CUYAHOGA COUNTY COMMON PLEAS
CASE NO. 399411

MARY LOU ZIMMERMAN, ET AL

VS.

THE CLEVELAND CLINIC FOUNDATION

ORAL DEPOSITION OF

DR. CLARK KERR

MAY 3, 2002

ORAL DEPOSITION Of DR. CLARK KERR, produced as a witness at the instance of the Defendant, and duly sworn, was taken in the above-styled and numbered cause on the 3rd day of May, 2002, from 9:11 a.m. to 11:43 a.m., before Linda York, CSR in and for the State of Texas, reported by stenographic method, at the offices of consultants in Infectious Diseases, Lubbock, Texas, pursuant to the Texas Rules of Civil Procedure and the provisions stated on the record or attached hereto.

APPEARANCES

For the Plaintiff: MR. ROBERT LINTON
(via telephone)
- and -
MR. MARK RUF
Linton & Hirshman
700 W. St. Clair Avenue
Cleveland, OH 44113
216.687.1999
fax 216.771.5803

For the Defendant: MR. ALAN PARKER
Reminger & Reminger
The 113 St. clair Building
Cleveland, OH 44114
216.687.1311
fax 216.687.1841

I N D E X

E X H I B I T S

DEPOSITION EXHIBIT NUMBER	MARKED
one, Report	20
Two, Dr. Kerr's CV	68

(Exhibits are attached in the Exhibit volume.)

INSTRUCTIONS FOR SIGNING A DEPOSITION

Rules of Civil Procedure under which this deposition was taken provide that the deposition transcript shall be made available to the witness or his attorney of record for examination and signature by the witness.

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when we have received the signed and notarized changes and signature Page, we will forward all attorneys of record a copy of that form and deliver the original transcript to Mr. Parker for safekeeping and use at trial.

If you have any questions about this procedure, please call our office at (806) 763-0036.

Linda York, RPR, CSR
Cathy Sosebee & Associates
P.O. Box 86
Lubbock, Texas 79408
(806) 763-0036

DR. CLARK KERR,

having been first duly sworn, testified on EXAMINATION by MR. PARKER as follows:

Q Thank you, very much, Dr. Martinelli. My name is Alan Parker --

MR. RUF: This is Dr. Kerr.

Q I apologize once again. I really do seem to have some sort of mental block on who's here this morning. Dr. Kerr, I'm Alan Parker. It's a pleasure to meet you. I'm here to take your deposition. Have you had your deposition

taken before?

A Yes.

Q All right. And so you understand that this is an opportunity for me to ask you questions. I try to make my questions clear. If for any reason they're not clear, please let me know and I'll try again. okay?

A Correct.

MR. PARKER: Also for, Counsel, just for the record, this deposition is being taken by agreement of counsel; is that correct?

MR. RUF: That's correct.

MR. PARKER: And so I don't even think there is a notice, but any defects as to notice, I take it are waived.

MR. RUF: Correct.

Q Dr. Kerr, can you state for us, please, your full

name?

A Clark McLaughlin, M-C-L-A-U-G-H-L-I-N, Kerr.

Q And what is your professional address?

A 4905 21st Street, Lubbock, 79407.

Q Is this your only professional office?

A That is my home and office address. I have an office in my home.

Q I see. And where are we today for your deposition?

A This is Consultants in Infectious Diseases.

Q How are you affiliated with Consultants in Infectious Diseases, if at all?

A Currently not, but actually was the founding individual of CID. And originally in Denver, and then here in

Lubbock.

Q Do you currently practice medicine?

A Not active clinical practice.

Q when did you last have an active clinical practice?

A In terms of clinical medicine and practicing it through April 30th of this year, 2002.

Q And what are the circumstance that have led you *to* terminate your clinical practice?

A I have Parkinson's disease. In fact chief onset Parkinson's disease now for probably about eight to ten years. And over the last several years, I've had to dramatically slow down.

Q Describe for me what your current professional activities consist of.

