State of Ohio,)
) SS:
County of Lorain.)

IN THE COURT OF COMMON PLEAS

Sandra Johnson, Adminstratrix, et al.,)
)
Plaintiffs,)
vs.) No. 98 CV 122198
Akbar Naeem, M.D., et al.,)
Defendants.)

DEPOSITION OF JONATHAN GLAUSER, MODI
Tuesday, August 8, 2000

Deposition of JONATHAN GLAUSER, M.D., a witness herein, called on behalf of the plaintiffs for oral examination, pursuant to the Ohio Rules of Civil Procedure, taken before Judi Sadler, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice at the offices of Mazanec, Raskin & Ryder, 100 Franklin's Row, 34305 Solon Road, Cleveland, Ohio, on Tuesday, August 8, 2000, commencing at 5:20 p.m.

I N D E X

E X H I B I T S

APPEARANCES:

On behalf of the Plaintiffs:

Richard Dempsey, Esq.
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On behalf of Defendant Elyria Memorial Hospital:

Leslie Spisak, Esq.
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On behalf of Defendants Dr. Marion R. Prince and Dr. Carroll Marion:

Colleen Healy Petrello, Esq.
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JONATHAN GLAUSER, M.D.

of lawful age, being first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

By Mr. Dempsey:

Q. Doctor, I'm Richard Dempsey, I represent Sandra Johnson who is the administratrix of the estate of her late husband, Moses Johnson.

I'm going to take your deposition today.

I'll try not to be too long. Mr. Spisak may have some questions for you, as well, on behalf of Elyria Memorial Hospital. If you don't understand a question that I ask you or he asks you, will you ask us to repeat it?

A. Yes.

Q. Repeat or rephrase, whatever you're comfortable with. I take it you've had your deposition taken before?

A. Yes.

Q. Okay. So you're aware that the court reporter is taking down the questions and the responses?

A. Yes.

Q. And as you've done thus far, please continue to give your answers out loud so the court reporter

can take everything down. Fair enough?
A. Yes.
Q. Okay, great. Where do you live?
A. I live in Shaker Heights.
Q. Where? What's your address?
A. 22790 South Woodland, Shaker Heights, Ohio 44122.
Q. Where were you born?
A. Philadelphia, Pennsylvania.
Q. When did you come to the Cleveland area?
A. I came to the Cleveland area in 1979 after my residency in emergency medicine, which I did in Minneapolis, Minnesota.
Q. Wait. What year did you come to Cleveland?
A. 1979.
Q. '79. And have you practiced here?
A. Yes.
Q. Are you licensed in Ohio?
A. Yes.
Q. When did you get your license to practice medicine?
A. It must have been around May of 1979.
Q. Board certified?
A. Yes.
Q. In?
A. Emergency medicine.
Q. Are you with a group?

A. Yes.
Q. What's the name of your group?
A. Oh, actually, I don't know the name.
by the Cleveland Clinic Foundation and ...
emergency department staffs, both MetroHealth
Medical Center and the Cleveland Clinic.
Q. Where do you practice or do you go to different
locations as they send you?
A. Mainly to Cleveland Clinic and 1 attend at Metro,
as well,
Q. Now, the Cleveland Clinic's emergency department,
is it on the -- where is it, on the south side of
the street or the north side of the street?
There's a Kaiser emergency department, isn't there?
A. We share the same building.
Q. Clinic and Kaiser share that building on the --
A. Carnegie. The south side of Carnegie between 89th
and 93rd.
MR. DEMPSEY: Just off the record.
(Discussion off the record.)
MR. DEMPSEY: Okay. Back on the
record,
Q. Now, you've been with the Clinic how long?
A. Approximately a year and a half.
Q. Okay. What's your prior experience to that? What

did you do?

A. I've been full time in emergency medicine since 1979. I worked full time at Mount Sinai Medical Center and then at University Hospitals, I left University Hospitals at the end of February 1999,

Q. Okay, So how many years were you with UH?

A. A little more than two.

Q. And prior to that, Mount Sinai?

A. Mount Sinai,

Q. For how many? About ten years? No, it would be longer than that,

A. More. 16, 17,

Q. Okay, What did you review in connection with this case? Everything that's in your letter -- do you have a copy of your letter in front of you or do you have one close by? I see that --

A. I reviewed the materials in my report and I'm trying to get a copy of my report here, Here.

Q. Okay. You see Items 1 through 9 in the July 6th report?

A. Yes.

Q. Have you reviewed anything other than those items?

A. No.

Q. Have you seen the depositions of Drs. Blinkhorn or Watts?

A. No.
Q. Have you been told what their opinions are in this case?
A. No.
Q. Have you seen their reports?
A. No.
Q. My understanding is that the opinions that you will offer at trial in this case are confined to the care that Mr. Johnson received in the emergency department at Elyria Memorial Hospital on the visits of November 10 and 23?
A. Yes.
Q. You have not offered any opinions as to what Mr. Johnson's cause of death was; is that correct?
A, No, They were listed on the autopsy,
Q. Do you have any reason to dispute those findings?
A, No.
Q. Okay, Is there anything in the -- let's see. Did you review -- so you did review the autopsy? Yes, okay.
A, Yes,
Q. And 1 assume you've seen the death certificate associated with that? I just want to know if there's anything in the coroner's findings that you take issue with or you believe is incorrect?

A. No.
Q. Okay. Did you have notes or did you ju your report from memory?
A. I took notes at the beginning of a couple of depositions.
Q. Do you have your entire file with you?
A. Yes.
Q. Are the notes with it?
A. Let's see. If I have notes, they would be with me here.
Q. Okay.
A. What would you like?
Q. I just want to take a look at your entire file.
A. This is my notes for Dr. Zivot's deposition. These are some notes for the medical records on Mr. Johnson. These are some notes on the deposition of Dr. Naeem.
Q. Okay. Are they throughout or just in the front?
A. Just in the front.
Q. You basically go through the deposition and you make reference to the page or the locations --
A. Yes.
Q. -- That assist you in preparing your report?
A. Yes.
Q. Okay.

A. Here are my notes for the deposition of Sandra Johnson and I did not take any notes for the deposition of Dawn Sturgeon,

Q. Does your file contain correspondence between yourself and Ms. Petrello?

A. I have a letter from Ms. Petrello.

Q. That's just asking you to review?

A. Yes.

Q. Let me take a peek at that.

And then she asked you to telephone her to discuss after you'd had a chance to review these items?

A. Yes. Once I've had an opportunity to review the records, please telephone me.

Q. And did you do that?

A. Yes.

Q. And what did you discuss at that point in time?

A. We discussed the nature of Mr. Johnson's illness and his emergency care,

Q. Okay, And then you generated a report? She asked you to generate a report, obviously?

A. Yes.

Q. And that's the report that's here?

A. Yes.

Q. Any other reports?

A. That's the only one that I've written.
Q. Any other drafts of this report?
A. No.
Q. Okay. Well, what is the extent of your prior, let's say, litigation experience either by way of deposition or at trial? How many cases have you looked at, and these would be legal cases as opposed to medical cases.
A. It's hard to estimate. It seems that I do a couple a year and so the extent would probably be at least 40 over the course of my 20-some years out of residency.
Q. Any for plaintiff's counsel?
A. Yes.
Q. Any for this particular firm, Mazanec, Raskin & Ryder, or Colleen Petrello or Ms. Harris?
A. Well, I just met Ms. Petrello today in person. I've been here before, so I must have reviewed a case in the past, but not the recent past. I mean, not this year.
Q. You don't recall what it was?
A. No, I don't.
Q. Have you confined your litigation experience to emergency department issues only?
A. Yes.

