IN THE COURT OF COMMON PLEAS

OF GEAUGA COUNTY, OHIO

PATRICIA M. FLETCHER,
Administratrix of the
Estate of VIRGIL G. SLUSHER,
Deceased,

Plaintiff,

vs. Case No.

GEAUGA HOSPITAL ASSOC, INC., 97PT0126
et al.,

Defendants.

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Deposition of DAVID GRISCHKAN, M.D., called for examination under the statute, taken before me, Barbara J. Watowicz, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of David Girschkan, M.D, 24025 Commerce Park, Beachwood, Ohio, on Thursday, June 1, 2000 at 11:00 a.m.

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APPEARANCES:

On behalf of the Plaintiff:

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On behalf of the Defendant

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APPEARANCES, Continued:

On behalf of the Defendant
Howard Darvin, M.D.:

Weston, Hurd, Fallon,
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On behalf of the Defendant
Bradley Blackburn, M.D.:

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DAVID GRISCHKAN, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF DAVID GRISCHKAN, M.D.

BY MR. MARGOLIS:

Q. Doctor, my name is Ron Margolis. Myself and my partner Dan Finelli represent the estate of Mr. Slusher. Have you had an opportunity, sir, to review the most recent report that was authored by Dr. Goldstone? 11:02:24

A. No, I have not.

Q. All right. Do you know who Dr. Goldstone is, Gerry Goldstone, the chief of vascular surgery at UH? 11:02:36

A. I don't know him.

Q. All right. Dr. Goldstone in his report indicates that when -- Dr. Goldstone indicates in his report that when Mr. Slusher was readmitted to Geauga Community emergency room on September 9th, 1998 that he was in the early stages of acute mesenteric ischemia. Do you agree or disagree with that statement, sir? 11:03:02

A. I have no way of making a comment 11:03:20

on that. 11:03:22

Q. Okay. So based upon your review of the records, you are unable to comment about whether when Mr. Slusher was readmitted to Geauga Community on 9-9-95 if he was suffering 11:03:34 from acute mesenteric ischemia?

A. You are asking two different questions I'm afraid. You first asked me if he was in the early stages of ischemia. Now you are asking me if he had ischemia. Those are 11:03:50 two very different questions.

Q. You are right, they are. Thank you for pointing that out to me. When he was readmitted on 9/9/95 to Geauga was he experiencing any form of bowel ischemia? 11:04:00

A. Yes, he was.

Q. Was he in acute mesenteric ischemia?

A. To some degree he had mesenteric ischemia. What level, I don't know. 11:04:12

Q. I want to chat with you a little bit about just some general medical concepts. Would you define for me chronic mesenteric ischemia?

A. Let me flashback to my medical 11:04:26

school days. I am sure I can get you an answer. It's a reduction of blood flow to various portions of the bowel. 11:04:28

Q. And how does chronic mesenteric ischemia differ from acute mesenteric ischemia? 11:04:36

A. Time frame.

Q. Are the symptoms any different?

A. It can be.

Q. What are the symptoms of acute mesenteric ischemia? 11:04:44

A. It can be anything from sudden abdominal pain to just sudden infarction of bowel without the common pain.

Q. Diarrhea?

A. It can have any number of symptoms. 11:04:56

Q. Is that one of them?

A. It can be.

Q. Blood from the rectum?

A. Can be.

Q. Nausea? 11:05:02

A. Can be. Again, it should be pointed out that none of these symptoms necessarily need to be included.

Q. Is chronic mesenteric ischemia characterized by postprandial pain and weight 11:05:14

loss in the patient? 11:05:18

A. Some cases, yes.

Q. Would you define ileus?

A. It's a general term for nonfunctioning of the bowel. 11:05:26

Q. Is there a difference between a vascular ileus? Is that a term, vascular ileus?

A. I have not heard of it.

Q. All right. What is a bowel perforation? 11:05:38

A. A hole in the bowel.

Q. What is a bowel infarction?

A. A loss of blood supply with subsequent necrosis of the bowel. 11:05:46

Q. If Mr. Slusher would not have undergone the surgery that he did on September 5, 1995, do you believe that his bowel would have become necrotic and he would have died on September 19th, 1995 as he did? 11:06:02

MR. TORGERSON: Objection.

You may answer.

A. I have no opinion.

Q. You would agree that Mr. Slusher prior to surgery suffered from significant 11:06:14

atherosclerotic disease? 11:06:18

MR. TORGERSON: Objection.

A. I don't know what you mean prior to surgery.

Q. Before surgery of September 5, 1995, he suffered from severe atherosclerotic disease? 11:06:24

MR. TORGERSON: Objection.

A. I am not sure to what degree. He certainly had atherosclerotic disease. 11:06:34

Q. Would you agree that before surgery of September 5, 1995 Mr. Slusher had extensive vascular disease?

MR. TORGERSON: Objection.

Q. With some involvement of the mesenteric vessels? 11:06:48

MR. TORGERSON: Same objection.

A. I can't comment on the degree or extent.

Q. Would you look at your report, sir, of July 2, 1999? 11:06:56

A. The answer is the same. I don't know to what extent so I can't comment.

Q. What do you mean in your report when you say it's a fact that this young man 11:07:04

had extensive vascular disease and would have been expected to have some involvement of the mesenteric vessels? 11:07:08

A. Usually the vessels that are involved in atherosclerotic disease include the mesenteric vessels as well as aortic vessels. 11:07:16

Q. Would some of the vessels that you are referring to be the SMA and IMA?

A. Usually the SMA and IMA can be involved. 11:07:38

Q. All right. Do the SMA and IMA, between the two of them, pretty much supply 90 percent of the blood flow of the bowel?

MR. TORGERSON: Objection.

Go ahead. 11:07:50

A. Yes.

Q. Your training is that of a general surgeon, is that accurate?

A. Yes.

Q. And other doctors refer patients to you for general surgical care, is that accurate? 11:08:00

A. Yes.

Q. And so when a patient comes to you for a general surgical consultation, do you 11:08:12

take a full history regarding that patient's health condition? 11:08:14

MR. TORGERSON: Objection.

Go ahead.

A. Yes. 11:08:22

Q. Why do you do that, sir?

A. To get a better feel for the diagnosis that I'm about to make.

Q. Is it the responsibility of the surgeon who is performing an elective surgical procedure on a patient to do a thorough preop evaluation of that patient? 11:08:34

MR. TORGERSON: Objection.