A At this exact time, I've practically cut out everything, in fact, the date I gave you in April was the start of a -- sorry, that April date I gave you 2002 was 2001. And since that date I've dramatically slowed down. I had a business Complete practice solutions, which I have totally closed as well in many parts for health reasons and conduct my business now strictly as Infection Info-Med.

Thankfully my health has improved significantly in the recent time, much is in large part due to having cut back on so much, and I've just recently gotten back into the clinical side again. And currently am working with a hospital system, which I consulted for actually in just the last week on quality assurance post-op infection problems and the lecture series with their staff. And they've asked me to

continue on in a quality assurance fashion with them again, consulting, which is the work that I used to do that really had closed off in the last year.

Q when you say the work you used to do as consulting, what do you mean by that term, what did you do?

A had obviously a huge clinical practice for about 15, 17 years. stopped that in '96, '97, continued on then as an epidemiologist, spending then most of my time in that at covenant. Except it may not have been covenant at that time;

it may have been St. Mary's and Methodist. That's a thousand bed institution. Just up the street from here. And continued to do and that was the contract with covenant system that closed April 2001. Along with that continue to do a lot of lecturing here, around the country, and a lot of epidemiology for consultation around the country as well.

Q Are you an epidemiologist?

A In terms of have I taken epidemiology, no. As part of my infectious disease at Duke, they were very big in the '70s and '80s on epidemiology, so we came out well trained for infection control epidemiology whereas, for instance, Dr. Sarria and Martinelli did not take the formal training in epidemiology,

Q Do you hold yourself out as an epidemiologist?

A Not as an epidemiologist.

Q okay. take it that you are an infectious disease physician who's taken course work and is otherwise familiar with many aspects of epidemiology; is that what you're trying to tell me?

A I hold myself out as a specialist in infection control.

Q okay.

A But infection control and the pure specialty of epidemiology, meaning the statistical side and all of that, what I call more mathematical side than I'm the best at, that

I do not hold myself out to be. But where it crosses over with infection control, yes, I hold myself as an expert in infection control.

Q Okay. I thought I heard you tell me that your clinical practice, by that I mean your practice that involved direct contact with patients stopped in 1996, 1997?

A I wouldn't say direct contact with patients stopped. In terms of being the primary attending, primary one responsible, writing orders on the patient, that stopped then.

Q Okay.

A And that was for health reasons. But in terms of patient contact and decision making, it changed from an individual manner, you might say, to more of a hospital manner. You're very involved in a thousand bed institution when you're running the infection control, epidemiology and such.

Q okay. Tell me what your work consisted of when your -- between 1997 and the cessation of your practice in April 2001?

A The large portion of it was epidemiology, both here and doing consultation work in different hospitals on request throughout the country. Those requests might take a month,

might be three months, might be just one visit, depending on what their needs were, and it would all relate to post op infections, quality assurance problems, quality control

issues, things like that. It consisted of rounding frequently with your staff, going through the ICUs, the neonatal . intensive care units, rehab, wherever there were problems or doing stat surveys. we ran a very efficient, very detailed infection control program.

Q Did you have any admitting privileges during that time frame, we're talking about from 1996, '97 when you stopped your clinical practice through April 30th, 2001?

A I had continued to have my admitting privileges, yes.

Q And did you serve as an attending physician during that time frame?

A NO.

Q Did you serve as a consultant in terms of direct patient care, in other words, an attending physician has you see a patient in order to make treatment recommendations?

A You would be called by various attendings to make recommendations, but your recommendations were made via your position with the hospital as head of infection control epidemiology. I was no longer writing on the chart in terms of a physician order that the nurses were following.

Q would it be fair to say that you were not making treatment recommendations or diagnoses for the purpose of that particular patient's treatment, rather you were rounding and being consulted from the perspective of the hospital's infection control issues?

11

A Not entirely. I say this in many respects a legal respect, because much to my consternation we are now -- the epidemiologist, infectious control people are now being held liable in suits related to infection, related to our decision process. So whereas five years ago I may have said yes, I tend to agree with that statement; now it may be what you imply, a more corporate sense, but really the law is not necessarily interpreting it that way, that they're taking out these individuals now and mentioning them.

