dr. Sechler's
8	anymore, but given that someone's over 60,	8	office's obligation and Dr. Sechler's
9	they've been in the hospital, they've been on	9	obligation to do what you just described for
10	antibiotics, and they've got severe diarrhea	10	us, get back in touch with the patient and
11	that has been with them for over 24 hours,	11	establish a plan, fair?
12	you've got to least think about C. difficile	12	MR. TORGERSON: I'll object.
13	disease, don't you?	12	You can answer, Doctor.
J	· •	13	-
114	A if chauld definitely be un there	1 1 1 1	A. If I put myself in Dr. Sechler's
14	A. It should definitely be up there in your differential diamonic yes	1	shoop on the appreciation and this matters t
15	in your differential diagnosis, yes.	15	shoes as the cardiologist and this patient
15 16	in your differential diagnosis, yes. Q. And like any other infection, as a	15 16	had called me, I would say, this sounds like
15 16 17	in your differential diagnosis, yes. Q. And like any other infection, as a general principle, the sooner you begin	15 16 17	had called me, I would say, this sounds like it could be of some serious concern. It
15 16 17 18	in your differential diagnosis, yes. Q. And like any other infection, as a general principle, the sooner you begin appropriate treatment for it, the better; is	15 16 17 18	had called me, I would say, this sounds like it could be of some serious concern. It doesn't sound to me like it's a particular
15 16 17 18 19	in your differential diagnosis, yes. Q. And like any other infection, as a general principle, the sooner you begin appropriate treatment for it, the better; is that fair?	15 16 17 18 19	had called me, I would say, this sounds like it could be of some serious concern. It doesn't sound to me like it's a particular cardiac problem. I would suggest that you
15 16 17 18 19 20	in your differential diagnosis, yes. Q. And like any other infection, as a general principle, the sooner you begin appropriate treatment for it, the better; is that fair? A. Well, as a general rule, that's	15 16 17 18 19 20	had called me, I would say, this sounds like it could be of some serious concern. It doesn't sound to me like it's a particular cardiac problem. I would suggest that you contact your I know what my nurse would
15 16 17 18 19 20 21	<ul> <li>in your differential diagnosis, yes.</li> <li>Q. And like any other infection, as a general principle, the sooner you begin appropriate treatment for it, the better; is that fair?</li> <li>A. Well, as a general rule, that's probably true.</li> </ul>	15 16 17 18 19 20 21	had called me, I would say, this sounds like it could be of some serious concern. It doesn't sound to me like it's a particular cardiac problem. I would suggest that you contact your I know what my nurse would tell. They would say, you should contact your
15 16 17 18 19 20 21 22	<ul> <li>in your differential diagnosis, yes.</li> <li>Q. And like any other infection, as a general principle, the sooner you begin appropriate treatment for it, the better; is that fair?</li> <li>A. Well, as a general rule, that's probably true.</li> <li>Q. Okay. And I would assume it's</li> </ul>	15 16 17 18 19 20 21 22	had called me, I would say, this sounds like it could be of some serious concern. It doesn't sound to me like it's a particular cardiac problem. I would suggest that you contact your I know what my nurse would tell. They would say, you should contact your family physician or your your internist
15 16 17 18 19 20 21 22 23	<ul> <li>in your differential diagnosis, yes.</li> <li>Q. And like any other infection, as a general principle, the sooner you begin appropriate treatment for it, the better; is that fair?</li> <li>A. Well, as a general rule, that's probably true.</li> <li>Q. Okay. And I would assume it's even more true with an elderly patient with</li> </ul>	15 16 17 18 19 20 21 22 23	had called me, I would say, this sounds like it could be of some serious concern. It doesn't sound to me like it's a particular cardiac problem. I would suggest that you contact your I know what my nurse would tell. They would say, you should contact your family physician or your your internist about this issue, but it sounds like it could
15 16 17 18 19 20 21 22	<ul> <li>in your differential diagnosis, yes.</li> <li>Q. And like any other infection, as a general principle, the sooner you begin appropriate treatment for it, the better; is that fair?</li> <li>A. Well, as a general rule, that's probably true.</li> <li>Q. Okay. And I would assume it's</li> </ul>	15 16 17 18 19 20 21 22	had called me, I would say, this sounds like it could be of some serious concern. It doesn't sound to me like it's a particular cardiac problem. I would suggest that you contact your I know what my nurse would tell. They would say, you should contact your family physician or your your internist