Q. Whether or not the standard of care v
emergency department?
A. Yes.
Q. Okay. Does University Hospitals hav
wait, strike that.
What is the percentage plaintiff's versus defendant's cases that you've reviewed over the years?
A. I would have a hard time estimating. I think I've probably done more for the defense.
Q. Have you ever worked for the Reminger law firm?
A. I have reviewed cases for the Reminger law firm.
Q. Had you met Mr. Spisak before? Have you met him?
A. I'm not sure if I met him before today. I may have.
Q. What about my law firm; do you know if you've ever reviewed cases for my law firm, Nurenberg, Plevin, Heller & McCarthy?
A. I don't know that I have.
Q. Throughout the time that you were at Mount Sinai, did they have a fixed emergency department? If somebody came in with a broken elbow or something, they could go right to the emergency room and there would be a set place that's the emergency room, that's where you would go?

A. Yes.
Q. Did you break down into acute versu
was it just an emergency department
A. At Mount Sinai it was not divided
Q. Okay. How about at University Hospital?
A. University Hospital used to have a fast track that was separate on another floor.
Q. Fast, did you say?
A. Well, it was called fast track. It was an urgent care center. It was operated independently. You'd still present to the emergency department triage desk, but if the triage nurse deemed it was not an acute problem, you would go up to Bolwell to be seen as opposed to the acute care emergency department.
They closed that in February -- January of '97 and I understand that they may be building something to reopen it.
Q. How about the Clinic?
A. The Clinic has a fast track -- has a -- it's -- what's it called? It has a nonacute area that patients could be triaged to.
Q. Do you understand the setup at Elyria Memorial Hospital on November 10, 1996 when Mr. Johnson was there?

A. My understanding was -- is that Med Expre
place in which patients who are deemed tc
nonacute were sent as opposed to the acute side -
the emergency department, but I haven't seen the
setup.
Q. Is that similar to what they had at University or
is that different, do you know?
MS. PETRELLO: Well, objection.
A. I don't know. I haven't seen it.
Q. Well, you read Dr. Prince's deposition?
A. Right. My understanding is it would be similar to
what University Hospitals had before **1997**, but I
can't attest to that. I haven't seen the setup at
Elyria.
Q. Okay. Is it the standard of care in the medical
community at large to take vital signs when a
patient presents to the emergency department?
A. I don't want to make semantics out of this because
the standard of care is dependent upon what the
policy is of the emergency department, so we have
to separate what the hospital's policy is from what
actual care is provided by the physician.
Q. Explain what you mean as it relates to taking
vitals. Give me an example.
A. Well, my understanding in this case that Elyria

Memorial Hospital had a policy that were triaged to the Med Express si nonacute side, did not routinely That was their policy at the time

Q. Did that policy change?

My understanding, I've been told that it has, but I can't attest to that. I've never been inside Elyria Memorial Hospital.

Okay. Have you ever worked at an emergency department where vitals were not taken of anybody that came in? Any hospital that you've ever been -- tell me every hospital whether it was, --yeah, anyplace that you've ever been, I want to know; your internship, your residency, your medical school, even one you went to as a kid when you sprained your ankle, I don't care. Any hospital that you've been at, that you worked at or visited, that didn't take vitals, I'm talking about the United States.

MR. SPISAR: I just want to make sure I understand this, You're asking this witness to tell you if he has ever been in any hospital in the world or just in the United States --

MR. DEMPSEY: Just in the United

States.

MR. SPISAK: -- Where never been taken on any one oc were ever taken, period?

MR. DENPSEY: Well, I'm going to break it down that way, sure.

MR. SPISAK: I don't understand the question,

MS. PETRELLO: Yeah, note my objection, as well.

A. I have worked -- all of the hospitals that 1 have been employed at full time have checked vital signs on patients. Now, there are clearly individual instances in which not all vital signs are taken for different reasons.

Q. Can you give me the examples that you can think of in your experience?

A. There are cases where people may come in with, say, chest pain where they have their pulse taken, their blood pressure taken and no temperature taken. It was felt that for some reason it didn't -- the immediate problem didn't have to do with that particular vital sign and it was left blank for some reason. But every place that I've worked at had vital signs taken in the acute side of the

emergency room department.
Q. What about on the nonacute care sid
A. Well, Mount Sinai didn't have a non
the emergency department, When I wa
Hospital there was no nonacute side
emergency department, At the Cleveland Clinic we take vital signs on the acute care side of the emergency department and I can attest that we have since 1999, since I've been there,
Q. And you did at University Hospitals?
A, University Hospitals when I was there did not have a nonacute side,
Q. But on the acute care side?
A. Yes.
Q. At University Hospitals they would take acute and nonacute conditions in their emergency room? They didn't separate them?
A. They didn't separate them out.
Q. And am I correct that they took vital signs of all the patients?
A. Yes,

MS. PETRELLO: At UH?
MR. SPISAK: At UH?
MS. PETRELLO: They didn't separate it.

MR. DEMPSEY: When he was there, they didn't?

A. When I was there, UH did not have a separate facility for nonacute fast track patients. They were identified in triage perhaps as not being acute, but they were all seen in the emergency department.

Q. Sure. When you went to -- I'm sorry. When you worked at University Hospitals, patients who came into the emergency room would be both acute and nonacute cases?

A. Yes.

Q. And all of those patients would have their vital signs taken?

A. Some of them, if they were deemed truly acute, may not have all of their vital signs taken.

Q. Truly acute?

A. Well, once again, if somebody came in with acute pulmonary edema or chest pain specifically, they would almost invariably get their pulse and blood pressure taken, sometimes not their temperature.

Q. But nonacute?

A. At University there was not a separate nonacute track. That closed in January of 1997. There was not a separate urgent care fast track there,

Q. But nonacute patients would have th pressure and temperature checked upo the emergency department?
A. Upon arrival at the time.
Q. Same at Mount Sinai?
A. Yes.
Q. Same at the Clinic?
MR. SPISAK: You're talking about a non and acute emergency department?
MR. DEMPSEY: Nonacute in an emergency department.
MS. PETRELLO: At UH, there's no distinction.
A. At Mount Sinai and University Hospitals everyone was seen in the adult emergency department, There was no separate fast track,
Q. It was called the emergency department, right?
A. It was called the emergency department.
Q. It was not called the acute or the nonacute, it was just called the emergency department?
A. Right. There was no separate fast track, there was no separate Med Express, there was no separate facility for seeing nonacute patients.
Q. The emergency department at Mount Sinai, when you worked there, saw acute and nonacute patients?

A. Yes.
Q. And they took vitals that would includ
pressure and temperature of nonacute p
Ae Yes. Now, back to your prior question, -- ----
patients who did not get a full set of vital signs?
Yes, there were.
Q. And those would be the acute patients where it
wasn't needed?
A. No, sometimes the nonacute. 1 could come up with
many examples where a particular vital sign was
eliminated and nobody thought that it was
clinically indicated to get it.
Q. Okay. Such as?
Ae Such as if you come in with a corneal abrasion
where clearly it's an isolated problem with one
organ system, and if somebody left out a
respiratory rate or a temperature and it was felt
to be clinically irrelevant to the presenting
problem, perhaps it was overlooked in triage and
the physician didn't think it added anything to the
care, so they didn't go back and recheck that
particular vital sign.
Q. Triage is the nurse taking the initial information,
vitals, whatever it may be?
A. Well, triage is a sorting out process. The triage

nurse's job is to assess who is sickest, who needs to come back in what setting. So for the next open bed, who's the sickest patient who gets it.

Q. What about at University, then? As I know it when you were there, University Hospitals, it was just called the emergency department?