A. It's too broad a question to answer. I don't know the answer to that. 11:08:46

Q. What is it about the question that makes it so that you can't answer it?

A. The manner in which you asked it.

Q. What specifically did I ask?

THE WITNESS: Could you read back the question, please? 11:08:56

(Record read.)

A. Each case would be different depending on the age group, condition, nature of the referral. I mean the variables are 11:09:22

endless.

Q. Would one of the issues be what the patient's known health history is, i.e., if the patient has vascular disease? 11:09:2

MR. TORGERSON: Objection. 11:09:34

Go ahead.

A. With all due respect, if you could just rephrase the question or reask it.

Q. Okay. Fair enough.

In this case do you have an opinion if chronic mesenteric ischemia would have been diagnosed before surgery if Dr. Darvin would still -- strike that. Let me ask it this way. 11:09:4

Do you have an opinion one way or the other as to whether Mr. Slusher suffered from chronic mesenteric ischemia prior to the surgery of 9-9-95? 11:10:0

A. I have no evidence for that.

Q. What is evidence of chronic mesenteric ischemia? 11:10:14

A. I guess you would have to have an angiogram to demonstrate evidence for that.

Q. Is there any clinical evidence of chronic mesenteric ischemia?

A. Not really. 11:10:24

Q. Okay. Postprandial pain, weight loss, would those be symptoms of chronic mesenteric ischemia? 11:10:24

A. You and I could have that most days after eating a Happy Meal at McDonald's. 11:10:36

Q. Well, could you answer my question? Is postprandial pain and weight loss a symptom of chronic mesenteric ischemia?

A. It's a nonspecific symptom.

Q. Is it one symptom of chronic mesenteric ischemia? 11:10:48

A. It could even be associated with pregnancy, but that does not mean that we're talking about pregnancy.

Q. I'm talking about chronic mesenteric ischemia. 11:10:56

A. It can fit any variety of symptoms you want.

Q. Do you have any criticisms of the care provided to Mr. Slusher by Dr. Darvin, the vascular surgeon in this case? 11:11:04

MR. TORGERSON: Objection.

A. I'm not a vascular surgeon so I can't really make any specific comments dealing with issues of the vascular condition 11:11:16

indicative to the bowel. I think certainly a vascular surgeon is the person involved in managing that. 11:11:18

Q. Do you believe that a vascular surgeon by virtue of their training and experience are in a better position to make a diagnosis of a vascular condition effecting a bowel than a general surgeon? 11:11:26

A. Generally, yes.

Q. Do you have any criticisms of the postoperative care that Dr. Darvin provided to Mr. Slusher? 11:11:38

MR. TORGERSON: Objection.

A. Not specifically.

Q. Do you have any questions about the operative technique demonstrated in the operative note of Dr. Darvin pertaining to the surgery of 9/9/95? 11:11:48

MR. TORGERSON: Objection.

A. I'm not a vascular surgeon, so I really can't make a comment on that. 11:12:00

Q. Have you done any abdominal surgery that involves vascular surgery as well?

A. Have I put any holes in the vessels while I'm doing my surgery, is that what you 11:12:12

are asking me? 11:12:14

Q. Have you ever performed abdominal surgery which also involved components of vascular surgery?

A. Not directly. I was very involved 11:12:22
in trauma care in the initial years of my practice and in those cases we had many patients who had contaminant vascular injuries, but generally we called in the vascular surgeon to handle that. 11:12:36

Q. In this case do you attach any significance preoperatively to the enlargement of Mr. Slusher's IMA?

A. Not particularly.

Q. Would you agree that two out of 11:12:48
three vessels -- would you agree that two out of three arteries must be occluded or stenosed before a patient will become symptomatic for mesenteric ischemia?

A. I can just state for the record 11:13:04
that I'm a general surgeon. I'm not a trained vascular surgeon. You are asking me questions that are more related to vascular issues.

Q. Okay. So you have no opinion as to that question? 11:13:16

A. You are asking me a vascular question. That's not my area of expertise. 11:13:16

Q. Okay. Do you have any opinion, doctor, as to when the last point in time was that Mr. Slusher would have been salvageable had his mesenteric ischemia been diagnosed and treated? 11:13:26

A. Frankly, I'm not sure that we have a firm diagnosis of mesenteric ischemia. He had acute mesenteric insult at the time he came in for the second admission on the 9th. In my mind there is a difference between ischemia and a sudden mesenteric insult. 11:13:47

Q. Please tell me what you mean by acute mesenteric insult. 11:13:5

A. The patient had documented hypertension on the 8th while he was under Dr. Darvin's care. Additionally, he had an episode of atrial fibulation. Putting the records together, this means he had some kind of emboli at that time and he may have had a second episode that prompted the stroke. And the abdominal crisis developed in the second admission. And those were the acute mesenteric insults. We're not talking about ischemia. 11:14:10 11:14:26

Q. Were echocardiograms done after his episode of atrial fibulation when he was in the hospital from 9/5 to 9/9? 11:14:32

A. I don't recall.

Q. Based upon his presentation to the emergency room on 9/9/95, do you have an opinion as to what period of time he would have been salvageable from his mesenteric insult that he was suffering from? 11:14:50

A. I think this was sudden and massive and it prompted the stroke and the mesenteric occlusion. And I think at the point that he presented in the emergency room he was unsalvageable. 11:15:12

Q. From the moment that he was admitted on 9/9/95? 11:15:22

A. Yes. Correct.

Q. Did you indicate that in your report?

A. Not specifically. 11:15:32

Q. All right. Are you aware -- you are not offering any opinions in this case in the field of neurology, are you?

A. No.

Q. Has it been documented anywhere in 11:15:42

the chart from 9/9 through 9/12 at Geauga that he had a stroke? 11:15:44

A. Yes.

Q. Where?

A. May I look through the records? 11:15:52

Q. Sure. Can you tell me what you are referring to, please?

A. Discharge summary dictated by Dr. DiBlasio. In the second line it says I was called by Dr. Crosby and he's the emergency room physician who informed me that the patient was in the emergency room and that he is apparently having or had had a stroke with paralysis on the right side. 11:16:24

Q. All right. And do you see in Dr. Crosby's report at the last paragraph at about this time Dr. DiBlasio then arrived and also about this time the patient had an essentially complete recovery from his stroke with his only ongoing problem being abdominal. 11:16:38 11:16:52

That's also in the emergency room section.

A. Show me where that is.

Q. That's in doctor -- as a matter of fact, let me do this. I made a copy for you. We're sort of jumping a little bit ahead. Right 11:17:08

here, at about this time. 11:17:24

A. Okay.

Q. And doesn't that record further indicate that it was the opinion of Dr. DiBlasio that the patient had a transient 11:17:46 cerebral vascular insufficiency due to hypovolemia?

