IN THE COURT OF COMMON PLEAS
OF SUMMIT COUNTY, OHIO

- - - - -

Karen Armour, :
Administratrix of the
Estate of M. Jean Speicher :
AKA Minnie Jean Speicher,
:
Plaintiff,
:
vs. Case No. 01 2002-07-4063
:
Patrick A. Rich, D.O.,
et al., :

Defendants. :

- - - - -

DEPOSITION OF THEODOR F. HERWIG, M.D.

- - - - -

Taken at the residence of Theodor F. Herwig, M.D.
657 Bay Drive
Westerville, Ohio 43082
November 20, 2003, 4:10 p.m.

- - - - -

Spectrum Reporting LLC
333 East Stewart Avenue
Columbus, Ohio 43206
614-444-1000

- - - - -

Spectrum Reporting, LLC
Specializing in Real-Time Reporting

APPEARANCES
(By Telephone)

ON BEHALF OF PLAINTIFF:
Howard D. Mishkind, Esq.
Becker & Mishkind
1660 West Second Street
Cleveland, Ohio 44113

ON BEHALF OF DEFENDANT PATRICK A. RICH, D.O.:
Andrew D. Jamison, Esq.
Reminger & Reminger
101 Prospect Avenue
Cleveland, Ohio 44115

ON BEHALF OF DEFENDANT DEAN P. RICH, D.O.:
Patrick J. Murphy, Esq.
Bonezzi, Switzer, Murphy & Polito
526 Superior Avenue
Cleveland, Ohio 44114

Thursday Afternoon Session
November 20, 2003, 4:10 p.m.

- - - - -

STIPULATIONS

- - - - -

It is stipulated by and between counsel for the respective parties that the deposition of THEODOR F. HERWIG, M.D., a witness herein, called by the Plaintiff for cross-examination, may be taken at this time by the notary by agreement of counsel and without other legal formality; that said deposition may be reduced to writing in stenotypy by the notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualification of the notary is waived.

- - - - -

THEODOR F. HERWIG, M.D.
being first duly sworn, as hereinafter certified, testifies and says as follows:

CROSS-EXAMINATION

- - - - -

BY MR. MISHKIND:
Q. Good afternoon, Doctor.
A. Good afternoon.
Q. Would you please state your name for the record?
A. Theodor, T-h-e-o-d-o-r, F., H-e-r-w-i-g, Herwig.
Q. Dr. Herwig, my name is Howard Mishkind, and I'm going to be asking you some questions concerning a letter you wrote dated July 9, 2003 --
(There was a brief interruption.)
Q. -- a letter you wrote July 9, 2003, to Mr. Murphy, and the opinions that you have in this case.
A. I have -- go ahead.
Q. We're doing this deposition by phone. What I would ask is that you make sure that you wait until I'm done entirely, even more than what

you would do face to face so that we don't have any words cut off during the course of the transmission, and also so the court reporter doesn't have more of a difficult time than she otherwise might have.
A. Very well.
Q. And I will do the same with you. Obviously I'll wait until you have finished your answer before I move on to the next question, okay?
A. Yes.
MR. MISHKIND: And again, for the court reporter's benefit, please let me know if my questions or my statements are being cut off in any respect, and I will pick up the phone and take it off speaker.
THE REPORTER: All right. Thank you.
Q. Doctor, to begin with, I have your letter dated July 9, 2003. Do you have that also?
A. Yes. I'm looking at it right now.
Q. I also have your CV that was faxed to me late yesterday from Mr. Murphy's office. And the CV is one page in length, is that -- is your CV more than one page?

Page 6

A. No. It's one page, and my current one is dated January, 2003.
Q. Okay.
A. And I have a copy here, if you want it marked.
MR. MISHKIND: Okay. Why don't we go ahead, just for purposes of the record, and have your report marked as Plaintiff's Exhibit 1 and your CV marked as Plaintiff's Exhibit 2.

- - - - -

Thereupon, Plaintiff's Exhibits 1 and 2 are marked for purposes of identification.

- - - - -

Q. Doctor, for the record, the report is Plaintiff's Exhibit 1 and your most recent CV is Plaintiff's Exhibit 2; is that correct?
A. That's correct.
Q. Are there any additions or deletions that need to be made to your CV to bring it up to November, 2003 standards?
A. I don't believe so.
Q. To follow up, your professional activities and your licensures and your

Page 7

associations are all the same?
A. They are.
Q. I also have a schedule here for your medical legal consultation, and I just wanted to go over a couple things on that before we move into the substance of your deposition.
A. Very well. Is yours dated January, 2003?
Q. Yes, it is, sir.
A. Okay. I have a copy of it in my hand.
MR. MISHKIND: All right. Why don't we go ahead and mark that as Exhibit 3?

- - - - -

Thereupon, Plaintiff's Exhibit 3 is marked for purposes of identification.

- - - - -

Q. And again, for the record, Exhibit 3 is your fee schedule for medical legal consultation; is that true?
A. Yes.
Q. A couple questions on that, sir. The deposition today, it says standard fee of $1200. Is that regardless of whether I take one hour or

Page 8

four hours for the deposition?
A. That's for anything up to four hours.
Q. So hypothetically, if I were to take two hours for the deposition, it's still $1200; is that correct?
A. Yes, it is.
Q. Okay. And I presume that you had a conference with Mr. Murphy before we hooked up on the phone today.
A. Yes, I did.
Q. And your conference with him consists of $250 per hour?
A. That's correct.
Q. Can you explain to me why the conference with the attorney is less than the deposition time?
A. That's a pretty good question. I suppose the smart alec answer is I should raise my fee to the attorney, but actually the deposition does require more in the way of alertness and caution in the way I choose my words and is a considerably more demanding enterprise.
Q. Okay. I don't want to be too demanding on you during the course of the deposition.