Q okay. Frankly, I'm not trying to reach legal conclusions, I'm sorry, I'm probably belaboring this more than it's worth. The problem that arises is probably my own ignorance and unfamiliarity, when it comes to words like consulting, because to me consulting can mean anything. So I'm trying to get the best picture I can of what it means for you to serve as a consultant to hospitals during this time frame that you were no longer engaged in a predominantly patient oriented clinical practice. Can you help me with that? Maybe you've done it as best you can, but if you can sort of describe the change in your career and your patient contacts and responsibilities, that would be helpful.

A well, I sort of thought I had done that about the best I can.

Q okay.

A I think it would just be a repeat of what I've said.

Q okay. Prior to the cessation of your clinical practice in 1996, '97, what was the nature of that practice?

A It was exclusively a consultant infectious disease practice right from the early '80s when I finished at Duke. That is all my practice has been. And initially I was chief infectious disease at St. Joseph's and head of their infectious disease teaching program. In fact, Dr. Martinelli and Dr. Duriex, I was their professor for when they did internal medicine. And ultimately they came back to join me obviously in infectious diseases.

we would round on -- or I would personally between 40 to 100 patients a day. And the few years that I was solo, I literally at times would round on 80 patients physically in a day, starting at 6:00 in the morning, going until 10:00 at night, 11:00 at night. This practice now probably carries over 100 patients a day on service with the three doctors. we were incredibly busy clinical infectious disease, not research, clinical infectious disease. And I think if it's there, we've seen it.

Q During that stage of your career, again we're talking about prior to the '96-'97 --

A correct.

Q -- time frame, your clinical practice was patient oriented as opposed to infection control oriented, is that fair, or am I missing --

A I have been chief of hospital epidemiology since the year I left Duke. So that has always been -- see, I regard that as clinical. To me that's all the same, infectious

disease, infection control, epidemiology, I see as very tightly interwoven.

Q But you did specifically write orders on patients, examine patients, and direct a significant portion of your practice to patient care during that time frame before 1996-97 cessation of your clinical practice; is that true?

A Absolutely. As I mentioned, I would physically see, be responsible for 60, 80 or more patients a day.

Q okay. we've talked a bit about your responsibilities from 1996-97 to April 30th, 2001. And what did you do professionally after April 30th, 2001?

A until the last probably six weeks or so I have been, rather than building up, knocking down for health reasons. I just, I got to the phase where I stopped taking new medical/legal cases, for instance, didn't take consultant work from out of town, and only in the last couple of months have I allowed myself to open up again to getting back to being busier clinically. And that's because I have the time now from having cut out all the other business sides.

Q From April 30th, 2001 until about six weeks ago, how many hours a week did you devote to your professional activities of all types, whether that's legal consulting,

whether that was consulting for health care institutions or whether that was lecturing?

A I could get down from zero hours in a week to maybe ten in a week.

Q what percentage of your professional time during this time frame of April 30th, 2001 until about six weeks ago, what

percentage of your time was spent in legal consulting?

A During that time the hours may have been much less, but the percentage would have been higher because I was cutting everything else out. So the hours might be the same, but the percentage would be maybe 60 percent. And normally it would have been much, much less than that.

Q I don't mean to pry, but what were the developments that have happened within the last six weeks that are permitting you to increase your activities?

A well, I think running the company, the time stress of it, just the physical stress, emotional stress of it, was too much for me, was forcing me bluntly to push drugs harder than what I should have. You see one result of a missing tooth. If you look to my legs, you would see the other result of it. It was just, I mean I had to give in to the fact that I've had Parkinson's for ten years and I had to cut back. And I've dramatically cut back and now can do other things.

Q so what are you now doing?

A what I mentioned earlier, I've started to actively go

out again, because it's my first love, and get back to the epidemiology and infection control, that kind of thing.

Q And what are you doing in that respect, are you consulting for anybody, are you on staff anywhere? I'm trying to understand.

A Theoretically I'm still on staff at Covenant, but I mentioned earlier that just in the last week or two, I've been consulting elsewhere on epidemiology, infection control, quality assurance. And they've asked that I continue with the

quality assurance side.