A. Yes.

Q. Is that different than a stroke, sir, a transient cerebral vascular 11:17:58 insufficiency due to hypovolemia?

A. It would be like a prestroke situation.

Q. Is it different from a stroke?

A. Just a milder from. 11:18:08

Q. Okay. This man's CAT scan was negative, was it not?

A. Yes, it was.

Q. Do you have an opinion in this case when Mr. Slusher's intestines infarcted? 11:18:16

A. Yes.

Q. When?

A. At the time that he presented to the emergency room on the 9th.

Q. Do you have an opinion in this case 11:18:26

as to when his intestines perforated? 11:18:26

A. It looks like it was probably only the 14th when he noticed free air in the abdomen at University Hospitals.

Q. Wasn't there an x-ray, sir, of 9/8/95 demonstrating free air in the abdomen? 11:18:36

A. That's surgical gas.

Q. Okay. Let's look at, if you want to, look at these records, sir. It's actually at 9/9. I think it's -- if you keep turning -- 11:18:50

A. What are you specifically looking at, an x-ray?

Q. Yeah.

A. It would be easier for me to --

Q. It's the x-ray, sir, of 9/9/95 of his abdomen. Here it is. 11:19:0

A. Go ahead.

Q. Doesn't this x-ray of 9/9/95 of his abdomen also have a finding of nondifferential air fluid levels on cross-table lateral view 11:19:36 suggesting a dynamic ileus?

A. Yes.

Q. How does this finding differ from the finding of the 9/14 film at UH so that you are concluding that the UH film air level was 11:19:50

due to a perforation? 11:19:54

A. There are a series of films that they had performed monitoring the patient. There was a change in the status on the 14th that there was actually free air underneath the 11:20:02 diaphragm that suggested that there was perforation.

Q. Have you reviewed any of the x-ray films themselves?

A. No. 11:20:10

Q. So your opinions are predicated upon the interpretation of the radiologist?

A. Yes.

Q. And the reports that you reviewed?

A. Correct. 11:20:18

Q. All right. How long did it take for his intestines to liquefy?

A. I don't know.

Q. And I apologize if I asked this before, but is the diagnosis of acute 11:20:32 mesenteric ischemia a diagnosis that you would expect a general surgeon to be able to make?

A. Again, it depends on the conditions, status, past history. There are many variables. 11:20:50

Q. Based upon those variables, what the patient's past history is, the exam, is acute mesenteric ischemia something you would expect a general surgeon to recognize or would that be something more so that you think a vascular surgeon would recognize and treat? 11:20:56 11:21:08

A. I think both types of surgeons can make the diagnosis with the appropriate conditions or possibly miss the diagnosis if the symptoms are not there. 11:21:22

Q. What would the symptoms be?

A. Anything from frank evidence of ischemia, necrosis, to subtle findings such as nausea and vomiting.

Q. What would the frank evidence be? 11:21:34

A. Evidence on x-ray of air in the bowel. Loss of vascular supply. So on. Isolated loops with a leaking effect.

Q. If a specialist performs a consult of a patient in the hospital at the request of another physician, is it the consulting physician's responsibility to review the medical records in the chart? 11:21:50

A. With the limitations that are placed on the referral. In other words, if you 11:22:02

are asked to check for an ingrown toenail that's specifically what you are going to look for. 11:22:06

Q. I want to switch a little bit to your background and your practice. 11:22:22

We're presently at the Center for Hernia Surgery?

A. Presently at my office at the Hernia Center, yes.

Q. Do you own the Hernia Center? 11:22:32

A. As of today I still do.

Q. Okay. Is that in some type of financial litigation?

A. No.

Q. Okay. You said as of today. 11:22:42 That's why I asked.

A. Surgeons today never know what tomorrow brings.

Q. What hospitals do you have admitting privileges at? 11:22:50

A. Meridia Hillcrest and I used to have them at Mt. Sinai.

Q. Tell me the nature of your present practice.

A. It probably involves about 70 11:23:02

percent hernia surgery and that's inguinal hernias, hiatal hernias, intestinal hernias with bowel resections for infarction of bowel. The other 30 percent is your gamut of general surgery. It's gallbladders, appendix, breasts. Lumps and bumps. Hemorrhoids. You name it. For the last eight or nine years it's been pretty well around the 70/30 percent mark. Prior to that it used to be 70 percent was general surgery and 30 percent was hernias. 11:23:04 11:23:16 11:23:32

Q. Of the 70 percent of hernia work that you do, what amount of that involves any bowel resection?

A. Oh, maybe one percent. At the most. 11:23:46

Q. Would it be the minority of surgery that you perform that involves bowel resection?

A. Fortunately, yes.

Q. All right. Would you tell me your Social Security number, please? 11:23:58

A. 550-96-0258.

Q. And your date of birth?

A. Do I have to? 7-31-48.

Q. Have you ever given testimony in a medical malpractice case on behalf of a 11:24:12

plaintiff who is bringing the claim? 11:24:16

A. Yes.

Q. Where and when?

A. It goes back a number of years.

Q. When was the last time you served 11:24:26 in the capacity of an expert witness on behalf of a plaintiff in a medical malpractice case?

A. Probably within the last eight months or so.

Q. Approximately how much expert 11:24:44 witness work do you do in the medical malpractice area?

A. I'm not sure how to answer that.

Q. How many cases do you presently have going where you have been retained as an 11:24:54 expert in a medical malpractice case?