A. Yes.

Q. There was no acute versus nonacute distinction?

A. No. There was still triage to assess who was sickest, who were the Category 1, 2, 3 patients who had to come back, but there was no physically geographic separate section when I was there.

Q. And the same would be the case at the Cleveland Clinic?

A. No. Cleveland Clinic has a separate section which is a fast track urgent care.

Q. Are you familiar with the fast track urgent care at the Cleveland Clinic?

A. Yes.

Q. Have you worked in it?

A. Yes.

Q. Are vitals taken there?

A. Yes.

Q. What vitals?

A. The standard vital signs are pulse, temperature,

blood pressure, respiratory rate.

Q. Is it the nurse's job to take the vitals or the emergency room physician's job to take the vitals?

A, In our institution it's done, in general, by nursing staff, If a physician feels that it is indicated, they're free to either request a repeat of the vital signs or fill in any blanks in the vital signs that weren't taken. It's the job of everybody who's taking care of the patient.

Q. In your entire career as an emergency department physician, which is how many years now?

A. 21 out of residency,

Q. Have you ever seen a hospital -- well, let's include residency and medical school. How many years of medical training?

A. 24,

Q. 24. Have you ever seen a hospital with an emergency department, acute or nonacute, that completely disregards a patient's vital signs?

MR. SPISAK: Note my objection to that.

MS. PETRELLO: Objection.

MR. SPISAK: There's no evidence to that fact,

A. Nobody can disregard vital signs, That's why

they're called vital. If I see your vital signs, I don't disregard them.

Q. What I'm saying is, you're familiar with what Elyria claims their policy was at the time Mr. Johnson came to the hospital?

A. My understanding was that people who were triaged to the Med Express side, that is, they were deemed by whatever nurse assessed them to be nonacute, did not routinely get vital signs. That was my understanding of their policy.

Q. Have you ever seen that policy at any other hospital in your 24 years in the medical field?

MR. SPISAK: Objection.

MS. PETRELLO: Objection.

A. I can't say that I've studied a lot of hospitals' policies along those lines.

Q. Fair enough. Let's just confine it to the hospitals that you have been affiliated with in the 24 years.

MR. SPISAK: Most of which haven't had nonacute facilities.

MS. PETRELLO: Objection, as well.

Q. Whether they've had acute or nonacute facilities, whether the distinction has been made or not, have you ever seen that policy at any of the hospitals

that you have been affiliated with?

A. The hospitals that 1 have been affiliated with have policies of routinely collecting vital signs on patients who present to the emergency department.

Q. Were you trained as to what vital signs are or why you take them? Is that part of your medical school training?

A. I don't know that there's specific training on why vital signs are taken. It's an assumption that vital signs -- vital signs may be important in the assessment of certain types of patients, and, in the word, the implication is that vital signs are vital.

Now, there's argument within the house of emergency medicine over what those signs -- those vital signs should be and whether they're really relevant to every patient. Many people think that, for example, pulse oximetry should be done on everyone as a fifth vital sign, that it's certainly more important than some of the others in a lot of patients. So what signs are vital can be arbitrary in some cases.

Q. Well, someone with knowledge relative to the standard of care as to what an emergency department does or the emergency physician does, to your

knowledge, is it the standard of care throughout the United States for an emergency department, whether it's acute or nonacute or whether they have an acute side versus a nonacute side to take vital signs?

MR. SPISAK: Objection.

MS. PETRELLO: Well, I'm going to make an objection,

MR. DEMPSEY: No speeches, just an objection. That's all you're allowed to make on the record,

MS. PETRELLO: Are you talking about 1996? Are you talking about 2000? And it does make a difference if it's acute versus nonacute and it makes a difference in what year.

MR. DEMPSEY: I've been very patient letting you make speeches, but 1 want to make my position clear. If there are any more speeches or clarifications -- if I screw up the question I've got to live with it at trial and you'll be able to say to the judge, He didn't say vital, he didn't say acute, he didn't say '96, he didn't say

2000. But as far as I understand, you're not allowed to make speeches because that could be sending signals over to the witness. I don't think you're trying to do that, I think you're trying to make things clear here. But, in fairness, if you're going to continue to make speeches, I'm going to have to stop the deposition, get a ruling from Judge Betleski and get a ruling that I be allowed to ask the questions without them.

I just want you to understand that.

MS. PETRELLO: Well, Richard, I'm trying to make the record clear.

MR. DEMPSEY: I understand.

MS. PETRELLO: And I'm trying to make it fair, all right? And there are issues as to the years and what you're talking about because you're mixing it up.

So to the extent that I can abide by your warning, I will. But to the extent that I can't, don't expect me to.

MR. DEMPSEY: We still like each other even if she called me Richard, and we're yelling at each other -- well, were

not yelling.

MS. PETRELLO: we're not yelling. My daughter would tell you I'm not yelling.

MR. SPISAK: I haven't heard anybody yelling and I haven't heard any speeches. I just want to say that on the record,

MR. DEMPSEY: Thank you, Mr. Spisak, on our next vice president.

Q. I'm asking you about the standard of care. Let's nail it down. Throughout the entire time that you have practiced -- and what year did you start medical school?

A. 1976.

Q. And when did you first step into a hospital as part of your medical school?

A. Oh, I'm sorry, I started medical school in 1972.

Q. In '72. And that was in what city?

A. Philadelphia.

Q. And you stepped into a hospital as part of your medical training and got your feet wet in 19- --

A. 1974.

Q. The third year of your medical school?

A. Yeah.

Q. From '74 up through the present it a fair statement that it ha understanding that regardless nonacute patients, regardless hospital has an acute or a nor! standard of care in this count your knowledge -- and again I understand that it's based on your experiences at the hospitals you've been with, and if it's based on reading journals or being familiar with other hospitals, for whatever reason -- that the standard of care is to take the patient's vitals when they present to the emergency department and those vitals would include blood pressure and temperature?

MR. SPISAK: Note my objection.

MS. PETRELLO: Mine, as well.

A. Okay. Speaking as a physician, I'm not a lawyer, let me explain what my perception of what standard of care is and why I think it's really important to the clinical practice of medicine.

Every place I've practiced has a policy of checking vital signs on patients who come into the emergency department regardless of their complaint. Where I have a problem with the concept is the care itself, Some vital **signs** are clearly --

historically, vital signs have been defined as respiratory rate, temperature, pulse and blood pressure. And sometimes they're left out and sometimes the physician doesn't care because they're not relevant to what the patient has. If you have a scratch on your eye it almost doesn't matter what your respiratory rate is,

It doesn't matter what your temperature is. Most people would rather have a pulse oximetry on a patient. That's going to tell me more, I'd rather have five vital signs. The care provided depends on what the patient has, not on any fixed rules.

And the reason, in this case, is that it's more than a matter of semantics because this particular hospital had a policy of not mandating vital signs on a patient who didn't appear sick to the triage nurse, And then you say, well, okay, that's the hospital's policy. Shouldn't the doctor have gotten it? But the doctor has to be allowed leeway on what's important and what's not in any given case, And if I think it's important to check five sets of blood

pressures or three sets of temperatures, then I want the leeway to do that, And if your temperature is left out on a chart and I don't

think it's important, that doesn't violate standard of care because I'm allowed clinical latitude there.

So every place I've worked has checked vital signs on every human being that's come in and sometimes they leave some out and sometimes they don't. And if they leave them out, it's my job to pick them up, but, to me, that does not define standard of care as I've practiced medicine.