Page 9

A. Swell.
Q. Okay. In addition to your report and the exhibits that we have just marked, when your report refers to "case material," can you tell me what case material you were referencing in your letter?
A. Yes. This includes a notebook marked Armour versus Rich, 460150, Akron General Medical Center, which is hospital records from Akron General. It includes a binder, Armour versus Rich, 460150, Barberton Citizens Hospital, 01-25-01 to 01-28-01, which is the Barberton hospital record. It includes a deposition of Dean Rich, D.O., Wednesday, December 18th, 2002. It includes a file, Armour versus Rich, BSMP file No. 460150, Patrick Rich, D.O., medical records, and it includes expert letters from Ohio Chest Physicians, from Health Systems Design, and from Dr. Mark Bibler.
Q. Any other material that you are referring to in terms of case material in your July 9 letter, sir?
A. No.
Q. Have you received anything from anyone

Page 10

relative to the Speicher case since you wrote your report?
A. Yes. Mr. Murphy sent me a transcript of Dr. Dean Rich's notes this afternoon.
Q. A transcript of notes?
A. Yes, a typed rendering of his less than completely legible progress notes for the 02-01-01 office visit.
Q. Were you not able to decipher his office note based upon the written record?
A. There were areas where I was less than 100 percent certain.
Q. And in reading over Dr. Dean Rich's deposition, were you able to get a literal translation of what Dr. Dean Rich wrote in his office note for February 1, '01?
A. Yes, I was. In his deposition, he read into the record his notes.
Q. Okay. Was this transcription, then, that was sent down to you today by Mr. Murphy then necessary for you?
A. Probably not.
Q. Anything else that you have received other than what you just stated?

Page 11

A. No.
Q. And do you have that transcription right there with you?
A. I do.
MR. MISHKIND: All right. I'd like to get a copy of that and have that marked as Plaintiff's Exhibit 4, if you wouldn't mind, sir.
THE WITNESS: Okay. I have a very small copying machine here, and I can get a copy. Or do you want me to give this to the reporter and have her send my original back?
MR. MISHKIND: You can give it to the reporter, and then when you guys are done go ahead and run it through the copy machine and you can hold on to the original.
THE WITNESS: Okay.
MR. MISHKIND: This is No. 4, is it?
THE WITNESS: Yes, sir.
- - - - -
Thereupon, Plaintiff's Exhibit 4 is marked for purposes of identification.
- - - - -
Q. For the record, Plaintiff's Exhibit 4

Page 12

is the transcription of Dr. Dean Rich's office note; is that correct?
A. Yes.
Q. Was that prepared by Mr. Murphy's office or was it prepared by Dr. Rich's office?
A. It appears to have been prepared by Dr. Rich.
Q. Have you ever talked to either Patrick Rich or Dr. Dean Rich?
A. I have not.
Q. Do you know either of them?
A. No.
Q. You mentioned you had the three expert reports. One is from Dr. Bacik. That's B-a-c-i-k. The other is Dr. Kotomy, and then Dr. Bibler. Do you know any of those physicians?
A. I never have met them. I don't know them.
Q. You have not seen, I take it, the deposition transcripts of the family?
A. I have not.
Q. Do you know what the testimony has been of, for example, Karen Armour, the daughter, relative to her mother's symptoms following the

Page 13

discharge from Barberton leading up to the office visit of February 1?
A. No, I don't.
Q. Would you agree that a patient's symptoms, certainly if in fact she had continuing shortness of breath following the discharge and had shortness of breath at the time of her visit to Dr. Dean Rich, that would be something important for you to know?
A. Yes, it would.
Q. Okay. Now, Doctor, besides the material that you've identified for me, and obviously since I'm not there with you, is there anything else that you have in your possession right now relative to this case other than what you've told us about?
A. No. I have records of transmittal from Mr. Murphy, which simply are identifying the materials that he mailed me, but that's all.
Q. Is there anything that you have requested, Doctor, that you wanted to see that, for whatever reason, has not been provided to you?
A. No.
Q. You have never seen the deposition of

Page 14

Dr. Patrick Rich; is that correct?
A. That's correct.
Q. Have you done any literature search or research for purposes of this case?
A. No.
Q. You do teaching, as I recall; is that correct?
A. Yes, I do.
Q. And does any of your teaching surround the topic of the diagnosis and treatment of DVT?
A. I've never given a specific lecture regarding DVT, but in our rounds, clinical teaching, office teaching, this is a subject which comes up very frequently; and in that sense, yes, I have taught regarding it.
Q. What about the diagnosis of pulmonary embolism? Has that also been the topic of lecture to medical students on your part?
A. Again, I've never given a lecture on that subject; but again, it's an important and serious thing which we consider frequently in clinical practice.
Q. Are there any sources, Doctor, that you would refer a medical student or a resident to

Page 15

that you consider to be reasonably reliable for purposes of the topic of the evaluation of suspected pulmonary embolism?
A. If I had a student who or a resident who asked for sources, I would probably start with Harrison's Textbook of Medicine, the current edition, and I don't know what number that is at the present time, as general information. And I suspect that probably a literature search would show something in Medical Clinics of North America and so forth, but I don't have any other specific favorite sources.
Q. Can we agree that from a standpoint of a reasonably reliable resource for information on the evaluation of suspected pulmonary embolism, that Principles of Internal Medicine by Harrison is a good resource?
A. As you know, we're very reluctant to label anything as completely authoritative, but Harrison certainly has been recognized as a good general textbook of medicine for many years.
Q. Even though we may not use the term authoritative, would you acknowledge that it's reasonably reliable?

Page 16

MR. JAMISON: Objection.
A. I would think that it's a good point of departure, yes.
Q. Doctor, there was a recent article in the new England Journal of Medicine in September. Do you get the new England Journal?
A. I do not.
Q. Okay. Would you agree with this statement: When the diagnosis of embolism is confirmed and effective therapy is initiated, recurrence of the embolism is rare and death is uncommon.
A. I have to think about that a moment. I think we believe that appropriate treatment of thrombophlebitis and embolic disease significantly reduces the risk of the patient of having further embolic problems. I certainly am not a person that can offer any numbers to support that or clarify it.
Q. With regard to the specifics on numbers, would you defer to a pulmonary doctor as it relates to a likelihood of death from recurrence of embolism?
A. Yes. Either a pulmonologist or a

Page 17

vascular surgeon I think would speak with more authority than I.
Q. Okay. Again, another question for you whether you agree with this or not: The majority of preventable deaths associated with pulmonary embolism can be ascribed to a missed diagnosis rather than to a failure of existing therapies.
A. Another time to think a little bit.
Q. Take your time.
A. I really don't think that I'm qualified to give an opinion on that. It's not -- it's not my special field, and I think others with more experience would probably be more reliable to answer that.
Q. Okay. What is your area of practice or subspecialty?
A. I'm a family physician. I take care of people as their primary contact physician. I work with my colleagues in treating patients with established diagnoses and in confirming diagnoses, and I do that for people of all ages and with all sorts of problems.
Q. Basically from crib to grave?
A. I say that I see people -- I take care