A. Maybe three or four.

Q. Okay. And how many cases do you review on a yearly basis?

A. Probably about five or six. 11:25:08

Q. Do you testify more on behalf of the plaintiff or the defendant?

A. Defendant.

Q. Can you give me any idea? Is it like 70/30, 90/10? 11:25:18

A. Probably 80 percent defendant, 20 percent plaintiff. 11:25:20

Q. Have you ever had a judgment rendered against you personally for medical malpractice? 11:25:28

A. Yes.

Q. When was that?

A. Probably 1995 or 1996.

Q. And was that the only one?

A. Yes. 11:25:36

Q. Did that go to court, sir?

A. No. That was settled by PIE at their insistence.

Q. Do you know Dr. Howard Darvin?

A. Yes. 11:25:4

Q. How do you know him?

A. Very peripherally. He comes to Hillcrest once in a while.

Q. So he's just a colleague that you sometimes would run into at the hospital? 11:25:54

A. Yes.

Q. What about Dr. DiBlasio?

A. I may have said hello once or twice at some meetings.

Q. All right. But you never saw him 11:26:00

at the hospital? You don't work at the same facilities? 11:26:02

A. No.

Q. Have you spoken to Dr. DiBlasio at all about this case? 11:26:08

A. No.

Q. Have you ever worked previously for Mr. Van Wagner in the capacity of an expert witness?

A. I don't think so. 11:26:14

Q. Have you worked previously for Mr. Van Wagner's law firm Ulmer & Berne in the capacity of an expert witness?

A. Yes.

Q. Approximately how many times? 11:26:22

A. Maybe once or twice in the last two, three years.

Q. I would like to refer you to your report that you wrote, sir, of July 28th, 1999. Did you discuss the conclusions and opinions that you arrived at in that report with Mr. Van Wagner prior to writing the report? 11:27:00

A. I don't recall. It's possible.

Q. Is this the first draft of the report? 11:27:14

A. Yes. 11:27:14

Q. You indicated -- let me ask you the question this way. Have you reviewed any materials since you authored the report of July 28th, 1999? 11:27:24

A. I don't believe so.

MR. VAN WAGNER: Well, Dr. DiBlasio's deposition.

A. I'm sorry. Dr. Diblasio's deposition. 11:27:32

Q. All right.

A. That's why I invited him along.

Q. Okay. Nothing else?

A. No.

Q. You indicate in the second paragraph of your report that Mr. Slusher was a 47 year old man with a one-year history of stomach pain. Where did you obtain that information from? 11:27:48

A. The records. 11:27:52

Q. What records, sir?

A. I think the initial consultation by Dr. Darvin was a request for consultation for chronic abdominal pain. And Dr. DiBlasio's history elicited a one-year history of 11:28:04

abdominal pain. 11:28:06

Q. Did he --

MR. TORGERSON: I'll move that go out.

But go ahead. 11:28:10

Q. Did he also have a history of weight loss at the same point in time that he had the stomach pain?

A. Yes.

Q. Now, you indicate in the second 11:28:26 paragraph Dr. DiBlasio was asked to see him for chronic abdominal pain in view of the lack of acute abdominal signs. What are you referring to?

A. Basically guarding and rebound 11:28:42 which is an immediate process and emergent process.

Q. What does guarding mean?

A. Guarding is a physical sign in which you palpate the abdomen and it's rigid 11:28:54 and it suggests that there is a perforation or some kind of an acute process going on inside the abdomen.

Q. As a general surgeon evaluating the patient for abdominal issues, what is the 11:29:06

significance of that positive guarding response? 11:29:08

A. Again, it suggests that there may be some acute process going on in the abdomen like a perforation or some kind of acute inflammation, infection, so on. 11:29:14

Q. All right. Would diarrhea be an acute abdominal sign?

A. No.

Q. Nausea? 11:29:2

A. No.

Q. Absence of bowel sounds?

A. No.

Q. Was the patient able to eat prior to his discharge on 9/9/95? 11:29:4

A. I don't know the specific answer to that, but I will tell you that four days, five days after aortic surgery I'm not sure many of us would have much appetite.

Q. Maybe I didn't make myself as clear as I needed to. Was the patient able to keep food down prior to his discharge of 9/9/95? 11:29:56

A. I don't know.

Q. Is that an important issue to be evaluated in the context of this patient prior 11:30:12

to discharge? 11:30:14

A. Not in relation to the patient who has had aortic surgery.

Q. So you would have no problem discharging a patient who had the type of 11:30:20 surgery that Mr. Slusher had even if they were not able to keep food down prior to discharge?

A. That's correct.

Q. What significance if any do you attach to the rectal bleeding that Mr. Slusher 11:30:34 demonstrated when he returned on 9/9/95?

A. Again, that needed to be worked up.

Q. Okay. For what purpose, sir?

A. It could be anything from hemorrhoids to something more severe. If a 11:30:54 patient presented to my office with those symptoms I would take the time to work them up and establish a diagnosis.

Q. Are you familiar with the concept that usually the diagnosis of mesenteric 11:31:04 ischemia is made if the clinician has a suspicion for the disease, a high index of suspicion?

A. I have no comment on that.

Q. Okay. 11:31:16

MR. TORGERSON: Read back the question. 11:31:44

(Record read.)

MR. TORGERSON: Stick an objection in there. 11:31:48

Q. Are you familiar with that concept to qualify it as a question?

A. I don't know.

Q. You have never heard it?

A. I don't know how to give you an answer on that. I have not come across that. 11:31:56

Q. What are the general surgical textbooks that you think may not necessarily be authoritative but are a reasonable discussion of general surgery? 11:32:1

A. You have Schwartz and Sandstone which are the standard texts.

Q. What would have been the findings of 9/9/95 which would have needed to be present for you to conclude that there were findings subjective of a surgical abdomen on his readmission to Geauga? 11:32:34

A. Evidence for guarding or rebound.

Q. I want to ask you these questions, doctor, now given the health history of 11:32:52

Mr. Slusher, not just general questions. 11:32:56

Given the health history of Mr. Slusher, specifically his atherosclerotic disease and his readmit to the emergency room on 9/9/95 with diarrhea and blood, isn't that, 11:33:10 diarrhea and blood, given his health background, a symptom of mesenteric ischemia?

A. Not necessarily.

Q. Could it be?

A. I don't know. 11:33:28

Q. Would mesenteric ischemia be one of the elements you would include in the differential in this patient on 9/9/95 with his health history and presenting symptoms?

A. Probably not. 11:33:40

Q. Is a distended abdomen a surgical finding or a finding that would cause you to be concerned about a perforation?

A. Not by itself.

Q. What else would have to be present 11:34:06 with it?

A. Guarding. Rebound.

Q. What do you mean when you say ischemia of the bowel is a diagnose of exclusion? 11:34:18

A. We're able to make a diagnosis of gallbladder disease by showing stones in the gallbladder. When you are talking about mesenteric ischemia, the symptoms really have to be ruled out in relation to other entities, ulcers, pancreatitis, colitis, intestinal hernia, adhesions. I mean the list is endless. 11:34:22 11:34:34

Q. And what tests would you order if you wanted to rule out ischemia of the bowel?

A. Again, taking in reference what I just said, I would have to do all of the other studies or all of the other diagnostics. You know, if it's GI, possibly an endoscopy. CAT scans. Just about every lab test you can think of. If all of those came back normal, then I would have to start looking for the odd entities and the unusual diagnostic things you start considering. 11:34:5 11:35:0

Q. Even if a patient has severe vascular disease? 11:35:22

A. Yes.

Q. How many cases of ischemic bowel have you treated in your career?

A. I've probably had one.

Q. And is that because you just don't 11:35:34

deal much with bowel disease per se, your practice is not related to treating bowel disease? 11:35:36

A. I don't think that's a fair assessment. I think this is a very rare entity. You don't see very many of these patients. 11:35:46

Q. Okay. So you are saying that the disease of ischemic bowel is a rare disease?

A. Very unusual, yes. 11:35:58

Q. Am I incorrect in saying that the majority of your medical practice does not involved surgical treatment of the intestines?