Q. If a patient comes in to you and they're complaining of maybe hip pain or some groin pain, you don't have vitals, a patient comes in to you overweight, Let's make them like Mr. Johnson, his physical characteristics as he presented on November 10th of --

A. Right.

Q. -- Of '96, I believe?

A. Yes.

Q. That patient comes in to you, hip pain, groin pain. What was it that he had?

A. My understanding, buttock pain, hip pain, groin pain.

Q. Okay, You would agree with me that when you saw that patient, that could be any number of things? The cause of that pain could be any number of

things?

A. Exactly.

Q. All right. Now, what are the potential or the possible causes, all that you can think of? I want to know everything that goes through your mind as the emergency room physician when you meet that patient.

MS. PETRELLO: And all the patient has is hip pain, is that what the question is?

MR. DEMPSEY: He has what Mr. Johnson had on November 10th.

MS. PETRELLO: Well, then, why don't you look at the records here. Are we talking about Mr. Johnson or is this a hypothetical? I'm not sure what you're asking.

MR. DEMPSEY: 1'11 ask him in a minute. Let's figure out what he presented with.

A. My understanding is that the patient presented with right hip pain for six days. Began to get pain after getting up from a cart after physical examination last week. He denies any back pain. Ambulates with a limp. In no **acute distress.**

Pleasant, alert, oriented times three. Skin warm and dry.

With any complaint, you could divide up the possible presenting complaint into anything that could be present, was it something he was born with, was it something infectious, was it something neoplastic. Could he have had a tumor in his hip? Could it evidence an injury? There are broad categories of anything that could cause a symptom. I don't have the patient in front of me, so I don't know what he looks like.

Q. Is his weight there?

A. No, but I'm given that his weight was about 240 pounds, so everybody seems to agree that he's somewhat overweight. And then you have order, your differential, Most doctors would do it in terms of what the commonest things are and what is common is musculoskeletal pain, is common back pain, muscle strain.

In the emergency department you have to maybe put things in a little bit different order because you have to think of what's most severe and what's most life-threatening, and for a hip, some acute fracture, he's a little young for that, Could he have a septic hip? That could be a

crippling injury. Those are the things that come to mind.

Q. Okay. Now, how do you determine whether or not it's orthopedic or infectious, for example, that could be the root of this pain, some infectious process or an orthopedic process? How would you make that determination? Considering that both of them are serious, within the realm of -- obviously the infectious being more serious and life-threatening than the orthopedic. You would agree with that?

A, Not necessarily. Orthopedic could be a hip fracture, it could be necrosis of the hip.

Q. But could it be life-threatening?

A. Quite serious, Immediately life-threatening? There's not much that goes along in somebody's hip that's going to be immediately life-threatening. Then you go into the vascular problems. Does he have an embolus and cut off the circulation to his leg? Most things that happen to a hip in a 40-some-year-old gentleman are not immediately life-threatening.

Q. Fair enough. So how do you rule out orthopedic versus infectious versus neoplastic versus -- what was the fourth one that you said?

A. Oh, congenital.

Q. Or spontaneous? You didn't use the word spontaneous, but --

A. Right. Well, first of all, we're presented with a problem that -- a problem with the hip is inherently not likely to be life-threatening immediately. It's hard to imagine a lot of things that could do you in tonight that could be going on with your hip. He ambulates with a limp.

Truthfully, even if he had a fracture of his hip, first of all, he wouldn't be able to ambulate, but it's not going to kill him tonight. If he has a bone tumor in his hip, that's not going to kill him either. If he had an infection in his hip, that can -- we know, in retrospect, he didn't, but that can cause problems over the course of a few days and it can cause severe degenerative arthritis and it can be a crippling injury.

But once -- and I don't want to -- I don't want to queer somebody's judgment that a triage nurse already assessed the man, and he didn't look sick, and he was sent to the Med Express side, but that's pretty much what I would go through in my mind. Somebody with a chief complaint related to a

hip, a joint, there's not an awful lot of life-threatening things that could be going on that day.

so -- but there are a few serious things that could.

Q. And you've named them?

A. Right.

Q. And none of them are immediately life-threatening?

A. No, I haven't named anything that was immediately life-threatening.

Q. A bullet, but we didn't have one?

A. Right, right, but if he was shot in the hip he probably would have given a history of that,

Q. I'm saying based on his presentation, would you expect him to go nonacute or acute?

A. Somebody who is walking in, you can justify putting somebody on to the nonacute side.

Q. Could you justify putting this person on to the acute side?

A. I wouldn't argue, if I was working on the acute side, if this person was triaged to the acute side, either.

Q. Either side you wouldn't have argued with?

A. He's not in front of me. The triage nurse has guidelines to follow and is presumably trained to

do the job and she identified him as being nonacute.

Q. Now, if you -- well, what did the doctor do to treat this patient?

A. He --

Q. She.

A. She, I'm sorry.

Q. That's okay.

A. She evaluated, noted the appearance of the patient, seemed to be not in acute distress. Pleasant, alert, oriented times three, skin warm and dry. Noted tenderness, she seemed to understand that. Decreased range of motion. She checked pulses. Did not appear to have anything threatening to the integrity of his leg.

Neurovascular intact. I don't see a detailed neurologic examination, But somebody, for example, who couldn't lift their foot or had an acute neurologic deficit would clearly have an acute medical emergency,

Got an x-ray of the hip. Didn't see a fracture. Gave him an injection for pain and clinically had the impression that this was a local musculoskeletal problem.

Q. What was the injection?
A. It was of Toradol. It's a pain medication, antiinflammatory medicine.
Q. Is it a narcotic?
A. It's a nonnarcotic. It's the same medicine as Motrin, Naprosyn. This happens to be the only injectable one,
Q. What was the dosage that he received?
A. 60 milligrams.
Q. Where did he receive the injection?
A. Well, it runs over the page. I was under the impression -- oh, here it is. Intramuscular,
Q. Is that an arm, hip area, thigh?
A. Probably gluteus, buttock.
Q. Buttock area. What was the dosage did you say?
A. 60 milligrams.
Q. Is that a normal dosage?
A. The usual dosage is usually 30 or 60 milligrams.
Q. Have you given patients 60 milligrams of Toradol?
A. I actually have. 1 prefer 30, but I have seen and give 60.
Q. Why would you give 60 if the usual dosage is 30?
A. Interestingly, some people felt a few years ago that 60 was more efficacious. There's no evidence that it works any better than 30, so 1 go with 30.

Q. Dr. Zivot testified in his report that 30 was normal and 60 was double to that. Did you take issue with that?

MS. PETRELLO: I'm going to raise an objection because even your own expert has withdrawn all his own criticisms, but go ahead.

A. If I could refer to my notes here on Dr. Zivot's testimony because 1 have a few. He listed an overdose of Toradol on Page 54 of his deposition. I do take issue with that, That's not an overdose and I don't think 60 milligrams of Toradol interferes with the health of anybody like this,

(Brief interruption.)

MR. DEMPSEY: Back on the record,

Q. Page 54 of Dr. Zivot's deposition testimony said he received an overdose of the Toradol.

A, Yes.

Q. You don't agree that's an overdose?

A. No, I don't agree that's an overdose, To me, an overdose is something with the potential to cause harm.

Q. He then says 60 milligrams, which is twice the recommended dose, Do you agree with that statement?

A. No. The recommended dose could be either one,
Q. What did you mean when you say usually it's 30, but sometimes you could do 60?
MS. PETRELLO: Objection.
A. There's evidence that 30 works just as well as 60 and there's no reason to use the 60.
Q. Colleen says that later in the deposition Dr. Zivot said that that was -- that he was not critical of that, that was not a deviation with giving the 60 milligrams. But you don't believe that giving 60 is a deviation from the accepted standard of care?
A, No, I don't believe that's a deviation.
Q. Now, the patient does not respond to the medication; isn't that true?
A, That is true, on that record, Now, my understanding, actually, was that he was improved later, but during the emergency visit, that's true. There's no documentation that the Toradol improved his symptoms.
Q. Now, would that make you suspicious that there might be something else going on?
A. Not in and of itself, People can still have pain after being given an injection of pain medication. That in and of itself doesn't prove that the pain is coming from something else.