Q where are you consulting currently?

A That is at San Angelo Community Hospital.

Q where is that?

A San Angelo.

Q And when was your first affiliation with San Angelo?

A April 22, 23.

Q Of 2002?

A Yes, that should be a Monday, Tuesday.

Q Is there any other health care facility that you're doing consulting work presently?

A No, because I just in the last couple of months allowed myself to accept these again.

Q And what have you done so far for San Angelo Community Hospital?

A well, I can't give you my report to them, which was

about four or five pages. But I've made a great deal of recommendations pertaining to infection control issues in, out of the OR, spent a lot of my time there actually in the OR, reviewing a lot of surgical cases and preps, a lot of quality assurance issues with the physician.

I've been asked to come back and do a lot of antimicrobial reviews, appropriate use of antibiotics, appropriate drug use, and also do quality assurance for them, because I have quite a reputation of being good at that, as an outside person, because being a 150, 200 bed hospital, they have trouble doing it internally, as a lot of hospitals do in this country.

Q How many days have you spent at San Angelo Community Hospital?

A I mentioned, April 21, 22.

Q okay. And have you been back there since that time?

A That was just last week. obviously a lot of time has been spent on that since I've been there.

Q Well, I guess I'm a little bit stuck on the "a lot of time" because it seems to me that's been a pretty brief contact with San Angelo Community Hospital. How many hours a week are you working now?

A well, you have to realize we're at the inception of something. So I'm not a sorcerer, I can't tell you what the future is going to be and how many hours and such. All I can

tell you is there's going to be a great deal of work just to finish off what my initial recommendations are to them. And it's the medical staff that have asked me to come back to do all the teaching to medical staff, lecturing, and it's the medical chief of medical staff that's asked me to come back and continue with the quality assurance and overview of their infection control system and such.

Q Is this a project work that you're doing for them or are you coming on as long-term employee or what's the arrangement?

A Employee is not -- not an employee.

Q You're a consultant?

A Their desire is as a long-term consultant relationship.

Q Dr. Kerr, how long have you been doing medical/legal

reviews?

A Probably 20 years.

Q And do you have an estimate as to how many cases you have reviewed over the 20 years?

A Total I couldn't give you.

Q In a typical year, how many cases do you review?

A In the first 15 years, probably anywhere from zero to three or four, two or three.

Q How did that change after the first 15 years?

A As I had to cut back on other things, I liked

medical/legal. obviously I was an incredibly busy clinician. And I had a lot of defense work that came my way, with some of the malpractice -- what would it be -- the malpractice, the medical malpractice companies, insurance companies. Mainly TMLT, which is Texas Medical Liability Trust.

Q And you're implying then that, in the last five years, the number of reviews that you did increased?

A Definitely.

Q Can you give me an estimate as to how many reviews you did on an annual basis over the last five years?

A I would say I've probably taken on ten to 15 cases a year, or I would review ten or 15 cases.

Q Have you testified in court?

A Yes.

Q How many times?

A Several. To say how many times now, going back over the years would be a guess, but it's under 20. It's more than five. very few cases go to court.

Q can you give me a reasonable estimate of the percentage of the cases that you testify on behalf of the patient versus those in which you testify on behalf of the health care provider?

A The first 15 years, it was probably about 80 percent on behalf of the health care provider. subsequent to that in the last five years to now has slowly switched, and it's

probably 60 to 70 percent now I would say on behalf of the plaintiff.

Q we talked about your medical/legal reviews and your testimony, are these predominantly in medical malpractice cases?

A Yes, but I'm not -- I'm trying to think what the other -- what the alternative is.

Q Automobile accidents, slip and falls, things like that. I assume that, because of your specialty, you're almost always involved in medical malpractice cases.

A Right. These are always infectious disease and medical malpractice.

Q okay. That's what I assumed, but I realized I hadn't asked the questions very artfully.

MR. PARKER: Off the record.

(off-the-record discussion.)

Q when were you first contacted with regard to the Zimmerman case?

A In one of these volumes is the opening letter from, I think, Mr. Linton. And I really cannot remember. I think it was back in 2000. I'm not sure.