A. Well, as I said, up to eight years ago I was doing 70 to 80 percent general surgery which involved the intestines. Even today with the hernia practice we do hiatal hernias, intestinal hernias. I do gastric stapling for morbid obesity. It's still quite heavily in the bowels. 11:36:16 11:36:32

Q. When was the last time you did a bowel resection?

A. I just about did one a couple of days ago with ischemic bowel.

Q. So you didn't actually do it? 11:36:42

A. No. 11:36:44

Q. When is the last time you did a bowel resection?

A. I'd say probably about six, eight months ago. 11:36:50

Q. What is the basis for your statement unfortunately in most cases the diagnosis is made far too late at surgical exploration or autopsy?

A. Because it's an exclusionary 11:37:06
diagnosis. When the patient presents with symptoms it's an ongoing entity so that you already have the necrosis and very often you'll make the diagnosis only at autopsy or at actual surgical exploration when you have ruled out 11:37:18
the other entities.

Q. Is that by virtue of your experience? Is that what you're using to make that statement?

A. No. 11:37:26

Q. Is there some text that you are relying on, some article?

A. Just general medical knowledge.

Q. Is it also your general medical knowledge that ischemic bowel is a very rare 11:37:36

disease? 11:37:42

A. It's a very unusual disease, yes.

Q. Now, the extensive vascular disease that Mr. Slusher had started where and stopped where? 11:38:00

A. I'm not sure I understand your question.

Q. Okay. In your report you wrote this young man had extensive vascular disease. Where? 11:38:12

A. We know that there is evidence that there was 90 percent of occlusion of his left carotid. He had very extensive disease in the aorta. I don't doubt that he had extensive disease elsewhere, too. 11:38:24

Q. And he would have been expected to have some vascular disease involving his mesenteric vessels, that is your opinion, is it not?

MR. TORGERSON: Objection. 11:38:34

A. It would be most likely, yes.

Q. All right. When we say mesenteric vessels, we're talking about the superior and inferior mesentery arteries?

A. Right. 11:38:44

Q. Prior to the time, you may not want to answer this because it may be a question that you believe is in vascular medicine, but prior to the time of doing an ABF surgical procedure would you want to workup and see the condition of his superior mesenteric artery? 11:38:5 11:39:02

MR. TORGERSON: Objection.

A. That's not my area of expertise.

Q. Is a distended abdomen considered an abnormal finding? 11:39:4

A. Under what circumstances?

Q. Under the circumstances of Mr. Slusher's readmission to Geauga on 9/9/95.

A. No.

Q. What is tympanic, T Y M P A N I C? 11:39:5

A. Tympanic.

Q. What does that mean, sir?

A. When you percuss the abdomen you get kind of a drum sound. It's called a tomomatic sound. 11:40:14

Q. What does that tell you as a general surgeon?

A. Virtually nothing.

Q. Is a tender abdomen an abnormal finding? 11:40:26

A. Under what circumstances? 11:40:26

Q. All of these questions are under the circumstances of Mr. Slusher's readmission on 9/9/95 to Geauga.

A. Well, if we're dealing with a 11:40:34
patient four days after having a large incision in the abdomen for aortic surgery it's not an unusual finding, no.

Q. If you suspect mesenteric ischemia, is the gold standard test to diagnose it by 11:41:28
angiogram study?

A. Yes.

Q. Do you have any opinion as to what the treatment is for acute mesenteric ischemia?

A. No. 11:41:42

Q. Is treating acute mesenteric ischemia in the scope of what a general surgeon does?

A. No. That's generally within the vascular surgeon's purview. 11:41:54

Q. In performing elective major surgery do you try to eliminate as many risks as are possible?

A. I guess that's a fair statement.

Q. And part of the way to do that is 11:42:10

to screen patients for health conditions before elective surgery? 11:42:12

A. We're being very general. I also have a problem trying to figure out what you're asking in terms of generalities. I can't answer that. 11:42:22

Q. You can't or won't?

A. I can't. I mean, are we talking about a 90 year old, a 20 year old? Are we talking about male, female? I mean, there are so many variables there it's hard to give you a blanket answer. 11:42:36

Q. Is there ever a time, whether it's any of the people that you have mentioned, that you would want to perform elective surgery without trying to screen the patient for their health history? 11:42:4

A. You know, if I'm removing a cyst or doing a lymph node, I'm not sure it's so critical. 11:42:58

Q. How about if it's a major abdominal surgery that is being done?

A. Sure. You are going to want to know what the background history is. Are they bleeders? Any medication problems? So on. I 11:43:06

don't think that's really what you are asking. 11:43:08

Q. That's exactly what I'm asking and so that there is no misunderstanding I'll ask it again on the record.

If you were performing a major abdominal elective surgery would you want to screen the patient and obtain what their health history is? 11:43:16

MR. TORGERSON: Note an objection.

Go ahead. 11:43:28

A. I mean it's part and parcel of obtaining a history and physical on a patient when you see them.

Q. So that would be something that you would do in the course of your practice? 11:43:34

A. Yes.

MR. TORGERSON: Objection.

Q. Can ileus be a sign of bowel ischemia?

A. It can be. 11:43:56

Q. Do you agree that intestinal ischemia requires its own diagnosis and plan of treatment?

A. I'm sorry. Could you repeat that?

Q. Certainly. 11:44:10

MR. MARGOLIS: Read it back. 11:44:10

(Record read.)

A. I'm really not sure I understand the question.

Q. In treating intestinal ischemia, is there a specific type of treatment that should be utilized or do you diagnose it and just slow it up to a point and see what happens with the patient? 11:44:28

MR. TORGERSON: Note an objection. 11:44:47

Go ahead.

A. It depends on the degree of ischemia you have, the symptomatology associated with it. There are medical treatments. There are surgical treatments. 11:44:52

It's just not an area that I'm an expert in or necessarily practice in.