The failure to respond to Toradol in and of itself does not make me suspicious that there is something else going on. Sometimes Toradol just doesn't work.

Q. Well, how do you, as the emergency department physician, come to the conclusion that it's a hip pain and not an infectious process? What I'm getting at, if infectious process is one of the possible diagnoses for hip pain, one of the possible explanations for hip pain certainly if an infection is there, you do want to treat it?

A. Absolutely so,

Q. And infections can become deadly, in other words, they can kill people if not treated?

A. Not -- infections absolutely can, In this particular case, how do I know that he did not have an infection causing his hip pain? Well, there are two things.

First, he didn't -- I'll quote Dr. Zivot. He didn't have any chills, fever, fast heart rate, any complaint of being hot or cold, Clinically he didn't have an infection.

Number two, and most convincingly, we have the gold standard on autopsy he didn't have a hip infection, He didn't have an infection in his

buttock, He didn't have an infecti(
He didn't have an infection in his
have any infection that could have
and between the 10th of November an
wasn't treated for any infection.

So I guess the gold standard is the autopsy and knowing that he wasn't treated for any infection and he didn't have a hip infection.

Q. He never was treated for an infection by anyone until they attempted to save him on the 23rd, of course?

A. Right. Until he was really an extremist, right.

Q. Really when it was too late. So, how do you -- how else might you know that a patient had an infection? You gave me some of the signs and symptoms.

Certainly you would agree that if a patient presented with a temperature, that could be a sign of an infection?

A. It could be a sign of an infection, In general, somebody really needs to have some signs and symptoms of an infection for you to start doing any diagnostic workup. As I said, as an emergency department physician, I really don't like to be judged in the retrospectroscope, that they had

something and doing something else.

Q. You mean doing something.

A. In this case, they have the benefit of the retrospectroscope. We know he didn't have an infection in his hip. He had hip pain; he didn't have an infection in his hip. It was never treated, so it would never have gotten better on his own.

He didn't have an infection in his hip. To say how did we know that on November 10th, 1996, well, we didn't know that. He didn't have any signs. He didn't have any complaint of anything that might lead to an infection. We only know that in retrospect because on autopsy he didn't have a hip infection.

Q. What would you have done if this patient presented to you with hip pain and an elevated temperature?

MS. PETRELLO: Objection.

A. If the patient had signs of a hip infection that was worrisome, the next step that you would do would be to evaluate with laboratory testing. He obviously got an x-ray, plain x-ray. There are other imaging studies you can do of a hip to tell if there's an infection in the hip.

Q. I asked Dr. Prince at Page 59 of her deposition --

A. Okay.
Q. -- At Line 11, Page 59: If a pa
the emergency department, let's
express side, with a history of
the hip region such as Mr. John
with me that pain could be due to an injury.
And she said, With the history of getting
off the cart that would be due to injury.
The answer was "yes."
The question: "There would be infection,
that is possible?"
Her answer: "Yes, possible."
Do you agree with what she has said there?
A. Yes.
Q. Okay. I asked her then: "If you had a history of
an injury such as this with six days duration, and
vital signs revealed an elevated temperature, you
might suspect infection?"
Her answer: "It's possible."
You would agree with that?
A. Yes.
Q. And 'if you did suspect infection, you would order
blood pressures' -- it should be blood work -- 'to
see if there's an elevated white blood count?'
'You can't do blood pressures'. 'That wouldn't

show an elevate white blood count?'

A, Right.

Q. And 'if you did suspect infection, y(blood work to see if there's an eleva blood count?'

The answer: 'Possibility.'

You would agree with that?

A. Yes.

Q. Would you have treated somehow if there was an elevated white blood count? Well, first of all, if a patient would come to your emergency department with a history of hip pain like this, you found an elevated temperature, you ordered blood work, how long would it take you to get that white blood count back?

MS. PETRELLO: Continuing objection. That's not in evidence, but go ahead.

A, Oh, any laboratory should be able to give you a white blood count within an hour, Maybe 20 minutes, 30 minutes. It depends on the lab.

Q. Let's say you found a white blood count -- what's the normal range?

A. The range -- normal range cited is 5,000 to 10,000 blood count,

Q. So if it's slightly elevate between 10 and 11,000,

what would you do?

A. I don't want to belabor this with philosophy, but I will. Any laboratory test has to be taken in the context of what you're dealing with, If you come to me with pain on the right lower quadrant of your abdomen and I'm worried about appendicitis, a white count could be very useful. If I draw your white blood count now and you have an elevated white blood count, I'd be crazy to send you to a surgeon to have your appendix taken out,

I only order lab tests if 1 have a clinical reason, So I don't order a test that I can't use regardless of the value,

Q. Someone clinically that you're not suspicious of an infection, is that what you said?

A, Okay.

Q. I'm asking the question differently. If you are suspicious of an infection based on hip pain and a temperature, those two findings, and you ordered a white blood -- I'm sorry, you ordered blood work in order to determine whether or not there's an infection, you'd be looking at the white blood count?

MS. PETRELLO: Objection.

A. That would be one of the things, but let me explain

a little further.

Q. Okay.

A. A test is only useful if it helps you make a clinical judgment. That is, if I'm worried about a specific thing like an infection in your hip and the question comes, how am I going to use the white blood count?

If your count is 8,000, that will help if I am going to send you home, based on a normal blood count. If your blood count is 20,000, I'm going to get you to hospital for tests, for scans of your hip, sedimentation rate. That test is useful. If it's not a useful test, it's not going to help me make a clinical decision. And if it's not going to help me make a clinical decision, I shouldn't order the test. Now, we don't have a white blood count from that day. We have a white blood count --

Q. November 2.

A. -- November 2.

Q. Well, it might have been November 5.

A. It was 12,900, which Dr. Prince wasn't privy to, didn't know about, and I guess my own attitude, as an emergency physician, if you're not going to use the result of a test, don't get the test.

But I don't see an indication of getting a

white blood count that day. I don't see how that would be useful.

Q. Let me stop you for a moment. If the patient has staph -- what was the infection in his body? Was it a staph infection?

A. The staph was in the pericardium, a staph infection.

Q. If the staph organism was in his body before it went to his heart, before it went to his pericardium, would it be diagnosable through blood work?

A. If blood cultures were positive, perhaps, yes, but I can't imagine anybody doing a blood culture on this man. I don't see any indication for getting a blood culture on this man.

Q. On the 10th?

A. Well, understand something. I don't particularly care for the concept of outpatient blood cultures anywhere. If you're so worried that somebody has a serious infection you don't send them home. If I'm worried enough to get a blood culture on you, I'm worried enough to confine you in a hospital.

Q. Or at least keep me there until you get the results?

A. But a blood culture takes a day or two so that is

not an option.

Q. What would the effect of staph be somebody's body -- be on their wh

MR. **SPISAK:** I'm to that.

MS. PETRELLO: Just a continuing objection to like all of this.

A. A white blood count is such a nonspecific finding. Classic is everybody assumes, well, you have a bad infection, white blood count goes up. But if you're really, really sick, you've got a low white blood count, It's very difficult to make a decision based in isolation on any white blood count, I could only give you a couple examples and they would be in patients with malignancies. If the patient is sick enough to worry about it, then you're going to need to do other tests,

Q. If a staph infection is brewing in somebody's body and it hasn't started moving to the pericardium, has seated somewhere, has seated somewhere where it can grow and fester, will it affect the patient's white blood count?