Page 18

of people from before they're thought of till after they're forgotten.
Q. Okay. Hopefully they're never forgotten.
A. Hopefully. And when the patient is gone, the family remains, and I try to serve them.
Q. And provide them some comfort as well when they lose a loved one?
A. Yes, and medical care when they need it as well.
Q. Certainly. Dr. Patrick Rich and Dr. Dean Rich, what is your understanding as to their area of practice?
A. As I understand it, Drs. Rich are both community-based family practice practitioners. I know that Dr. Dean is boarded in family practice. I don't know about Dr. Patrick, but I would assume that they do a practice very similar to mine.
Q. I believe one or both of the doctors -- and I say it this way because you haven't read Patrick's deposition. But one or both of the doctors indicated that from a standpoint of the diagnosis and treatment of BVT or the ruling out of the existence or nonexistence

Page 19

of pulmonary embolism, that the standard of care is the same for an internist as it is for a family physician. Do you agree with that statement?
A. Yes. I think the standard of care for a family physician is in almost every incidence the same as the standard of care of a specialist.
Q. So we wouldn't have any difference in terms of what the standard of care is for an internist that's presented with signs and symptoms of a DVT or signs or symptoms of a PE as compared to a family practice doctor in the same situation; is that true?
A. I agree.
Q. Okay. Doctor, I want to just ask you a few questions about your medical legal experience. In terms of the percentage of work that you do by way of review of cases, can you tell me what percentage is at the request of plaintiff's counsel and what percentage is at the request of defense counsel?
A. Interestingly, my work has been just about evenly balanced between cases given to me by plaintiffs and defense counsel.
Q. In terms of your -- that's pretty much

Page 20

been consistent throughout the years?
A. Yes, it has.
Q. You've been doing this for how many years now, sir?
A. Probably 10 or 12.
Q. And are you in the active clinical practice of medicine currently?
A. Yes, I am.
Q. What percentage of your time do you spend in the active clinical practice?
A. 100 percent.
Q. Okay. Other than when you're called upon in this setting.
A. That's correct.
Q. Can you give me an idea of how many cases you review on a yearly basis?
A. Over the years, it's been pretty steadily about 10 or 12 cases a year.
Q. And how many times are you called upon to give deposition testimony?
A. About half the time.
Q. So five to six depositions a year?
A. Correct.
Q. And trial testimony where you actually

Page 21

walk in the courtroom and give testimony?
A. That's, of course, much less common, but I would say I average perhaps two to three a year.
Q. And are the percentages concerning depositions and trial testimony, is it equally balanced, fifty-fifty?
A. Pretty much, yes.
Q. Now, you and I have never met before, have we?
A. That's correct.
Q. Have you worked with Mr. Murphy or any of the attorneys from Bonezzi, Switzer, Murphy & Polito before?
A. Yes, I have.
Q. Can you just give me an idea roughly, I guess we'll start with how many cases are you currently participating as an expert for them?
A. I probably have two or three cases that are pending presently. As you know, there's several large firms that do defense work as there are plaintiff's work, and as a result, I have a number of cases within the same firm. I really don't have any numbers.

Page 22

Q. Okay. Over the years how many cases have you worked with Mr. Murphy personally as an expert?
A. Probably four or five.
Q. How about actual testimony, deposition or in trial?
A. I think I've only been deposed on his cases, I think this is only the second one that I've been deposed on. I'm not -- I'm not sure of that, but I think this is only the second, and I've never gone to trial on his cases. Oh, wait a minute. No. No, I have not gone to trial on any of his cases.
Q. I take it you have gone to trial on some of the cases for the other lawyers in his office.
A. I -- actually I don't think so. I was in trial in a case one of his partners was involved in, but I was on the other side.
Q. Okay. I'm starting to show my age. I just lost my train of thought. It probably was going to be a brilliant question, too.
A. It will come.
MR. JAMISON: One in a while we dodge

Page 23

the bullet, Howard.
MR. MISHKIND: Yeah, right. I knew you couldn't pass that opportunity up.
MR JAMISON: I couldn't.
Q. Now I remember what it was. Have either of the cases you've worked for, either written reports, depositions, or at trial involved issues of the diagnosis and treatment of a patient with a pulmonary embolism?
A. Yes. There have been several.
Q. Can you tell me just generally when those cases were and what the outcome of those cases were?
A. I have reviewed cases for a plaintiff's attorney. I think the one I remember probably went back about five years. I've -- primarily I've reviewed them for defense attorneys.
I really don't know what the outcome was. I've not gone to court, and I've not been privy to what resolution was made of the case.
Q. Do you recall the names of any of those cases either by way of a patient or the doctor where a PE was involved?
A. I'm sorry. I don't.

Page 24

Q. Can you tell me when the last time your deposition was taken?
A. In any matter?
Q. Yes, sir.
A. I think I've done a couple earlier this year. I kind of live in the moment, and --
Q. We all do.
A. And I really can't tell you who it was and when and where.
Q. But you think it was a couple earlier this year?
A. I'm sure I have, yes.
Q. Do you have any depositions scheduled for the balance of this year?
A. I don't believe so.
Q. And this case is set for trial December 9th, and I know you're scheduled to testify toward the end of that week.
A. Yes.
Q. And I take it you're planning on appearing live, in person, as opposed to video?
A. Yes. If you haven't settled it, I expect to be there.
Q. Okay. Have you ever been named as a

Page 25

defendant in a malpractice case, sir?
A. Yes, I have.
Q. How many times?
A. Three.
Q. Any of those currently pending?
A. No.
Q. Any of those cases involve pulmonary emboli?
A. No, they didn't.
Q. The outcome of those three cases, were they all dismissed?
A. The first one was dismissed with prejudice 40 years ago. There was one that was failure to diagnose a breast cancer where $9,000 was paid. That was probably about 30 years ago. And there was one where an elderly lady managed to hang herself on her Posey restraint, and my insurance paid $15,000 on that one.
Q. Doctor, could you tell me how many years young you are?
A. I am 71.
Q. Okay.
A. There are not too many people that will own up to being in practice for 40 years, will