Streamlined · Centralized · Standardized

¥	Page 41		Page 43
1	question on the 26th. If Sally Huerster's	1	practice physician, or an emergency department
2	testimony is that she also called on the	2	depending on the severity and duration of the
3	27th, I take it your answer would be the	3	diarrhea
4	same, sir; is that fair?	4	MR. TORGERSON: Object.
5	A. Yeah. And I would probably wonder	5	0. – fair?
6	why she hadn't contacted her internist.	6	MR. TORGERSON: Objection.
7	Q. And I would ask you the same	7	Sorry. Go ahead.
8	question for the 30th, sir. If she called	8	A. Again, I think the key thing you
9	you on the 30th with the same information,	9	said at the end was depending on the severity
10	again, the obligation would be the same,	10	and the duration of diarrhea. Unfortunately,
11	wouldn't it, to contact the patient back with	11	we all get diarrhea at one time or another.
12	a plan of action, fair?	12	But your your antenna should be up, if
13	A. Well, if this patient and I'm	13	you may, in a lady like this patient who's
14	saying I'm putting myself we're talking	14 .	had preexisting cardiac problems, preexisting
15	hypothetical, as you said. And if this is	15	lung problems, has been treated with
16	my patient and now she's called me the 26th,	16	antibiotics, and now having quite a bit of
17	the 27th, and now the 30th, and she's having	17	diarrhea.
18	diarrhea and I've suggested to her to contact	18	Q. And, certainly, sir, if the phone
19	her internist or her family practitioner and	19	call had been made on the 26th to Dr.
20	that's not happened, I'd certainly want to	20	Sechler's office by Christine Huerster and Dr.
21	know why that's not happened because that's	21	Sechler never got back to the family about
22	in my opinion, that's who the patient	22	this particular problem, the diarrhea,
23	needs to be contacting who would have the	23	certainly, you couldn't defend him on the
24	more appropriate expertise to manage this	24	standard of care in this regard, can you, or
25	problem.	25	you can't defend his group on the standard of
			,
1	Page 42		Page 44
1	Q. If – if Sally Huerster's		care, can you, if that, in fact, happened,
2	daughter-in-law, Christine Huerster, called the	2	sir?
3	office on the 26th, then it was Dr. Sechler's	3	MR. DZENITIS: Objection.
4		1 4	
	obligation, sir, and the duty and obligation	4	You can answer.
5	of his group, the Cardiovascular Clinic, to	5	You can answer. A. Well, again, I what I feel is
5 6	of his group, the Cardiovascular Clinic, to get back in touch with her and convey that	5 6	You can answer. A. Well, again, I what I feel is the standard of care is precisely what I
5 6 7	of his group, the Cardiovascular Clinic, to get back in touch with her and convey that information to her or her daughter-in-law just	5 6 7	You can answer. A. Well, again, I what I feel is the standard of care is precisely what I described to you. I don't know the facts
5 6 7 8	of his group, the Cardiovascular Clinic, to get back in touch with her and convey that information to her or her daughter-in-law just as you've said; is that fair?	5 6 7 8	You can answer. A. Well, again, I what I feel is the standard of care is precisely what I described to you. I don't know the facts well enough to say exactly what the
5 6 7 8 9	of his group, the Cardiovascular Clinic, to get back in touch with her and convey that information to her or her daughter-in-law just as you've said; is that fair? A. I think that if, as since Dr.	5 6 7 8 9	You can answer. A. Well, again, I what I feel is the standard of care is precisely what I described to you. I don't know the facts well enough to say exactly what the correspondence was between the doctor, the
5 6 7 8 9 10	of his group, the Cardiovascular Clinic, to get back in touch with her and convey that information to her or her daughter-in-law just as you've said; is that fair? A. I think that if, as since Dr. Sechler was the patient's cardiologist, I	5 6 7 8 9 10	You can answer. A. Well, again, I what I feel is the standard of care is precisely what I described to you. I don't know the facts well enough to say exactly what the correspondence was between the doctor, the nurse, the nurse, the patient, the nurse, the
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5 6 7 8 9 10 11 12 13	<ul> <li>of his group, the Cardiovascular Clinic, to get back in touch with her and convey that information to her or her daughter-in-law just as you've said; is that fair?</li> <li>A. I think that if, as since Dr.</li> <li>Sechler was the patient's cardiologist, I think that if this patient sought out help and assistance that it was important that Dr.</li> <li>Sechler and/or his nurse communicate with the</li> </ul>	5 6 7 8 9 10 11 12 13	You can answer. A. Well, again, I what I feel is the standard of care is precisely what I described to you. I don't know the facts well enough to say exactly what the correspondence was between the doctor, the nurse, the nurse, the patient, the nurse, the the I guess it was the niece. I don't know that for sure. But what I will say is this, is that when my patients get
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12 (Pages 45 to 48)