A. It might.

Q. How?

A. A white blood count can't diagnosis a staph

infection,

Q. Agreed.

A. And --

Q. But it can show infection?

A. No.

Q. It won't show what infection?

A. A white blood count is such a nonspecific finding that I do not equate infection and elevated white blood count, if that's what you're getting at. If you look at the causes for elevated white blood count, infection is one of them, but there are a lot of others and that's why I don't care for blood counts to make clinical decisions out of context.

Q. Do you order them?

A. I order them because I may be worried about something that would affect my judgment in somebody who has had cancer, chemotherapy. I'm worried if their blood count is very, very low, they can't fight off infection. If they have leukemia, I'm worried if their white blood count is very, very high. It depends on the context of it,

I can't see any indication this day on November 10 for getting a blood count. I don't know how I would use it in isolation out of context. Is it possible, viewed in retrospect,

that his hip pain was coming from an infection in his hip? Sure, but we know it wasn't. He didn't have an infection in his hip. I don't go looking for infections elsewhere if they don't have symptoms elsewhere.

Q. If you found an elevated temperature, you might order a white blood count, If you had pain and elevated temperature, you might order a white blood count?

A. I might.

Q. And if in this patient giving this history, this presentation on the 10th, you had done that and you saw that the white blood count was 12,900 a few days before, let's say **12,900**, what would you have done next?

MS. PETRELLO: Objection.

MR. SPISAK: Same objection,

Q. And what I was getting at before was if this organism was in his body since that white blood count of 12,900 on the 4th or 5th, would it have elevated since then if the organism was in his body?

That's what I was getting at. So you can answer that question and go back and say what was it if it was 12,9 on that day?

MR. SPISAK: I have no idea what you asked. Could I have it at least read back so maybe the second time around 1 could do better, or do you want to re-ask it?

MR. DEMPSEY: I'll re-ask it.

Q. What I was saying, I was getting at A equals B. What I meant before, what I was getting at if -- where are Dr. Naeem's notes?

The white blood count of 12, 9 was found on -- 12,900, the physical was November 2 and Dr. Naeem put it on that chart note, but this was November 7, I think, was when the lab study was done.

A. I think that's true.

Q. Five days later. That's when they found the white blood count of 12,900?

A. Yes.

Q. The normal range is 4?

A. It's -- it depends on the laboratory. As a rough estimate, since I don't know Elyria Memorial's laboratory, let's say 5,000 to 10,000. Sometimes it runs as high as 11 and as low as 4,

Q. Yeah. This lab, it was 4 to 10,500, So 12,900 is what was found on the 7th. So if he had the staph

organism in his body, by the 10th, would the white blood count be higher if you took it? Would it be the same? That's my question.

MS. PETRELLO: Objection.

A. It's pure conjecture and it sort of flies in the face of any reasoning in emergency medicine because if you don't know how to use the test, don't order the test. And not -- I really want to steer clear of primary care practice because I don't understand why the white blood count was drawn and I don't see that it was used in any way, and Dr. Prince wasn't privy to the results anyway. So to cast a net over somebody's entire body to look for some evidence of infection just broadly when they present with hip pain, and we know in retrospect they didn't have a hip infection, I can't understand the reasoning for ordering any tests, especially one that we wouldn't know how to use, You come -- the tests comes back as mildly elevated and abnormal.

Nobody uses the test and I'm not sure anybody would understand how to use the test in an emergency setting. This man didn't look sick enough to confine and blood cultures will take a day or two to do, so I don't see why a test be done if you're not going to use the test. If you

don't want to know the answer, don't ask the question.

Q. Well, that's -- well, okay.

If blood work had been done on the 10th at the emergency room and you received the results that were received on the 7th, what would you have done? Same elevated white blood count.

MS. PETRELLO: Objection.

MR. SPISAK: Objection.

A. I guess I'd first say since it's hypothetical and I can't say that I would have ordered the test, I would have first kicked myself for ordering the test because now we're presented with a test that's mildly elevated, not alarmingly so.

But I ordered the test and, therefore, I should have some rationale for doing it and acting on it. I'd have to see the patient in front of me. Say apparently he looked well, he looked well to the triage nurse. He didn't look like he needed to be confined for an inpatient workup for some ill-defined elevated white blood count. I don't know what I would do with the test. I don't think I would have ordered it and I don't know how I would have used it.

Q. Even if you would have gotten that result, you

would have sent him home?

A. No. Again -- once again, the hypothetical is I've ordered the test. Now I've got a test that I wouldn't have ordered perhaps, perhaps didn't think it was indicated, but now I'm presented with an abnormal result. What do I do with it besides kick myself for ordering the test.

I would take another look at the patient, reassess them clinically and say, Do I have any reason to pursue this further in the emergency department or in the Med Express, or is this something that the primary care doctor can follow up on, if the patient has access to follow up. And say, You look pretty well. I don't know why you have an elevated white blood count, but I think this is something your primary care physician could look into. I don't have a reason to.

Q. So what you would have done is -- if you got an elevated white blood count, is brought it to the patient's attention?

A. Yes.

Q. And say, Take this to your primary care physician?

A. Yes. You need to see your primary care physician and give him a full court press. You really don't say, Look, **something** is **going to happen** to **you in**

the next couple of days and I don't know what because I have this nonspecific laboratory abnormality. Or say, Mr. Johnson, you look pretty well. I don't know what to do with this abnormal test, but if you have access to a primary care doctor, let's have you see him in a timely way and let's follow this up, because I'm uncomfortable. You have something vague going on. I don't know what. 1 wish I hadn't ordered this test, but now that I have, I need to follow up on it. Please see your doctor pretty soon and, if need be, I'll call him and express my concerns.

Q. Is that something you typically do when you receive an abnormal test, do you let the patient do it or do you take it upon yourself to contact the -- what did you call them, the primary care physician?

MS. PETRELLO: Objection.

A. If I'm truly -- I don't like to act in a void on a test. Putting everything together, I have to make an ultimate disposition. Either the patient needs further -- I'm assuming at Elyria Memorial there's only two dispositions one can make on a patient. They either go home or they're admitted. At the Cleveland Clinic we can put them in an observation bed area for 24 hours.

If a patient looks well enou
but I am concerned, yes, I think i
to contact the patient's either pr
physician or an appropriate specia
Johnson worries me. I have a bad
him. I'd like you to see him tomorrow, if that
were the case. Yes, I think that's appropriate for
the emergency physician to make that call.

Q. Would you tell the primary care physician that the patient had a temperature?

MS. PETRELLO: Objection.

A. If the patient had a temperature it was documented, yes, that's part of the report. If they had an abnormal pulse or blood pressure, I would tell them that, too.

Q. If the emergency department doctor got an abnormal temperature and an elevated white blood count, yourself, would you tell -- elevated temperature, elevated white blood count 12,9, would you say "I suspect infection" to the primary care physician?

MS. PETRELLO: Objection.

A. Given -- well, of course, if that's your concern, that's what you tell the primary care physician. Once again, these are pure hypotheticals. For better or for worse, we do not have a set of vital

signs on the 10th of November. We're all agreed on that, What they would have been would have been everybody's conjecture. Although it's not conjecture in my mind. Ne did have normal blood pressure the next day, he had a normal pulse the next day, he had no complaint of fever or chills, so it's pure conjecture that he would have had any abnormal vital signs had they been taken. I have no reason to think they would have been.

Q. If he had an infectious process going on in his body would he have had abnormal vital signs?

A. Perhaps.

Q. What would the abnormal vital signs have been?

A. Well, it depends on what the infection is, where it is and how serious it is. Truly serious infection, septic syndrome patient, can be tachycardic, have rapid heart rate. Truly sick people have a low blood pressure, elevated respiratory rates. Very, very sick patients have either a low temperature or very, very high temperature, The temperature can be all over the map.