Page 26

they?
Q. No, I guess not, but I congratulate you. I just want to ask you a couple basic medicine questions, and then we'll move on to the specific opinions that are --
(The phone connection was broken; short recess taken.)
MR. MISHKIND: Back on the record.
Q. I think I was indicating to you I wanted to ask you some basic medicine questions.
A. Yes.
Q. And then we'll get into the opinions that are involved in this case.
Before I put away your CV entirely, is there anything on your CV by way of your activities or professional associations that are particularly germaine to the issues involved in this case as it relates to the suspicion of or work-up of a patient for a pulmonary embolism?
A. I don't believe so.
Q. Okay. What is deep vein thrombosis?
A. The deep veins ordinarily are considered to be the deep femoral veins in the calf and in the thigh. It's not the femoral in

Page 27

the calf. That would be the deep popliteal there. And thrombosis is a condition where a clot forms within the blood vessel.
Q. What are the common signs and symptoms of a DVT?
A. The most common sign is a painful calf, swelling, perhaps heat. Those are the most common signals that a venous thrombosis has occurred.
Q. How is a DVT diagnosed, Doctor?
A. That's a difficult thing to do. We have two clinical tests that are considered standard, the Homan's sign and a test of calf tenderness, but both are considered unreliable. We also do ultrasound Doppler studies of the veins, which is useful for detecting clots in the veins of the thigh, but is not of much value for veins in the calf.
Q. If you have a diagnosis of DVT, how is it treated?
A. The treatment is pretty much straightforward. We put the person at rest, physical rest so they're less likely to dislodge a soft, friable clot. We elevate the legs to promote drainage of blood. We may use compressive

Page 28

stockings to reduce pooling of blood in the legs, and we use blood thinners. Initially ordinarily it's Heparin, and that is used until the prothrombin time is in the desired range with the use of Coumadin. We ordinarily continue that treatment for at least several months, and -- well, that's basically the treatment.
Q. Would you define for me what a pulmonary embolism is?
A. Pulmonary, of course, means lung. Embolism is when a foreign matter goes through the artery and lodges in the distant tissue. So you can get a blood clot. You could presumably get a bolus of air which formed an embolism. You could presumably get any kinds of foreign material which travel through the vessels and lodge in the lung. Traditionally we talk about a clot which has come from some of the large veins in the lower body, which then travels and lodges in the pulmonary artery of the lung.
Q. What are the common signs and symptoms of pulmonary embolism?
A. That, also, can have a variety of symptoms. Cough, shortness of breath, unexplained

Page 29

fever, chest pain are all possible symptoms of pulmonary embolism.
Q. In a patient that does not have a history of pulmonary disease, is a pulmonary arterial pressure on an echo such as what we have in this case consistent with a patient that is high probability of having a pulmonary embolism?
A. An elevated pulmonary pressure needs to be explained. Pulmonary embolism is a likely possibility, yes.
Q. Was it reasonable in your opinion for Dr. Patrick Rich to admit the patient to Barberton to rule out congestive heart failure and to rule out pulmonary embolism?
A. Yes, I think that was a reasonable admitting position.
Q. And the rule out pulmonary embolism from a sign or symptoms standpoint, what was the history that caused that to be a reasonable reason for admission?
A. I have to say that I really have not reviewed Dr. Patrick Rich's records. I feel very inappropriate in commenting about his work. I haven't seen his deposition. I have looked at the

Page 30

hospital records, but my focus has really been entirely on Dr. Dean Rich's work on the office record.
Q. When you were provided the record for Dean Rich, that obviously was contained within Dr. Patrick Rich's records; is that correct?
A. That's true.
Q. So while you didn't read Dr. Patrick Rich's deposition, you're aware that Dr. Patrick Rich saw this patient on January 25, 2001, correct?
A. Yes.
Q. And there was a history that he obtained on the patient that caused him to admit the patient to the hospital for the rule out -- to rule out PE, right?
A. Yes.
Q. Perhaps I'm misquoting you, but what you're saying is that in terms of what symptoms were appreciated on January 25th that caused him to say we need to admit her to rule out conditions, are you able to tell me from the record what it was that you believe to be reasonable on his part that he had on this patient

Page 31

that caused him to want to evaluate her for pulmonary embolism?
A. Well, in his notes of January 25th he says -- he comments about the swelling of her leg, shortness of breath with walking, and a little tachycardia that he found. And I think that one always has to recognize that the information in the notes really doesn't -- doesn't explain what the doctor saw completely and what he was thinking completely, but these were appropriate things to support an admission, I think.
Q. And again, recognizing that you haven't seen his deposition, but based upon the office note, with those symptoms and if we include that it was a sudden onset of shortness of breath that followed the left leg swelling, would you agree that one factor that would need to be high in the differential would be whether the patient had the DVT?
A. Yes, I think that's true.
Q. And whether or not the patient was at high risk of pulmonary embolism at that time?
A. Yes.
Q. Would you agree that deep vein

Page 32

thrombosis is the most common cause of pulmonary emboli?
A. I really don't know if I have that information. We believe that pulmonary emboli come from the large veins of the lower body, but there are several places that could come from.
Q. Again, in terms of that question, would you defer to a pulmonary specialist?
A. Yes.
Q. How would pulmonary emboli be diagnosed in the clinical setting by a family practice doctor or an internist?
A. We have several tests which we depend on. The VQ scan is probably the most universally available, but is not a specific test. It gives us degrees of probability. The spiral CT of the chest is being used more and more now and can be very helpful, and of course the ultimate test is a pulmonary arteriogram.
Q. Would that be a pulmonary angiogram?
A. Yes.
Q. Okay. And would you agree that if suspicion for pulmonary emboli exist, that a diagnostic study should be done promptly to

Page 33

confirm or to rule out the diagnosis?
MR. JAMISON: Objection.
A. I would have to agree with that, yes.
Q. Was it reasonable for Dr. Patrick Rich, from what you can tell from the record in terms of his test results, for him to rule out congestive heart failure?
A. Yes, I think so.
Q. From what you can tell from the record, did Dr. Patrick Rich rule out pulmonary embolism during the hospitalization?
A. I found no record of any specific test such as I mentioned.
Q. Can we agree that given the patient's history and her admitting diagnosis as well as the results from the echocardiogram showing the pulmonary arterial pressure that it would have been reasonable and prudent for Mrs. Speicher while in the hospital to undergo a VQ scan or a pulmonary angiogram to rule out or confirm the existence of pulmonary emboli?
MR. JAMISON: Objection.
THE WITNESS: I was just waiting to see if the reporter needed to identify the objector.