[			······································
1	Page 45 Q. Okay. Is it fair to say, sir, to	1	Page 47 I think that what I was pressing
2	summarize your opinion, as you at least told	2	you on was how is it that your opinion as to
3	me in your deposition, that Sally Huerster's	3	the cause of death differs from Dr. Crane's
4	cause of death was a combination of things?	4	if, in fact, I've articulated it correctly?
5	It was a combination of the mucus plug	5	What was your answer, sir?
6	superimposed on sepsis; is that fair?	6	A. I do not believe that the – I
7	A. Well, to say that she had sepsis,	7	
8	I think, is stretching it a little bit. And	8	believe, to put this question into context, we must
9	the reason I say that is is we we have	9	Q. Sir, excuse me. Would you please
10	certain markers or, what we call, parameters	10	just read your answer.
11	that define what sepsis is, and one of the	11	MR. TORGERSON: Let me interpose
12	hallmarks of sepsis is a low blood pressure.	12	an objection to reading his answer without
13	And throughout her course, she never had a	13	foundation.
14	low blood pressure that would be consistent	14	Thanks.
15	with sepsis. She indeed had an infection.	15	A. Okay. Now, let's get this
16	There was no question about that. But what	16	straight again. Sorry. I'm not sure. Do
17	sepsis is is when the infection gets in the	17	you want me just to read verbatim what I
18	bloodstream and the bacteria release certain	18	said starting with what line and on what
19	types of poisons or toxins, which then have a	19	page?
20	dramatic effect on the entire cardiovascular	20	Q. Yes, if you would, please, sir.
21	system where there is a lack of adequate	21	A. Okay. Tell me what line and what
22	tissue oxygenation and a collapse of the	22	page you want me to read.
23	cardiovascular system. That's sepsis. And	23	Q. I'm sorry, sir. This would be
24	really I don't think at the time of her	24	page 33.
25	demise was she truly septic.	25	A. Okay.
	Page 46		Page 48
1	Q. Doctor, I'd like to direct your	1	Q. And my question to you is on line
2	attention to your deposition transcript,	2	14, and your answer begins on line 19,
3	please. Do you have that in front of you?	3	please.
4	A. Yes, I do.	4	A. Okay. But I think that what was
5	Q. Yes, sir.	5	pressing you on how
6	Sir, we had a chance to talk in	6	Q. That's my question. Your answer
7	that case on September 1, 2004; is that fair?	7	begins on line 19 right down there.
8	A. Yes.	8	A. So you want me to read starting at
9	Q. Okay. Sir, did I ask you the	9	line 19?
10	following question on page 5 of your	10	Q. Yes, sir, your answer.
11	deposition, starting at line 15? One of my	11	A. Okay.
12	goals here is to walk away from this	12	Q. I'll read the questions I asked
13	deposition with a full understanding of your	13	you and if you would read me the answers,
14	opinions in this case as well as each and	14	please, sir.
15	every basis for the opinions. So as we go	15	A. All right. Very good.
16	through this, if for some reason I have cut	16	I do not believe that the high
17	you off and not let you answer fully, will	17	potassium levels, the low bicarbonate level,
18	you tell me that so you can go ahead and	18	in and of themselves caused the cardiac
19	give me your full answer.	19	arrest and the demise. What caused her
20	And what was your answer, sir?	20	demise, I think, probably was a combination
21	A. Yes, I will.	21	of the mucus plug, which was documented on
22	Q. Okay. Sir, I'd like to direct	22	the autopsy, which most likely created lack
23	your attention to page 33, please. Did I	23	of air exchange, if you may, in this patient,
24	ask you the following question at line 14,	24	which subsequently led to low oxygen levels
105	sir?	25	that in the face of probably sepsis that
25	She :	20	mat in the face of probably sepsis that