Q. Intestinal ischemia?

A. Correct.

Q. Do you agree with the statement that the diagnosis of acute mesenteric ischemia before the bowel becomes perforated is the most important factor in improving a patient's survivability suffering from that disease? 11:45:22

A. That's correct. 11:45:38

Q. Is there any Plaintiff's attorney whose name you could provide me that you have reviewed a case for and given an opinion that there was malpractice? 11:45:48

A. Paul Kaufman. And I think Howard Mishkind is another name that comes to mind. 11:46:00

Q. Do you agree that if the doctor's negligence in the treatment of a patient causes the patient harm that the doctor should be held responsible for that harm? 11:46:28

A. Definitely.

Q. Sir, I'm going to ask you some questions about these records. If you want to try to locate them in your records, you are certainly welcome to. But in an attempt to try to expedite things I did put them in the record that I'm going to be reading off of. 11:46:46

A. That's perfect.

Q. Okay. 8/2/95 Mr. Slusher underwent an angiogram and in his history and physical for that angiogram indicated under past history paragraph two that he had poor appetite and lost 15 pounds in one year. 11:46:58

Are those symptoms in and of themselves representative of mesenteric 11:47:16

ischemia of the bowel? 11:47:20

A. Absolutely not.

Q. Are they representative of any mesenteric issues involving the bowel?

A. No. 11:47:32

Q. And then on the third page which appears to be the nurse's evaluation of him admitted on 9/5/95 when he went in for surgery it indicates diminished appetite?

MR. TORGERSON: Wait a minute. 11:47:54
When he actually went in on 9/5?

MR. MARGOLIS: Yeah.

Q. Patient's admission history and assessment, Geauga, 9/5/95. It says diminished appetite. Develops burning pain after eating. 11:48:08
Weight loss, 15 pounds in one year.

Is that symptoms of any type of mesenteric ischemia?

A. No.

Q. What was the cause of the diarrhea 11:48:28
that Mr. Slusher was suffering from in the hospital from 9/5 through his discharge 9/9?

A. Probably nonspecific.

Q. Is diarrhea in and of itself a symptom of mesenteric ischemia in its early 11:48:46

stage? 11:48:50

A. No.

Q. If you would look at -- if you could look at this page. It says critical flow sheet. 11:49:00

A. I've got it.

Q. If you would turn one more page over. CK stands for creatine kinase?

A. Kinase.

MS. ATWELL: What date? 11:49:16

MR. MARGOLIS: That is 9/6/95.

Q. And creatine kinase, as I understand it, is an enzyme secreted by a muscle, is that accurate?

A. Yes.

Q. With mesenteric ischemia will the CK level be elevated?

A. I don't know.

Q. If you would look, sir, at this one page in the packet, sir, that starts off with 11:50:00 Geauga Hospital admission note 9/9/95. Do you see that? It probably would be the second packet in.

A. I've got it.

Q. Okay. If we could please turn in 11:50:12

to the lab of 9/9/95 which would have been taken when he was admitted to the emergency room. Do you see that? 11:50:30

A. I've got it.

Q. Okay. 11:50:42

MR. TORGERSON: Is this just a group of stuff that you put together taking them out from each admission?

MR. MARGOLIS: Yes.

MR. TORGERSON: All right. 11:50:50

Q. The CK level at that point is 383. Is that a significant finding based upon his overall health picture that he presented to the E.R. on 9/9/95?

A. Frankly, it's an isolated increase. I'm not sure what to make of that. 11:51:04

Q. Is that an increase that would be consistent with mesenteric ischemia?

A. I'm not sure of the answer to that.

Q. Is there any significance to that increase from 9/6/95 of 231 to 9/9/95 of 383? 11:51:16

A. Well, it does show an increase, but the upper limits of normal are 228. So the 231 at the initial level is just about in the realm of normal. 11:51:38

Q. What about the 383? 11:51:38

A. This is certainly elevated, but it looks like an isolated elevation. I would expect with mesenteric ischemia to see a marked elevation of LDH and other enzymes. 11:51:46

Q. Lastly, doctor, if would you turn to page -- go to the CK level of 9/11 which is 1,972. Would that be a finding that would be consistent with mesenteric ischemia?

A. Again, I'm not sure of the relation of an isolated CK increase to mesenteric ischemia. 11:52:04

Q. Do you have any opinion, sir, as to why it increased on 9/9 from 383 to 9/11 to 1,972? 11:52:20

A. If he's getting intramuscular shots of medication it can cause that. Muscle necrosis or ischemia just from nonuse.

Q. Wouldn't there --

A. Bumping your muscles into everything from your guardrails to whatever else can cause an increase in your CK. 11:52:32

Q. Wouldn't there be an elevation of CK once the bowel starts to be deprived of blood? 11:52:48

A. I really would anticipate finding a much greater level of other enzymes. 11:52:50

Q. Okay. But my question is pertaining to CK.

A. I can't comment on an isolated increase of CK. I don't know. 11:53:00

Q. Okay. And then, sir, if you could please go to this packet that starts 9/9/95 with it looks like Dr. DiBlasio's admit note.

What is the significance -- and, doctor, all of the questions that I'm asking you now are in the context of Mr. Slusher. 11:53:24

A. Okay.

Q. Okay. What is the significance of the high output from the NG tube that occurred when he was brought into the emergency room on 9/9/95? 11:53:34

A. Let me see. He has nonfunctioning bowel. It's backing up.

Q. Are three liters of fluid, is that a lot of fluid? 11:53:48

A. It can be.

Q. What is -- can you tell me, and I apologize for my ignorance, what a liter is in ounces? 11:53:58

A. I was afraid you were going to ask that. There is 30 ml's to an ounce. So that's roughly about 33 ounces. 11:54:00

Q. Okay. Doesn't Dr. DiBlasio conclude that there was guarding in his abdomen when he indicates his abdomen is slightly distended and somewhat firm although he is guarding? 11:54:18

A. The guarding that I'm familiar with is where a physician feels the abdomen and calling it frank guarding is not talking distension. If I poke your belly hard enough, as I'm pressing it, you will guard a little bit too. But that's not guarding they're talking about. 11:54:32 11:54:46

Q. The guarding that you are referring to that is noted in the chart is frank guarding or is it just guarding?

A. This does not give me the perception of true guarding. 11:54:58

Q. And my question is, you know, as a general surgeon when you see that there is an abdomen that you would characterize as guarding, how do you indicate that in your chart? 11:55:12

A. Diffusely guarding. Rigid. This sounds more like in the area that he's pressing there is some localized guarding. You'll also note that there is active bowel sounds. 11:55:1