Page 34

MR. JAMISON: Jamison.
THE WITNESS: Can you repeat that question?
MR. MISHKIND: That's why we bring the court reporter along.
THE REPORTER: (Reading) "Question: Can we agree that given the patient's history and her admitting diagnosis as well as the results from the echocardiogram showing the pulmonary arterial pressure that it would have been reasonable and prudent for Mrs. Speicher while in the hospital to undergo a VQ scan or a pulmonary angiogram to rule out or confirm the existence of pulmonary emboli?"
A. I would have to say yes, it would be reasonable to have done those tests.
Q. And given the facts that you have from the record in the hospital and the office records of Dr. Patrick Rich and Dr. Dean Rich, can we agree that from what you can see that the failure to rule out pulmonary embolism during that hospitalization represents a departure from accepted standards of care on the part of Dr. Patrick Rich?

Page 35

MR. JAMISON: Objection.
MR. MURPHY: Objection.
A. I really hate to be put in a position to answer that since I've not really looked at this case with regard to Dr. Patrick Rich, and I have no idea what his reasoning was for not pursuing that test. I really feel that it's inappropriate for me to answer that.
Q. Well, Doctor, certainly if you felt that Dr. Patrick Rich's care was appropriate, even though you were only asked to concentrate on Dr. Dean Rich, because the records are from the same office and we're dealing with a relatively short period of time, you would have certainly commented on that, correct?
A. Actually I did not.
Q. Well, if you felt that his care, Dr. Patrick Rich's care was entirely consistent with the standard of care, you certainly are qualified to testify on that point, correct?
MR. JAMISON: Objection. I think he already said he was asked to do that. Go ahead.
MR. MISHKIND: I'm not saying whether he was asked to do that. I said was he qualified

Page 36

to do that.
A. If I would have been asked to review Dr. Patrick Rich's work, I believe I would be qualified; but as I've not reviewed it, I feel that it's inappropriate for me to either criticize or support what he did.
Q. All right. Doctor, if you were caring for this patient -- I take it you consider yourself to be a reasonable and prudent family practice doctor.
A. Yes.
Q. If you had admitted this patient with a recent history of left leg swelling with a sudden onset of shortness of breath that had increased within the last several days and you admitted the patient to rule out CHF and rule out PE, and you ruled out CHF but had an echo that showed pulmonary arterial pressures of 55 to 60 and no prior pulmonary history on the patient, what would you have done in order to comply with the standard of care?
MR. JAMISON: Objection.
A. I believe I would have ordered a VQ scan and a work-up for PE.

Page 37

Q. And do you believe that that would have been in keeping with or in compliance with the standard of care?
MR. JAMISON: Objection.
A. Yes.
Q. Okay. Do you see any evidence that a VQ scan or a work-up for PE was done by Dr. Patrick Rich while the patient was in the hospital?
A. I did not.
Q. Okay. As I understand it, pulmonary emboli, if left untreated, can cause blood oxygen levels to fall drastically in some instances; is that correct?
A. That's true.
Q. Okay. Bear with me for a second while I shift to the hospital record. Doctor, you've read over Dr. Bacik's report, the pulmonary expert, correct?
A. Yes, I have.
Q. Just to simplify matters, there are a number of opinions that he provides at the end of his report.
A. Yes. I have it in front of me.

Page 38

Q. Are there any areas of disagreement that you have a basis to state on the record as his views in this case?
A. Let me look at it here. I believe on his opinion No. 3 concerning the thyroid function studies and so forth, I think that the diagnosis of early hypothyroidism is not necessarily a misdiagnosis. I think there's no reason to believe that that was not a correct diagnosis. I think that's a small point, but I do disagree with that.
I think that in item No. 4, he states that Dr. Dean Rich had opportunity to review the hospital data, and I do not believe that's true. It's my understanding that the records from the hospital had not reached the office by the time Dr. Dean saw her.
On item No. 5, I don't believe I'm qualified to have an opinion as to the relationship of her stroke and her embolism. This is something that I'm unfamiliar with and I am not entitled to an opinion there.
As far as the life expectancy, again, I am not -- I'm not going to render an opinion

Page 39

there.
Those are my only objections to that letter.
Q. Now, I think you were referring to Dr. Bibler's letter.
A. Yes. Isn't that what you --
Q. I'm not sure whether I --
A. Okay.
Q. I was going to actually get to Dr. Bibler's letter. I thought I was asking -- and I may be wrong, but I thought I was asking about Dr. Bacik's, but in any event, you've answered question number next. In terms of -- so let's keep on Dr. Bibler's a moment.
In terms of her thyroid, do you believe that the pulmonary arterial pressures of 55 to 60 would be explained by a low PSH?
A. I know of no such connection.
Q. Can we agree that in terms of differential diagnosis, with the information that you're aware of from the hospitalization that a pulmonary embolism would be much higher on the differential than a possible early hyperthyroidism?

Page 40

A. Again, as a -- not knowing the relationship between hyperthyroidism and pulmonary artery pressure, I don't know. I would think PE would be more likely, however. I agree with you.
Q. In terms of potential for fatal outcome, is a patient more likely to die of complications from untreated pulmonary embolism than untreated hyperthyroidism?
A. Yes. Pulmonary embolism is far more lethal.
Q. Let's move to Dr. Bibler. I'm sorry. Now you've got me -- and I may have said Bibler before, too, so --
If we could move to Dr. Bacik's report for a moment, which is another report that you had reviewed.
A. Yes.
Q. And he has opinions expressed on page 3. If you could just take a look at those opinions and tell me whether you agree or disagree.
A. In his first paragraph on page 3, Dr. Bacik says, "Had appropriate therapy been administered, Ms. Speicher would have survived."