Q Had you ever had any contact with Mr. Linton before that date?

A I do not believe so.

Q Have you ever served as an expert witness or as an

expert consultant for Mr. Linton's firm?

A No, I do not believe so.

Q okay. Do you have an understanding as to how Mr. Linton got your name?

A No.

Q what were you asked to do?

A To review the care of Ms. Zimmerman and to give an opinion as to the issues on the case.

Q I've been provided with a report, and I'm going to show you what's been marked as Exhibit one. can you tell me what that is?

A That is the report following our review of the case.

Q Are you the author of the report?

A Dr. Martinelli and I.

Q I can see that Dr. Martinelli and you both signed this report. How is this drafted?

A You'll have to -- we did it on our word processor.

Q I'm trying to understand how two people author a single draft *of* a report. It seems to me that most often somebody proposes a draft and then solicits comments on it.

A well, actually if you understood the relationship between the doctors in this office and myself, we sit around, and still do, and fire at each other. And after both of us had reviewed the case, we sat around and tried to, in essence,

destroy each other, came up with common grounds, common ideas,

sat down, put it on paper.

Q who typed it?

A I think I started. Martinelli got fed up with my typing and he took over. I think that's how it ended up.

Q when was it done?

A when the report exactly was done, I'm not sure. There should be a date -- oh, I'm not sure. I would have to look on billing records to see when that was at least billed for. I assume there was a date on it.

Q You have billing records for this case?

A You're asking a difficult question. Having shut down my business, I dearly hope so. But since my business got shut down, I have not done anything that I've billed the Linton firm for, so I will, but it's going to be somewhere in my archives at home.

Q If there are billing records for this case, who maintains them?

A I should have them somewhere at home. or on a zip disk.

Q How much time have you put into this case?

A without those records in front of me, it's hard to say, because you know, you spend a significant amount of time and then you go for months or a couple of years without almost looking at it, and then you again spend significant time before the deposition trial, I would think probably 15, 20

22

hours.

Q Have you billed for any of your time yet?

A oh, yes, the time spent upon the initial contact receiving the records, Mr. Linton has been billed, and I'm certain the preparation of this document has been billed.

Q what are your fees?

A $400 an hour. And $600 for deposition and trial.

Q The $400 an hour is the fee that applies both to review of materials and authoring of the report?

A Yes.

Q Does Dr. Martinelli bill in addition to the fees that you're billing for review, I assume?

A correct.

Q You mentioned a moment ago about your business having been shut down. What was the name of that business?

A complete Practice solutions.

Q And is it Complete Practice Solutions that is the corporation that bills for your expert witness consulting?

A No, that's Infection Info-Med.

Q Infection Info-Med?

A correct.

Q Does Infection Info-Med conduct any business other than providing your services as an expert witness?

A Yes, it in essence is the umbrella that I do everything under. I do my hospital consulting under. I do

23

epidemiology, everything.

Q I'm confused as to the relationship between Expert (sic) Info-Med and Complete Practice solutions.

A There is no relationship, except I'm primary of both, or was of CPS. Infection Info-Med is something that I've had for years and have done lecturing under, outside consultation work under, and such.

Q And what does complete Practice Solutions do? I'm sorry. I'm confused.

A Nothing now.

Q what did it do before?

A It provided service and sales of software and such medically related.

Q You told me a few minutes ago that the business that shut down was complete Practice solutions and that that was what was going to make it difficult for you to locate billing records for this case?

A correct.

Q Yet you also told me that the billing for your services as an expert witness would be through Infection Info-Med?

A correct.

Q So I'm terribly confused.

A well, you probably have a bigger office than I do. when you lose your secretary for one, you lose your secretary

to everything. so I now am Infection Info-Med in every position from top to bottom, which means I have records in my basement now at the house of everything that I've ever done, hopefully, in Infection Info-Med, but I have no idea where it

is. So I hope -- and they have to be there, but I'm now my own secretary and I have to find it.

Q I may find myself coming back later to some of these issues, especially when I talk about your curriculum vitae, but let's talk about this case. That's really what we're here about.