Q. That are reduced. 11:55:28

A. Yes. But nonetheless still bowel sounds. That means it's an active, viable bowel.

Q. Do you know whether in Dr. DiBlasio's deposition it indicated if there was any guarding of the bowel in the 9/9/95 evaluation he did in the ER? 11:55:3

A. I don't recall specifically.

Q. What would have been the appropriate window of time for Dr. DiBlasio to wait to do an upper endoscopy under these circumstances? 11:56:0

A. An upper endoscopy?

Q. I believe that's what he says or maybe I'm wrong. I apologize. It says at some point we may need to evaluate the upper GI tract with endoscope. I'm interpreting that to mean an upper GI endoscopy. Maybe I'm wrong. 11:56:16

A. He also goes on to note -- in fact, the flavor of his deposition seemed to indicate 11:56:30

somewhat different, but it also says, following what you said, the possibility of a small bowel follow through contrast study of the GI tract will also need to be done. He's thinking globally of just investigating the bowel. 11:56:34 11:56:44

Q. What period of time do you believe is appropriate to wait under these circumstances until these tests are done?

A. Given the patient who comes in with these kinds of signs and symptoms, you have to recognize that you are dealing with potentially a dangerous neurologic problem. That's not the patient you want down in x-ray waiting for some barium to be put in or left in a corridor somewhere which is pretty standard waiting for some further testing. So this is the kind of patient you kind of have to sit on for a while. 11:56:56 11:57:08

Q. But, doctor, Dr. Crosby the emergency room doctor indicated that by the time Dr. DiBlasio arrived that the patient had essentially completely recovered from his stroke and his only ongoing problem was his abdomen. So where is this neurological problem that you have described? 11:57:24

A. That's what he came in with, with 11:57:42

paresis of the right side. 11:57:4

Q. But you'll with agree me, won't you, that when Dr. DiBlasio arrived, that his stroke had resolved and the only remaining problem was his abdomen, that's what the doctor 11:57:54 noted in his chart?

A. But that does not preclude the next bout being a permanent episode.

Q. So do you wait to work up the abdomen issue out of concern that there may be 11:58:0 a next bout of neurological issues?

A. Yes.

Q. Okay. How long do you wait?

A. Get a neurologist and have him determine what the underlying process is. Once 11:58:1 you feel comfortable that you are not jeopardizing the patient you can proceed with a work up.

Q. And --

A. Recognizing again that we don't 11:58:22 have an acute abdomen.

Q. Okay. Any significance to his white count being elevated on admission of 9/9/95?

A. I think it was barely elevated, if 11:58:48

I recall. I think it was 12,800. The realm of normal is somewhere around 12,000. That's not anything to get excited about. 11:58:50

Q. But despite that fact Dr. DiBlasio assumed care of this patient after his 9/9/95 readmission to Geauga? 11:59:02

A. It sounds like by process of elimination he was there.

Q. Does it cause you concern as a general surgeon when there is such a large amount of fluid that comes out of an NG tube such as three liters? 11:59:22

A. Not really. I have had had substantially more than that in some patients.

Q. And I guess the reason for that is that whatever the contents are that are in the stomach, they are not moving their way through the bowels, is that correct? 11:59:40

A. Correct.

Q. What is hypovolemia? 11:59:50

A. It's low volume fluid in the vasculature.

Q. Is there any significance to you as a general surgeon as to what the color is of the fluid that comes back out of the NG tube? 12:00:12

And, you know, I'm not trying to dance with you here. If you want to look at page four it looks like it says 2100 c.c.'s dark slash green liquid. 12:00:18

A. It's bile that you are describing. 12:00:34

Q. Okay. Is bile normally a substance that is in the stomach?

A. Yes.

Q. And the fact that that would be coming out of an NG tube, why would that occur? 12:00:46

A. The patient probably has an ileus. Fluid is just not being propagated. You still have a lot of gastric juice being put out, bile. Pancreatic fluid is all backed up in the NG tube. 12:01:02

Q. Because the bowels are not working?

A. Right.

Q. Is it any significance to you if during his time in the emergency room that there were no bowel sounds heard in his left lower quadrant, left upper quadrant? 12:01:14

A. I think in retrospect that goes along with the fact that that patient most likely had an acute mesenteric insult and that's the repercussion. 12:01:28

Q. If the patient has an acute mesenteric insult, what is indicated medically in following up on that acute mesenteric insult? 12:01:30

A. You know, in honesty, in most cases you are not going to make that diagnosis at the appropriate time. In most of those situations It becomes a diagnosis of exclusion. So I think your questioning is somewhat unfair unless you know ahead of time that that patient specifically has that particular problem. 12:01:40 12:01:54

Q. What about if you know ahead of time that the patient had postprandial pain, the patient had weight loss for a year, that the patient underwent a major abdominal surgery and that the patient has, to quote your report, extensive vascular disease that would have been expected to have some involvement of his mesenteric vessels? 12:02:08

A. The symptoms you have described fit very much for a patient with a chronic ulcer disease. Reflux esophagitis. Biliary dysfunction. Adhesions. Intestinal herniations. I could go on probably for another 20 minutes rattling off diagnostics. 12:02:34 12:02:46

Q. Would any of those diagnostics include mesenteric ischemia? 12:02:52

A. Probably way down on the list at the very bottom.

Q. Even with the information that I asked you to assume in my question? 12:02:58

A. Absolutely.

Q. Even knowing that he has extensive vascular disease which you would have expected to effect the mesenteric vessels? 12:03:0

A. Correct. Because we know also at University Hospitals when the patient came in they had the same information that was available at Geauga Community.