Page 41

I think I'd qualify that a bit and say it's more likely she would have survived.
Q. And you recognize, having done this before, that more likely means greater than 50 percent, correct?
A. Yes.
Q. And you realize that in the law, the burden of proof is to prove more likely than not as opposed to a epidemiological certainty --
A. Okay.
Q. -- or to a beyond a reasonable doubt. You recognize that, correct?
A. Yes.
Q. Okay. I'm sorry. Go ahead.
A. On his second paragraph, I don't feel I'm qualified to have an opinion on what he states there.
Q. Okay.
A. The combination of many factors, particularly the likelihood of 50 percent, I'm not qualified to have an opinion there.
And I'm also not qualified to have an opinion on paragraph 3.
Q. So as far as the relationship between

Page 42

the PE and the PE causing hypotension which then caused a stroke, you don't feel qualified to comment on that.
A. That's correct.
Q. Okay. I'm looking for your report and then I'm going to hopefully focus the balance of my questions on the opinions that you have in your report, and then we'll be done. That's assuming I can find your report; if you could see what my office looks like.
A. I believe an empty desk is the mark of an empty mind.
Q. I still have an empty mind even with a cluttered desk. I'm a multi-talented individual.
Okay. Now, in your report, Doctor, you indicate that symptoms presented by Miss Speicher at that visit -- and we're talking about the February 1 visit, true?
A. Correct.
Q. And the medical history provided and the physical exam were compatible with Dr. Rich's diagnosis of bronchitis, correct?
A. Yes.
Q. And based upon that, you believe that

Page 43

Dr. Dean Rich complied with the standard of care in terms of his treatment of the patient on that limited visit; is that correct?
A. That's correct.
Q. Now, based upon your review, can you tell me what information Dr. Dean Rich had from his father prior to the February 1 visit as it relates to the patient's recent hospitalization?
A. I'm not aware that Dr. Dean Rich had any information about Ms. Speicher's prior hospitalization.
Q. Certainly Dr. Dean Rich would have had the January 25, '01 office notes when he saw the patient, correct?
A. Yes.
Q. So is it fair to say that Dr. Dean Rich would have been aware that his dad had admitted the patient to rule out CHF and to rule out PE?
A. Correct.
Q. Do you see anything in the deposition or in the records that there was any dialogue or discussion with the patient as to her understanding of what was or was not ruled out during that hospitalization?

Page 44

A. I am looking through the deposition right now, and I didn't flag the page, but it's my memory that she told Dr. Dean Rich that she had been in the hospital for her shortness of breath and so forth and had been diagnosed with hyperthyroidism and that her symptoms had cleared.
MR. MURPHY: You might be looking for page 37, Doctor. I'm not sure.
THE WITNESS: Thank you.
MR. MISHKIND: I knew we brought Pat along for some reason.
A. Yes. On page 38 is the information that I was remembering.
Q. Okay. Now, if the patient had shortness of breath on February 1 as opposed to resolved shortness of breath, how would that impact the opinions that you hold on Dr. Dean Rich?
A. Shortness of breath is not a really typical major complaint with bronchitis, and in a patient complaining of shortness of breath, I'd expect a more vigorous evaluation.
Q. In the context of a patient that Dr. Dean Rich knew had recently been admitted to

Page 45

the hospital to rule out CHS and to rule out PE, if the patient also had shortness of breath on February 1, what would that vigorous evaluation, in your opinion, have required?
MR. MURPHY: Objection to that. Like I said, I think it's contrary to Dean Rich's testimony.
MR. MISHKIND: I recognize that. I'm asking him to assume that it will be in evidence that there was shortness of breath on February 1.
Q. And in the context of the recent hospitalization, again, what would be your opinion, Doctor, in terms of what would be incumbent on the part of Dr. Dean Rich in order to comply with the standard of care? What should he have done?
MR. MURPHY: Before he answers, for the record, I'm not objecting to the hypothetical so much about Mrs. Armour's testimony. That's going to be a jury question, I'm sure. But your question goes to Dean Rich was aware for the reasons that his father previously admitted her to the hospital previously. I don't think that's contained in his deposition, so --

Page 46

MR. MISHKIND: Let me just respond to that. He may have said that, but certainly he had Dr. Patrick Rich's office note there says rule out CHF and rule out PE. So he can say what he wants to in his deposition. I think the office records clearly indicate what Patrick Rich was admitting the patient for. But we can debate that until the cows come home.

Q. Doctor, now that Pat and I have had this nice conversation, are you still with me on the question?

A. Yes.

Q. Okay.

MR. MURPHY: I'm done.

A. I would think if the patient had told Dr. Dean Rich that she'd been admitted for a possible embolism and that she continued to be short of breath, and especially if she said that her leg was still swollen and so forth, that a much more elaborate work-up would have been necessary. I think most family physicians would have obtained an electrocardiogram in the office, possibly a chest x-ray, and if the lungs were clear and the leg was soft and nontender, that

Page 47

might be all they would do at that time.

Q. Would it be reasonable for Dr. Dean Rich to have called over to the hospital to get the results of any tests that had been ordered or performed during that recent hospitalization?

MR. MURPHY: Are we still on the same hypothetical here or not, or --

MR. MISHKIND: Yes.

Q. Let me redefine it, Doctor, so we're on the same page. Assume that the patient came to doctor -- just one second. That's my cell phone. Let me turn it off. I had every other phone protected, but -- now if I can only figure out how to turn it off.

In my hypothetical I was asking you to assume that the patient had shortness of breath on February 1 rather than shortness of breath that had resolved, okay?

A. Okay.

Q. I didn't ask you necessarily to assume that there was swelling in the leg at the time of that visit, but a history that within the previous office notes that the patient had left leg swelling earlier the week prior to January 25th,

Page 48

with sudden onset of shortness of breath, worse last several days, and then resulting in the admissions to the hospital. If those are the facts, as well as the cause that Dr. Dean Rich detected, with that in mind and knowing that Patrick Rich had admitted the patient to rule out CHS and to rule out PE, under that set of circumstances, what would have been a reasonable and prudent course of action for Dr. Dean Rich to have taken?

MR. MURPHY: Objection; Murphy.

A. Okay. That was a pretty long question. As I understand what you're asking me is given persistent shortness of breath, given the knowledge that Mrs. Speicher had been admitted to rule out a DVT and that it had not been done in the hospital, the rule out had not been done, what should Dr. Rich have done? And of course, with that scenario, probably she should have been admitted for a more vigorous work-up for a DVT.

Q. Would that admission that's hypothetical have been an immediate admission or is this something that could have been done in the next couple days?

Page 49

A. No. If she was short of breath, increasingly short of breath, I think it would be an immediate admission.

Q. How would the patient have known typically whether she was or was not given a clean bill of health with regard to the existence of pulmonary embolism?

A. Not too many patients know what pulmonary embolism is, and I would think that most likely, this is pure conjecture, that the physician would say we have things cleared up and it's okay. Everything's okay and you can go home.

Q. If there's questions on the part of Dr. Dean Rich, again following my hypothetical persistent shortness of breath in the context of the recent hospitalization knowing what his father had marked down on January 25th in terms of ruling out CFH and ruling out PE, if Dr. Dean Rich had any questions, would it have been reasonable and prudent for him to have called over to the hospital results of any of the tests that had been done?