Q. Can it be normal?

A. Yes.

Q. Do you think that it's a good idea to have an emergency department that does not take vitals?

MS. PETRELLO: Objection.

MR. SPISAK: Note my objection,

A. That's certainly not my preference.

Q. Why?

A. For patients who are potentially sick, vital signs are named that because they're vital, more vital in some patients than in others. And some vital signs are more important than others. I'd rather have pulse oximetry done on everyone, but that's not done.

Q. Pulse oximetry requires modern day equipment?

MS. PETRELLO: Well, the -- objection.

A. The equipment has been available for 15, 20 years.

Q. Well, that's since 1980?

A. Yes.

Q. 1985?

A. Yeah.

Q. I tend to call that more modern day. You're going to follow --

MR. SPISAK: You're showing your age now.

MS. PETRELLO: Do you know how they take temperatures these days with the little thing in the ear?

A. Once again, it depends on the presenting complaint. If we're dealing with somebody with asthma, the most important sign might be the respiratory rate. If we're dealing with somebody with a dysrhythmia, their most important vital signs might be their blood pressure. Some others, their most important vital signs is the pulse oximetry.

Q. Have you seen any records that say it wasn't the standard of care for Elyria Memorial to do vital signs?

MS. PETRELLO: Objection. Asked and answered.

A. I haven't seen any policies from Elyria Memorial.

Q. I haven't seen them. I've asked for them and they haven't been produced.

A. I haven't asked for them and I haven't seen them.

MR. DEMPSEY: Les, I renew my request for that. I know the people say we didn't do that at that time so go about your business, but I did ask for them on February 1st of this year and I'd renew my request that those documents be produced.

Q. The nurse simply didn't take the vitals. That was the Nurse Dawn Sturgeon said she didn't.

A. Yeah, I read her deposition.

Q. She said -- this was on Page 15. In '96 there was a time period, I'm not sure how long that time period was, but I'm only saying that it was in 1996 because of this record, We were told it was not okay -- strike that.

We were told that it was okay to not obtain vital signs on a patient attending the Med Express area of the department as long as the patient was a result of an injury.

I said: Who said that?

§he said: I can't remember. I believe it was in writing at one time.

I said: I would request those records, all writings advertising that it was not necessary to obtain vital signs of patients coming to the Med Express allegedly due to injury,

I asked if it was a manual or a memo or a book. And she said she believes it was a memo and it's no longer a policy.

Now, she says, based on the JCAHO regulations all patients coming into the emergency room regardless of whether or not they're going to Med Express or the emergency room, they are to have vital signs.

Do you know what the JCAHO is?

MS. PETRELLO: Objection,

A. That's Joint Commission for Accreditation of Health Care Organizations. It gets back to the semantics, You want to pin me down on standard of care, whether it's what constitutes care, and what constitutes mandated regulations by a regulatory agency, and --

MS. PETRELLO: That's all right, you've answered that question.

Q. You're going to give that same answer again -- am I correct, you're going to repeat what you said earlier. Or do you want to add something?

A. I don't have anything to add.

MR. DEMPSEY: Well, Colleen asked you to stop and he was just going to give me the answer.

MS. PETRELLO: Well, he answered the question.

Q. If he wants to add something, in fairness, be my guest, Tell me every benefit you can think of to not take a patient's vital signs. You can't think of any, can you?

A. I can't think of any benefit, It's not particularly time consuming or labor intensive, 1

guess the major benefit that I can thi
relate to this case. It's a task that
1 don't want somebody dictating what
and then declaring that it's standard
it doesn't-- if it's not necessarily going to help
patient care.

Not to say that vital signs don't help patient care, I just don't like a regulation for its own sake.

Q. Okay, But in terms of patient care overall you cannot think of any benefit to having a rule or a regulation or a standard in place in a particular hospital to not take vital signs?

MS. PETRELLO: Objection.

A. No.

Q. And that same answer would apply to emergency rooms, whether acute or nonacute, Med Express, whatever you want to call them, Same answer, right?

A. Same answer,

Q. Do you remember seeing in any of these depositions -- I'm asking you to do my work for me, and I'll do it while we're sitting here -- but do you remember seeing in any of these nurses' depositions that it was the standard of care at EMH at this time to

take vitals?

MS. PETRELLO: Objection. The testimony relates and he's not here to spit back up their testimony.

MR. SPISAK: Objection.

A. I've only read one RN deposition indicating that she was not mandated to.

Q. Right. But the one who didn't do it said that she was not mandated to do it. That was Dawn Sturgeon. Is there a place in the form or document, whatever the sheet is that Mr. Johnson's history and notes were taken down on the 10th on, that one could record vital signs? Are you looking at the record from the 10th?

A. Yes.

Q. Is there even a -- I understand that according to certain -- according to the nurse who didn't take the vital signs, this hospital didn't take nonacute patients' vital signs that came to Med Express. Is there anywhere on their chart to even record the vital signs?

A. Yes, there is.

Q. Where is that?

A. That's on the upper left-hand portion of the physician ledger,

MS. PETRELLO: We'll stipulate the record speaks for itself.

MR. SPISAK: We'll stipulate that the form says what the form says,

Q. Where is that?

A. That's in the upper left-hand corner, It says visual acuity, left eye, right eye, blood pressure, respiratory, pulse, temperature, police notified, yes, no, There's a lot of blanks on the form.

Q. What is this?

A. Time 11:35.

Q. What does it say?

A. T, temperature; P, pulse,

Q. What does it say there? Is that the nurse's initials? Can you read that?

MS. PETRELLO: Objection. If you know.

A. I don't know.

MS. PETRELLO: You must have asked the nurse that, didn't you?

Q. I think it says "def." Deferred?

A. I'd have to ask the nurse,

Q. Right.

MR. DEMPSEY: Les, do you have those standards?

MR. SPISAK: I will check. I don't recall as I sit here whether I do or not.

MR. DEMPSEY: Because according to your expert, Mary Jane Martin Smith -- do I have all the names in there?

MR. SPISAK: That's it.

MR. DEMPSEY: Mary Jane Martin Smith says that Elyria Memorial Hospital's policy and procedure regarding vital signs states that when patients are admitted, I don't know if that's an oral policy or something written.

MR. SPISAK: I don't know if she's referring to the deposition. I'll check to see whatever she reviewed.

MR. DEMPSEY: Okay, Thanks.

MR. SPISAK: I think you got them.

Q. Before we leave I'd like to get copies of your notes, just have you briefly state on the record what you wrote. Because I don't know if I can read it. Is there anything there that's not just a summary of -- for example, somebody says white blood count was 12,900 and you wrote, Page 11, 12,900, as opposed to, Never take white blood count

in emergency room because -- some opinion.

A. No.

Q. These are strictly notes?

A. Strictly notes,

Q. Strictly notes?

A. I don't write opinions in my notes.

Q. Nothing more than that, summarizing the depositions?

A. Right. You may have all of them.

(Brief interruption.)

Q. In your report you wrote, at the second full paragraph after the nine itemized items that you looked at, Although he had myocarditis, pericarditis and a myocardial abscess, I note that no infection was found, Why do you note that? Was that going back to the fact that there was no hip infection or why was that?

A. There was no infection found anywhere else, Well, there was no hip infection, but there was no infection noted from anywhere else, I don't know where he got the infection from.

Q. He died as a result of staphylococcus aureus bacterium settling into one of the ventricular walls and causing a pusy mass and blowing out that ventricle; is that your understanding?