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	Page 49		Page 51
.1	was not fully under control. The antibiotic	1	direct your attention to page 39, if I could,
2	hadn't controlled the problem coupled with	2	please. On – page 39, line 4, sir, did I
3	abnormal potassium and bicarbonate levels.	3	ask you the following question?
4	They all added up to her demise.	4	So really then the cause of death
5	Q. Doctor	5	is actually a combination of the mucus plug
6	A. But I can tell you that in	6	and the sepsis, which was not fully under
7	patients who die strictly of hyperkalemia, it	7	control; is that fair?
8	is that they have very dramatic changes on	8	And what was your response, sir?
9	their EKG rhythm strips, which this patient	9	MR. TORGERSON: Objection.
10	did not have.	10	Foundation.
11	Do you want me to continue to read	11	A. Am I should I just read
12	this answer?	12	verbatim or I'm not allowed to say
13	Q. No, sir. That's okay.	13	anything else? I just read what you want me
14	I'd like to direct your attention	14	to?
15	to page 35. At the top, I asked you the	15	Q. At this point, would you please
16	following question, sir, and I would like you	16	just read verbatim
17	then to read me your answer.	17	A. Okay.
18	Did the sepsis cause the kidney	18	Q. – what your answer was.
19	failure?	19	A. I would say that would be, in my
20	What was your answer, please, sir?	20	opinion, the best guess.
21	MR. TORGERSON: Objection.	21	Q. And my next question to you, sir,
22	Foundation.	22	was: Would you hold that opinion to a
23	A. I think the sepsis probably caused	23	reasonable degree of medical probability?
24	pretty much organ, total body shutdown towards	24	And what was your answer, sir?
25	the end, in the last 24 to 36 hours of this	25	MR. TORGERSON: Objection.
		I	
	Page 50		Page 5
1	Page 50 patient's illness. The sepsis basically	1	Page 5 Foundation.
1 2		1 2	Page 5 Foundation. A. Yes, I would.
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2	patient's illness. The sepsis basically hampered the kidney function such that she	2	Foundation. A. Yes, I would.
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2 3 4 5 6 7 8	<ul> <li>patient's illness. The sepsis basically</li> <li>hampered the kidney function such that she</li> <li>was less capable to rid her body of the</li> <li>poisons we all need to get rid of every day,</li> <li>as well as because of her chronic</li> <li>cardiovascular problems and her chronic</li> <li>pulmonary problems, her immune resistance was</li> <li>down, and despite using the appropriate</li> <li>antibiotics, they weren't working.</li> <li>Q. Then did I ask you the following</li> <li>question, sir?</li> <li>Was the sepsis more than likely</li> <li>more than likely than not caused by the C.</li> <li>difficile disease?</li> <li>And what was your answer please,</li> <li>sir, on line 18?</li> <li>A. Again, it's a little difficult for</li> <li>me to render an opinion on that, but I think</li> <li>if it wasn't the C. difficile infection, I</li> <li>don't know what else it could be. But I</li> <li>certainly or but I would certainly defer</li> </ul>	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	<ul> <li>Foundation.</li> <li>A. Yes, I would.</li> <li>Q. Furthermore, sir, we've talked about sepsis in your deposition. And do you agree now, sir, that, in fact, she was septic after reviewing your deposition transcript in this case?</li> <li>A. No. I basically stand by what I said before we started the question-and-answer session, and that is that, yes, she could have been septic but we did not have the absolute proof.</li> <li>If you lined up ten doctors, ten infectious disease doctors, I would submit to you that more than likely you would have an argument about whether or not she was truly septic.</li> <li>I think she had an infection. To say sepsis and what your definition of sepsis is, what my definition of sepsis is, what an infectious disease doctor's definition of</li> </ul>



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www-setdepo-com

14 (Pages 53 to 56)

.1	Page 53	1	Page 55 DESCRIPTION OF EXHIBITS
(	compromise. Were there blood cultures that	2	EXHIBIT DESCRIPTION
2	were positive to confirm that there was C.	2 3	
3	difficile in her bloodstream? No, there		1 (Curriculum Vitae)
4	wasn't. So I think it's you used the	4	•
5	word first sepsis, and I guess I fell into	5	•
6	going right along with it along with the	6	
7	mucus plug. But, you know, I can't sit here	7	
8	today and say for sure that this woman had	8	
9	true sepsis.	9	
10	Q. Did you have an opportunity to	10	•
11	review your deposition after it was taken,	11	
12	sir?	12	
13	A. Yes, I did.	13	
14	Q. Okay. Did you ever attempt to	14	
15	contact me to convey the change in your	15	
16	opinion with regard to the sepsis issue, sir?	16	
17	A. I don't believe that I'm really	17	
18	changing my opinion.	18	
19	MR. BURNETT: Okay. That's all I	19	
20	have. Thank you.	20	
21	MR. TORGERSON: I'm satisfied with	21	
22	the testimony. I have no questions at this	22	
23	time.	23	
24	MR. DZENITIS: No other questions.	24	•
25	Thank you, Doctor.	25	
$ \begin{array}{c} 1\\ 2\\ 3\\ 4\\ 5\\ 6\\ 7\\ 8\\ 9\\ 10\\ 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 19\\ 20\\ \end{array} $	MR. BURNETT: Thank you. THE WITNESS: Thank you. THE VIDEOGRAPHER: End of deposition. (Signature not waived.) And, thereupon, the deposition was concluded at approximately 6:44 p.m.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	CERTIFICATE State of Ohio : SS : County of Franklin : I, Sharon T. Pontius, Notary Public in and for the State of Ohio, duly commissioned and qualified, certify that the within named BARRY S. GEORGE, M.D. was by me duly sworn to testify to the whole truth in the cause aforesaid; that the testimony was taken down by me in stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony given by said witness taken at the time and place in the foregoing caption specified. I certify that I am not a relative, employee, or attorney of any of the parties hereto, or of any attorney or counsel employed by the parties, or financially interested in the action. IN WITNESS WHEREOF, I have set my hand and affixed my seal of office at Columbus, Ohio, on
21 22 23 24 25	•	21 22 23 24 25	this 3rd day of November, 2004. SHARON T. PONTIUS, Notary Public in and for the State of Ohio and Registered Merit Reporter. My Commission expires March 13, 2006.