Q. Well, when the patient came into UH he was having more neuro problems, was he not? 12:03:2

A. Correct. But at the time there was still the history of the weight loss, postprandial pain, recent femoral surgery. It still was very much a diagnosis of exclusion. 12:03:36

Q. Is a tense abdomen an abnormal finding?

A. Again, I apologize. Are we referencing just this admission on the 9th?

Q. Yes, sir. If you would look please 12:03:56

to this physical examination of doctor, it looks like Audi. He indicates the abdomen is tense. There is mild tenderness in the right upper quadrant. Bowel sounds are present but hypoactive. 12:03:58 12:04:10

A. What that suggests is an ileus.

Q. Couldn't one of the causes of ileus be ischemia?

A. It can.

Q. Could you please be kind enough, sir, to locate the 9/14 x-ray report in your records from UH? 12:04:30

A. Okay.

Q. Can I see it, please? Thank you. And the distinction that you are drawing between the 9/14/95 x-ray report and this 9/9/95 x-ray report pertaining to the free air is what? 12:05:48

A. I think if I may read directly from the report of 9/14/95. 12:06:48

Q. Yes, sir.

A. In the area under recumbent portable chest it says there is a lucency that suggests air in the peritoneal cavity. Following paragraph, there is evidence of 12:07:04

significant distension of a loop of small bowel in the left upper quadrant. Under impression it says free air. I'm told this has been communicated to Dr. May. The floor was also called. Radiologists do not do that unless there is an acute emergency. 12:07:10 12:07:24

Q. How does that differ from the 9/9/95 film that indicates severe to moderate dilation of multiple loops of small bowel, lack of chronic extension, suggests bowel obstruction but the nondifferential air fluid levels in the small bowel seen on cross-table lateral suggests postop ileus. I guess is the air in a different place in the abdominal cavity? 12:07:42 12:07:58

A. It is, because now we're quite a bit further out from the surgery time. The surgery on the fifth. Now we're about ten days past the day of surgery. But the real difference here is that they are talking about a significant distension of a loop of small bowel. We're not talking about a diffuse process anymore. If you'll read the previous KUBs that were done throughout the stay at University Hospitals there is a marked 12:08:08 12:08:22

difference from this last report to the interpretation of the previous report. 12:08:22

Q. Okay. Is the air though in a different part of the abdominal cavity?

A. I think it's more localized at this point which suggests that there is a localized perforation. 12:08:30

Q. Okay. Doctor, are you one of the general surgeons that are on call to emergencies? 12:08:42

A. Yes.

Q. And approximately how often do you get called in as a general surgeon on call?

A. Too often.

Q. Are we talking a couple of times a month? 12:08:50

A. Usually we'll take about a week a month.

Q. Do you have any patients that are presently in the hospital now under your care? 12:08:56

A. No.

Q. When was the last time that you operated at Hillcrest Hospital?

A. What's today? Friday.

Q. Do you still perform surgery out of 12:09:06

your location here? 12:09:1

A. No.

Q. Did you at one time?

A. No just minor stuff.

MR. MARGOLIS: Okay. If either 12:09:16
counsel want to ask questions, I know that we are under a 1:00 deadline here. Please feel free to do so as I'm reviewing the notes.

MR. TORGERSON: I have no questions. 12:09:3

MS. ATWELL: I have no questions.

Q. How long would it have been in your opinion appropriate for Dr. DiBlasio after 9/9/95 to have waited for return of bowel function? 12:10:1

A. Generally as long as it takes to attain that. It could be one day. It could be a week or more.

Q. Is there a point in time where bowel function does not return that you deem it 12:10:26
appropriate to do something other than wait under the circumstances of Mr. Slusher?

A. Thank you for qualifying that. I think the real issue again is are there other signs being demonstrate that alter your 12:10:40

diagnostic plan. If the patient develops guarding or rebounding or evidence of acute abdomen, obviously you no longer wait. Otherwise, if the patient is stable, demonstrating good vital signs, so on, we just monitor the patient and wait for the bowel function to return. It can take weeks. 12:10:44 12:10:52

Q. How does one differentiate between a diagnosis of bowel obstruction or ileus?

A. It's a very difficult diagnosis to make. You go by clinical patterns. If there is air in the colon, for example, beyond that point in the small bowel, it suggests there is a mechanical obstruction. If it's just diffused involvement then it's suggestive more of ileus, but very often it's a clinical differentiation. 12:11:16 12:11:28

Q. And how is the clinical differentiation made?

A. Partly by the history of the previous surgery. Partly of the patient having recent surgery. If you had surgery five years ago and you come in with evidence of dilated bowel, it would be more likely to be obstruction. If you recently had surgery the 12:11:40 12:11:52

most likely diagnosis would be ileus. 12:11:5

Q. As you reviewed these, as you have reviewed these records, do you have any -- does anything pop out to you as it pertains to the care Dr. Darvin provided this patient? 12:12:18

MR. TORGERSON: Note an objection.

A. In terms of the quality of his care?

Q. Yes.

A. Again, I'm not a vascular surgeon, so I can't put a comment on his performance. 12:12:2

MR. TORGERSON: Objection.

Q. What about his -- you have performed intestinal surgery on patients and followed them up postop, have you not? 12:12:3

A. Yes.

Q. Do you have any comments about Dr. Darvin's follow-up postsurgical care of this patient.

MR. TORGERSON: Objection. 12:12:46

A. In terms of?

Q. Of the care that he provided the patient?

MR. TORGERSON: Objection.

A. I don't have any specific 12:12:56

complaints. The only obvious issues would be diagnosing this patient after surgery with any ongoing problems. 12:12:56

Q. Doctor, do you have any comments about the preoperative workup that Dr. Darvin performed on this patient? 12:13:08

MR. TORGERSON: Objection.

A. Again, I'm not a vascular surgeon, so I can't comment on that.

Q. Thank you very much for your time. 12:13:18

A. Thank you.

MR. TORGERSON: Once again, I have no questions.

MR. VAN WAGNER: We'll read it.

(Deposition concluded.)

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CERTIFICATE

The State of Ohio,)

SS:

County of Cuyahoga.)

I, Barbara J. Watowicz, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, DAVID GRISCHKAN, 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 the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

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 for either party, 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 5 day of Dec, 2000.

Barbara J. Watowicz, Notary Public within and for the State of Ohio

My commission expires March 20, 2002.

I N D E X

SIGNATURE OF WITNESS

The deposition of DAVID GRISCHKAN, MD, taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

It was agreed by and between counsel and the parties that the Deponent will read and sign the transcript of said deposition.

AFFIDAVIT

The State of Ohio,)

) SS:

County of Cuyahoga)

Before me, a Notary Public in and for said County and State, personally appeared **DAVID GRISCHKAN, MD**, who acknowledged that he/she did read his/her transcript in the above-captioned matter, listed any necessary corrections on the accompanying errata sheet, and did sign the foregoing sworn statement and that the same is his/her free act and deed.

In the TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at this_____ day of_____ A.D 2000.

_____

Notary Public

_____

My Commission Expires:

DEPOSITION ERRATA SHEET

RE: PATRICIA M. FLETCHER, ETC. VS.
GEAUGA HOSPITAL ASSOC., INC., ET AL

RRS File No.: 1037

Deponent: DAVID GRISCHKAN, MD

Deposition Date: JUNE 1, 2000

To the Reporter:

I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.

_____