A. That's my understanding.
Q. A staph is an organism?
A. Yes.
Q. It gets into the body through an opening usually?
A. I don't see where it got into his body,
Q. You don't know?
A. This is a very, very rare occurrence -- event, I don't know how it happened.
Q. You don't know how it got into his body?
A. No,
Q. You're familiar with the organism?
A. Yeah.
Q. You would agree that it travels around the body until it finds a weakened area to settle down and set up shop and cause damage?
MS. PETRELLO: Objection.
Q. Do you know -- I was trying to just use general terms, obviously, It could settle in an arthritic joint, it could settle in a weakened area of the myocardium or the pericardium, for example, if weakened or compromised? You'd agree with that?
A. I don't know where the organism entered his body, I don't know why it settled in his pericardium. It's a very unusual infection and I don't know where the site was.

Q. And you don't know when?
A. I don't know when.
Q. You say in that same paragraph, I also note that although heart failure was noted as the primary cause for death, no myocardial infarct was noted, either acute or recently resolving.
What was your point there?
A. Well, my point there was probably a reaction to reading Dr. Zivot's deposition where he claims that the patient had a myocardial infarction on, I believe, November 2nd.

The day that an EKG was taken, it showed some nonspecific T-wave abnormalities. I thought it was just an interesting statement to make that he must have had a myocardial infarction sometime in the office on a day when he wasn't having any chest pain or shortness of breath, and the EKG was a routine EKG. I couldn't see any evidence that he had a myocardial infarction then, and I was looking for it on the autopsy.

A myocardial infarction that's a couple of weeks old is still detectable on an EKG.
Q. So if he had a myocardial infarct on Dr. Naeem's EKG on the day of that physical, November 2, there would have been evidence of **that MI on** autopsy?

A. I would have thought so. Of course, some evidence while he was having it. My read was that the EKG was part of his routine primary care.
Q. Did you look at that EKG?
A. I did.
Q. Is it abnormal?
A. It's abnormal, but I don't read an acute myocardial infarction into it,
Q. Was there anything that you would have done to that EKG? If the patient was in the hospital and you ordered an EKG and you saw those findings, would you have done something about it?
A. Well, you're talking in my practice as an emergency physician? I'm not here to pass judgment on a primary care doctor,
Q. You're not critical of Dr. Naeem?
A. No, I don't do primary care.

MS. PETRELLO: In fairness, I obviously didn't have him focus on Naeem's care,

Q. Absolutely. And I understand that Dr. Naeem indicated that Mr. Johnson, based on that EKG -- well, based on his presentation and EKG, he was to do certain things like watch his weight, watch his salt intake or whatever it was about his diet, but

he was also supposed to follow up and get a stress test?

A. That was my understanding of what Dr. Naeem had suggested.

Q. Anything about that that you would be critical of or does that sound okay to you?

A. Once again, I don't do primary care.

Q. I understand.

A. My role in evaluation of coronary artery disease is somebody who is symptomatic from it. They come to the emergency department because of symptoms related to the heart, whether they have shortness of breath or whether they have chest pain, and I do an EKG within the context of their symptoms. I don't do screen EKGs.

Q. Would you ever find somebody that was symptomatic where you might be suspicious and order an EKG?

A. Absolutely. I'd like to think that any test that I order, I have a reason for it.

Q. Without any chest pain or diaphoresis or some other ongoing problem?

MS. PETRELLO: Just note a continuing objection.

A. I don't do screening EKGs in the emergency department. If you pass out, if you're feeling

light-headed, if I'm worried about you for some reason or even if you have a fractured hip and I'm worried that you're not stable to go to surgery, but I have to have a reason for doing it. Then if I detect an abnormal EKG, I act on it.

Q. What would you have done if you would have received this EKG?

MS. PETRELLO: Objection.

A. Once again I'm not a primary care physician. I wouldn't have done it in this setting and I wouldn't have received it in this setting.

Q. Based on that EKG does this look like a person at great risk? As a physician now, I'm just asking you as a doctor.

MS. PETRELLO: Objection.

A. What is the point here?

Q. I want to know if this guy is going to keel over on the 2nd and needs to be admitted to the hospital according to the doctor?

MS. PETRELLO: What difference does it make? We're talking about the care on November 10, so how he looked a year ago, five years ago, two years ago, it doesn't matter.

MR. DEMPSEY: Sure it does. This

is exactly what he walked into the emergency room with. I'm not suggesting that an EKG should have been ordered in the emergency room.

Q. I'm just asking you, based on your review of that medical record of November 2nd, does this person look like he's in dire trouble?

MS. PETRELLO: Objection, to the extent you can answer that.

A. Okay. My read is no, that the EKG was done as part of a routine health screening exam. As far as all the risk factors go, I'm certain if he were overweight he had been overweight for months. He had been smoking for a long time. He had been hypertensive for a long time. He had all the risk factors that he had for a very long time. But in a setting of an outpatient visit, whether it's to the Med Express side or to the emergency department, he had hip pain. It's not suggestive -- yes, he also had risk factors for heart disease, but that's not within the purview of our practice. If somebody comes in with hip pain we focus on what might be his chief complaint.

Q. Right. You wouldn't do an EKG, obviously?

A. I wouldn't do an EKG. I don't think it was

indicated,

Q. I'm not -- I'm just asking if he looked like a goner on November 2nd to you or in dire straits, in big trouble?

A. There's nothing that on November 2nd or the 10th that he looked like somebody that was going to be dead within a month.

Q. And you are not critical of Dr. Naeem?

MS. PETRELLO: Objection. Asked and answered and --

A. I'm not here to pass judgment on Dr. Naeem,

Q. And you will not testify that Dr. Naeem somehow deviated from the accepted standards of care at the time of trial?

A. No. You're -- the only thing that you brought up about an elevated white count was that Dr. -- My answer to that is that Dr. Prince wasn't privy to the results, didn't order the test and if you want to act on the results, it's the purview of the person who ordered the test to have the results to do it, but I'm not critical of Dr. Naeem.

MR. DEMPSEY: Almost done. Do you have any questions, Les?

MR. SPISAK: (Shaking head.)

MR. DEMPSEY: Let me just

collect my thoughts for a minute. I think I'm done, I just want to make sure that I am.

Dr. Glauser, thank you very much.

THE WITNESS: Thank you.

MR. DEMPSEY: I don't have any other questions, Let me just look at your notes quickly and see if there is anything I want to ask you about.

MR. SPISAK: Richard, I'm going to run,

(Plaintiffs' Exhibits 1 through 4 marked for identification.)

(Deposition concluded at 7:15 p.m.)

(Signature not. waived.)

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August 15, 2000

Dr. Glauser
C/O Attorney Petrello
Solon, Ohio

In re: Johnson vs. Naeem, et al.,

Dear Dr. Glauser:

On Tuesday, August 8, 2000 your deposition was taken before me in the above-entitled matter. The deposition has been transcribed and is now ready at Attorney Colleen Petrello' office where you may read and sign same, pursuant to the Ohio Rules of Procedure.

If the deposition is not signed within 7 days, it may be filed without your signature.

Please call Ms. Petrello's office at (440) 248-7906 if you have any questions.

Leonard R. Gavlen

cc: All listed, page 2.

Q. Page Line Notation.

_____.

Dr. Glauser.

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

I, Judi Sadler, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified do hereby certify that the within named witness, JONATHAN GLAUSER, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy/computer in the presence of said witness, afterward transcribed by me, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid. I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment. I do further certify that I am not a relative, counsel or attorney of the parties herein, or otherwise interested in the event of this action. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 14th day of August, 2000.

_____
Judi Sadler, RPR. My commission expires 9/14/04.