MR. MURPHY: Objection; Murphy.

A. I think if he suspected a condition

Page 50

which was related to the prior hospitalization, he certainly could have -- could have called to obtain information. I don't know what day of the week it was that he saw Mrs. Speicher and whether the record room would have been -- may have made things available to him, but that's another question.
Q. Assuming that the records were available and it wasn't a Sunday or a Saturday whereas the records might be otherwise less available, would it be reasonable and prudent for a family practice doctor where there was a question as to the results of any test in a patient that had persistent shortness of breath to call over, try to get that information?
A. This sort of thing certainly can be done, but we ordinarily don't do it unless there's a reason.
Q. Sure. Absolutely. And I take it you have on occasion, where you're perhaps seeing someone on a coverage basis for someone in your office and there's a history given about a recent hospitalization, whether it's a lab result or a x-ray, you have a question as to what the results

Page 51

were, you have on occasion called over to the hospital to get that information, correct?
A. Yes. It's unusual, but we have done that.
Q. All right. In the context again of my hypothetical that the patient had shortness of breath, had a cough, and there was no evidence that Dr. Dean Rich had available to him on that visit to confirm or to rule out whether this patient had testing done for a DVT or a PE, would it have been reasonable and prudent for him to have called the hospital to get that information?
MR. MURPHY: Objection; Murphy.
A. Can I have that question back again, please?
MR. MISHKIND: Sure. Again, if the court reporter won't mind indulging me?
THE REPORTER: (Reading) "Question: All right. In the context again of my hypothetical that the patient had shortness of breath, had a cough, and there was no evidence that Dr. Dean Rich had available to him on that visit to confirm or to rule out whether this patient had testing done for a DVT or a PE, would

Page 52

it have been reasonable and prudent for him to have called the hospital to get that information?"
A. I think if Dr. Dean Rich suspected thromboembolic disease, it certainly would have been reasonable to do that; however, there's nothing in the patient's presentation as listed in Dr. Dean Rich's note to indicate that is a concern.
Q. And I appreciate that looking at his note, and that's in large part the reason that you have said that you have no criticism of Dr. Dean Rich, correct?
A. Yes. This is the information I have to work with.
Q. Sure. Now, where the medical assistant marks down "shortness of breath" as the chief complaint, normally when a patient comes to a doctor's office and they mark down "chief complaint," what does that represent in lay terms?
A. This is supposed to be the very words the patient speaks as to why they're there.
Q. Okay. And based upon everything that you've reviewed, are you able to balance the note of "Chief complaint, shortness of breath," against

Page 53

Dr. Dean Rich's note that the shortness of breath had resolved?
A. Yes. He says in his note on the, let's see, one, two, three, four, fifth line, he says, "SOB resolved."
Q. But I guess my question to you, and I guess it wasn't artfully stated, is the chief complaint that was given to the medical assistant as to why she was at the office was shortness of breath, correct?
A. Yes.
Q. It doesn't say I'm here for a cough or I'm here because my cough resolved. Do you follow me?
A. Correct. Yes, I do.
Q. Can we agree that there's at least some inconsistency? Perhaps it's explainable, but there's some inconsistency between what the medical assistant marked down in terms of what Mrs. Speicher said her reason was for being there and Dr. Rich's note when he actually saw her during his examination.
MR. JAMISON: Objection.
A. I guess the best way to respond -- that

Page 54

I can respond to that is that the medical assistant put down a very quick, short note. When Dr. Rich took the history, he got a more elaborate, more detailed, and somewhat different history. And this is not uncommon.
Q. So you're giving the benefit of the doubt to Dr. Dean Rich's note as opposed to what the medical assistant marked down as the chief complaint --
MR. JAMISON: Objection.
Q. -- is that correct?
A. Yes, I am.
Q. Okay. Doctor, in the context of my hypothetical with the patient truly having a continued shortness of breath on February 1 with the history of rule out CHF and rule out PE, with the patient also presenting with clots, how would you have handled the patient on February 1, again assuming that the shortness of breath wasn't a matter of history, but it was a matter of continued presence?
MR. MURPHY: Objection; Murphy. Hypothetical; I think you just asked that.
MR. JAMISON: Objection.

Page 55

Q. I conceivably could have.
A. I think that for a person complaining of shortness of breath, a simple difference in treatment would have been to use a medication to relieve bronchospasms, such as Albuterol, Med Neb, perhaps. I might have stopped the Tenormin, which is known to cause shortness of breath in some people. There are a lot of possible approaches to the patient with a cough and shortness of breath.
Q. Would PE have been within your differential given the history on January 25 that was contained in Dr. Dean Rich's father's record?
A. Knowing that the patient had been very recently in the hospital and worked up and admitted for PE, if I knew that, I think PE would be rather low on my list of possibilities a week later.
Q. Again, you're assuming that the care provided in the hospital had been to rule out PE as opposed to overlooking the ruling on it, PE?
A. I suppose so, yes.
Q. Do you have an opinion, Doctor, in the fact there had been at least an index of suspicion that that patient's symptoms were peaking in

Page 56

origin, if you had given the type of treatment that you talked about a moment ago, including stopping this Tenormin or giving some other treatment, if this was related to ongoing pulmonary emboli, would that treatment in the office have been successful?
A. It may have afforded some temporary relief of symptoms, but would probably not have altered the ultimate outcome.
Q. Do you have an opinion on February 1, 2001 if the patient had been admitted to the hospital for further work-up to in fact rule out PE whether or not a VQ scan would have been high probability for PE?
A. I think that very likely over 51 percent of VQ scan or a PE work up would have been positive.
Q. And the Heparin would have been the standard treatment of choice?
A. Yes.
Q. Okay. And if that had been the case, why in fact the patient was admitted with a diagnosis of PE, do you have an opinion to a reasonable degree of medical probability as to

Page 57

whether the patient would have survived the effects of the pulmonary emboli?
MR. JAMISON: Objection; Jamison.
A. I really am not expert enough in this sort of determination to have an opinion.
Q. Fair enough. Doctor, let me just check my notes for a moment to see. I may be done.
Before I actually try to find my notes again, from the standpoint of why you are not critical of Dr. Dean Rich, have we covered all the bases upon which you are relying, to be more specific, the office record of Dr. Patrick Rich and Dr. Dean Rich and Dr. Dean Rich's deposition testimony?
A. Yes, I think we have.
Q. And again, depending upon whether my hypothetical relative to shortness of breath continuing is or is not factually accurate, that may change your opinion in terms of what Dr. Dean Rich should have done under the circumstances, correct?
A. I would think that at any time my opinion could be changed by new information.
Q. And again, if that new information that