Streamlined • Centralized • Standardized The Evolution of Deposition Management

1	Page 57 CAPTION		Page 59 DEPOSITION ERRATA SHEET
2	The Deposition of Barry S. George,	2	DEI OSTIION ENGLIN SILLEI
3	M.D., taken in the matter, on the date, and	$\frac{2}{3}$	RE: SetDepo, Inc.
4	at the time and place set out on the title	4	File No. 5205
5	page hereof.	5	Case Caption: Michelle R. Freeman vs.
6	It was requested that the deposition	6	Cardiovascular Clinic, et al.
7	be taken by the reporter and that same be	7	Carciovascalar Chine, et al.
8	reduced to typewritten form.	8	Deponent: Barry S. George, M.D.
9	It was agreed by and between counsel	9	Deposition Date: November 1, 2004
10	and the parties that the Deponent will read	10	Deposition Date. November 1, 2001
11	and sign the transcript of said deposition.	11	To the Reporter:
12	and orgit the transcript of said deposition.	12	I have read the entire transcript of my
13	•	13	Deposition taken in the captioned matter or
14	•	14	the same has been read to me. I request
15	•	15	that the following changes be entered upon
16	•	16	the record for the reasons indicated. I
17		17	have signed my name to the Errata Sheet and
18		18	the appropriate Certificate and authorize you
19		19	to attach both to the original transcript.
20	· · · · · · · · · · · · · · · · · · ·	20	
$\frac{20}{21}$		21	Page No. Line No. Change to:
22	•	22	
23		23	Reason for change:
24		24	Page No. Line No. Change to:
25		25	
	· · · · · · · · · · · · · · · · · · ·		
1	Page 58 CERTIFICATE	1	Page 60
1	STATE OF :		Reason for change:
23	COUNTY/CITY OF :	23	Page No. Line No. Change to:
4	COUNTION .	E 7	1
	Refore me this day personally	•	Person for change:
	Before me, this day, personally	4	Reason for change:
5	appeared, Barry S. George, M.D., who, being	45	Reason for change: Page No. Line No. Change to:
5 6	appeared, Barry S. George, M.D., who, being duly sworn, states that the foregoing	4 5 6	Page No. Line No. Change to:
5 6 7	appeared, Barry S. George, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in	4 5 6 7	Page No. Line No. Change to: Reason for change:
5 6 7 8	appeared, Barry S. George, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and	4 5 6 7 8	Page No. Line No. Change to:
5 6 7 8 9	appeared, Barry S. George, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof,	4 5 6 7 8 9	Page No. Line No. Change to: Reason for change: Page No. Line No. Change to:
5 6 7 8 9 10	appeared, Barry S. George, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of	4 5 6 7 8 9 10	Page No. Line No. Change to: Reason for change: Page No. Line No. Change to: Reason for change:
5 6 7 8 9 10 11	appeared, Barry S. George, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof,	4 5 6 7 8 9 10 11	Page No. Line No. Change to: Reason for change: Page No. Line No. Change to:
5 6 7 8 9 10 11 12	appeared, Barry S. George, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition.	4 5 6 7 8 9 10 11 12	Page No. Line No. Change to: Reason for change: Page No. Line No. Change to: Reason for change: Deposition of Barry S. George, M.D.
5 6 7 8 9 10 11 12 13	appeared, Barry S. George, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of	4 5 6 7 8 9 10 11 12 13	Page No. Line No. Change to: Reason for change: Page No. Line No. Change to: Reason for change:
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# Videotaped Deposition of Barry S. George, M.D. - November 1, 2004

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