Have you prepared any report other than the one that is identified as Exhibit one?

A No.

Q And does the report identified as Exhibit One, does it cover the subject matters that you anticipate testifying on in this case?

A Yes.

Q Are there any other subject matters that you anticipate testifying on?

A In my opinion, this covers our opinion, in my opinion.

Q You may or may not be aware that there are other experts who will be testifying as to other kinds of criticisms in this case. And I want to make sure that I understand the parameters of where you're critical in this case. And so I

want to start off with this report, Exhibit one, and again just make sure that there are no additional areas that you feel you need to amend in order to fairly apprise me of the subject matters you'll be talking about.

A Our opinion's going to -- is here, contained within this report.

Q okay. I take it then -- the report does not address,

for instance, anything about indications for or appropriateness of the cingulotomy, capsulotomy, or psychosurgery in general; is that correct?

A I'm an infectious disease physician.

Q All right. And there --

A I pretend no specialty into neuropsychiatric.

Q That's fine. And so you will not be offering opinions as to those issues; is that fair?

A No, nor have we been asked to.

Q That's fine. similarly, your report does not discuss anything about institutional review board reviews, I take it you're not going to be addressing that issue, correct?

A I'm unaware of that issue so , . .

MR. RUF: Doctor, that goes to the psychosurgery issue.

THE WITNESS: Okay.

A NO.

Q And that's fine. These aren't -- these are not a

series of trick questions. This is to make sure that I cover the subject matter I need to cover, and that I am not surprised at trial if you testify to things that I'm not seeing in the report. I want to make sure they're not in the report, and I want to make sure you're not testifying to them at trial.

The issue of the use of multidisciplinary panel selection boards for psychosurgery candidates, that's not something you've spoken to in your report. I take it it's not something you'll be testifying to at trial, correct?

A correct.

Q The safety or efficacy of psychiatric surgeries, you're not going to be talking about that, correct?

A correct.

Q I don't see any allegations of fraud or fraudulent conduct in your report, I take it that you're not going to be expressing opinions about fraud or fraudulent conduct?

A I think the answer to that is no.

Q No, you're not going to be expressing such opinions, correct?

A correct.

Q As to the issue of whether the potential brain abscess should have been drained, is that something that you defer to the neurosurgeons? I don't see it addressed in your report.

A well, that to me is not an issue that we address specifically here. To me, that's an issue of the total care. And I think that is for discussion. So the issue of the abscess, I'm not saying it won't be discussed. It's not a critical part, to be honest with you, of this report.

Q I take it that in discussing infection, cause of infection and whether or not there was substandard care in the infection, we're going to be talking about the abscess, I understand that?

A correct.

Q Will you be expressing an opinion as to whether or not this patient's presumed abscess should have been surgically drained?

A Personally, I don't take it as a presumed abscess. To me, there definitely was an abscess. If asked, we will discuss the issue of extirpation of the abscess drainage, stereo tactic drainage. So it's part of the discussion. It's not a critical issue that was addressed here in terms of commentary.

Q okay. It was not addressed in the report in terms of commentary, is that what you're telling me?

A Right, But it's part of the treatment of this lady.

Q Do you have an opinion as to whether the failure to surgically drain the abscess constituted a breach in standard of care?

A Yes, we have an opinion on that.

Q And what is that opinion?

A Given -- it's not in this report, it's we do not feel it was a breach of the standard of care. we may have different opinions, different attitudes, but you can differ on what you might ideally do, but not regard it as a necessary breach of the standard of care.

Q In the report marked as Exhibit One, I don't see any criticisms in the standard of care as to the treatment of Mrs. Zimmerman's infection once that infection was clinically recognized. Did I read it correctly?

A correct.

Q Do you — will you be expressing an opinion as to whether there was impropriety in the treatment of the infection once the infection was recognized?

THE WITNESS: Can you repeat the exact wording

of that question, please?

(The court reporter read back the record as requested.)

A We have an opinion -- I have an opinion. And that is I feel the infectious disease and the treatment, once the infection was recognized, was reasonable and appropriate, we may do things differently, but there are different ways to accomplish the same. So I guess that's -- when I state, this is our opinion, I state that we have opinion on all this

management because of the abscess.