Page 58

I'm suggesting in the shape of a hypothetical fashion to you is in fact what the evidence is at trial, can we agree that shortness of breath on a continuing basis would be a factor that you would have to take into account in terms of having to modify your opinions?
A. Yes. I would have to -- have to think it over again. There would be many possible responses to shortness of breath. Revisiting the possibility of embolism was only one.
Q. Okay. What else would it be that you would revisit?
A. I think the cardiac status should always be an issue, and the question of inflammatory lung disease, bronchitis, atypical pneumonia, and so forth, bronchiospasm certainly would need to be considered, and acute bronchitis, which is what Dr. Rich made his diagnosis. Certainly it's still a possibility.
Q. But again, you recognize that you deal with a differential in terms of those kind of things that are potentially life-threatening in the near term versus something that is less lethal to the patient in the nearer term, correct?

Page 59

A. I'm not quite sure what you mean there.
Q. If you have a number of explanations for the shortness of breath, you want to look at the totality of those explanations and determine on your differential which possible explanation is the most likely to kill the patient and which is most likely to be benign in nature?
A. I've had that question many times before.
Q. You mean I'm not a unique individual?
A. No. I'm afraid that's a question that comes up again and again. There's actually sort of a four-box grid, isn't there, the most lethal on one axis and the most likely on the other, and we really weigh lethality against likelihood, and we simply cannot work up every possible patient for the most lethal possibility.
Q. Well, what would be the most lethal possibility in a patient with shortness of breath with the recent history that Mrs. Speicher had on February 1 when she presented to Dr. Dean Rich?
A. I would think probably the most lethal and most likely combination would be hard, since 50 percent of us are going to die with our hearts

Page 60

anyhow, and that had been a consideration a week earlier. Obviously pulmonary embolism is a possibility, but there are, you know -- a collapsed lung could conceivably be, a pneumothorax. There are several, several possibilities when you consider shortness of breath.
Q. If we took two that you put at the very beginning of the differential, congestive heart failure or PE, would it have been incumbent on the part of Dr. Rich, Dean Rich, in order to comply with accepted standards of care to have had the patient re-admitted to the hospital for further work-up for either or both of those conditions?
MR. MURPHY: That's your hypo, again, right, Howard?
MR. MISHKIND: Yes.
MR. MURPHY: Okay.
A. Recognizing your hypothetical situation, yes, I would.
Q. And failing to do that, indicating my hypothetical, would be a deviation from accepted standards of practice --
A. Yes.

Page 61

Q. -- true? Now let me take a look at my notes and I may be done, Doctor.
A. Okay.
Q. Just a couple finishing questions. As it relates to the care at Akron General Hospital when she presented on February the 5th, do you have any comments as it relates to the quality of care that she received during that admission?
A. No, I don't.
Q. And in terms of when the window of opportunity to prevent Ms. Speicher's death closed from a probability standpoint, do you intend to provide any testimony along that time line?
A. No, I don't.
Q. Doctor, based upon your understanding of the facts in this case and of the hypothetical that I've asked you to assume, have we covered all of the opinions that you have in this case?
A. I believe we have.
Q. Okay. And to the extent that you review any of the depositions of the family members and have a different sense of the facts in terms of the hypothetical that I presented to you and arrive at any different opinions, will you

advise Mr. Murphy before you take the stand in December?
A. Certainly.
MR. MISHKIND: Okay. I think, with that, I have no further questions. Thank you, Doctor.
THE WITNESS: Thank you.
MR. JAMISON: I don't have any questions.
MR. MURPHY: I don't have any questions, either.
MR. MISHKIND: Doctor, with regard to signature, do you want to read the depo?
THE WITNESS: Please.
MR. MISHKIND: All right.
- - - - -
Thereupon, the foregoing proceedings conclude at 5:40 p.m.
- - - - -

WITNESS SIGNATURE PAGE

I have read the entire transcript of my deposition taken on November 20, 2003. The changes and/or corrections, if any, which I desire to make to my testimony have been noted on a separate errata sheet. I request that those changes, if any, be entered into the record by attaching the errata sheet to the original transcript.

_____
THEODOR F. HERWIG, M.D.

Spectrum Job No.: RM5370

State of Ohio : CERTIFICATE
County of Franklin:
I, Reva Chafin Mundy, a Notary Public in and for the State of Ohio, do hereby certify the within named THEODOR F. HERWIG, M.D. was by me first duly sworn to testify to the whole truth in the cause aforesaid; testimony then given was by me reduced to stenotypy in the presence of said witness, afterwards transcribed by me; the foregoing is a true and correct transcript of the testimony so given; and this deposition was taken at the time and place as specified on the title page.
I do further certify I am not a relative, employee or attorney of any of the parties hereto, and further I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in the action.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on November 25, 2003.

_____
Reva Chafin Mundy, Notary Public - State of Ohio
My commission expires June 23, 2007.

INDEX

(Plaintiff's Exhibits 1 through 4 attached to original transcript.)

Spectrum Reporting, LLC

333 East Stewart Avenue, Columbus, Ohio 43206
P - 614-444-1000 F - 614-444-3340

November 25, 2003

Theodor F. Herwig, M.D.
657 Bay Drive
Westerville, Ohio 43082

Re: Karen Armour, et al., vs. Patrick A. Rich, D.O., et al.,

Dear Dr. Herwig:

Enclosed you will find the transcript of your deposition taken on November 20, 2003 in the above-captioned case, which is being sent to you for the purpose of reading and signing.

Please do not mark on the transcript. Any corrections or changes you wish to make in your testimony should be typewritten or printed on the attached errata sheet, indicating the page number, line number and desired correction or change. After you have read the transcript, sign your name where indicated at the close of the testimony.

The Rules of Civil Procedure allow seven days after you receive this letter for you to read and sign your deposition. Please return the original signed transcript and errata sheet(s) to Spectrum Reporting, LLC within that time.

Your prompt attention to this matter is greatly appreciated.

Sincerely,

Christy Heaney
Production Manager

cc: Howard D. Mishkind, Esq.
Andrew D. Jamison, Esq.
Patrick J. Murphy, Esq.