Q was there any breach of standard of care in recognizing the onset of this infection?

THE WITNESS: Will you repeat that again?

(The court reporter read back the record as requested.)

A By that you're not talking causation issues and such, your question is, once post op, do we feel there was any breach in the standard of care getting to the diagnosis made on 10/4, 10/5 of the infection?

Q I think that's one fair way to restate my question.

A I have concerns, per the hospital record, on issues of the record. I will not call itself a major breach in the standard *of* care, but I have some real problems with parts of that record.

Q okay. Was the onset of infection recognized in a timely and appropriate manner?

A Yes, I think so.

Q Do any of the institutions that you have been

affiliated with perform psychiatric surgeries?

A Perhaps I -- I can't say for sure. Here at Covenant, I'm quite certain not. In Denver, I truly do not know. Except when I was in Denver, I'm not sure if they were doing the stereo tactic techniques that they are now. But you said psychiatric surgery, and I think the answer would be no.

30

Q Do you recall treating a patient post op from psychiatric surgery?

A Post op psychiatric service, no, or else my answer would have been different.

Q Sure. So you have never treated a patient in, a post op patient from a cingulotomy?

A Well, you switched there from psychiatric to cingulotomy.

Q That's a good point, You're absolutely right.

A We do do stereo tactic surgery. So that I mean, I'm approaching the time I'm going to get it myself, so the switch in your question, the first to psychiatric is definitely no. I have followed and reviewed a lot of stereo tactic surgery. Now cingulotomy, I can't tell you for sure exactly what they've been.

Q okay. Can you give me an estimate of how many patients, if any, you have followed post cingulotomy?

MR. RUF: Well, objection, he just said he doesn't know about cingulotomy, He knows about patients stereo tactically.

Q That's fine. I understood that as well. But I wanted to make sure that I understand the question fairly,

that he --

A So cingulotomy I can't -- I can't give you a number.

Q okay. can you tell me whether you have treated

patients postoperative from anterior capsulotomy?

A Again you're asking such a defined question, no.

Q Do you know whether you've had experience treating patients post operatively from limbic leucotomy?

A Again, asking that question, I don't know.

Q okay. You have told me -- and you're itching to tell me that you've treated patients postoperatively from stereo tactic surgery. Let's make sure we're talking about stereo tactic brain surgery.

A correct.

Q How many patients have you seen postoperatively from stereo tactic brain surgery?

A Actually none. My following of it has been reviewing for any complications and such, so it was from the infection control epidemiology side.

Q At what institutions have you reviewed such cases?

A covenant.

Q How many such cases have you reviewed?

A I'm not sure what the total number was. The reason we reviewed it was when they started doing it, they were doing quite a few, in terms of, I think, more than a couple a week.

Q Can you give me a reasonable estimate of the number you've reviewed?

A over 20.

Q over what time frame?

A I'm not sure how long a time frame that was, probably a six-to-eight month, six-to-12-month time frame. It became a rather new surgery with one or two of our neurosurgeons, and we went in and did a complete review retrospective in terms of what had been done, prospective to insure that there weren't problems with it.

Q when you looked at these roughly 20 cases, did all 20 of these cases involve postoperative infections, is that why you were reviewing them, or you were reviewing an entire series?

A we were reviewing them to insure that there was nothing that was going to catch us untoward, and no, they were all uncomplicated.

Q All right. Mrs. Zimmerman obviously suffered a postoperative infection. what were the possible sources of that infection?

A There are three potential sources. One, given at the time she had positive cultures both from her wound and from the blood, obviously there's a potential of bacteremia spread. secondly, there's a potential of it being a secondary wound infection that tracks down to ultimately formation of the abscess. And thirdly is an inoculation of the bacterium directly into the site of the abscess at surgery.

Q Any other possibilities?

A Those would be the three mechanisms.

Q which mechanism was responsible for Mrs. Zimmerman's infection, if *you* know?

A My opinion, of which I feel with a great degree of certainty, is that it was inoculated at the time of surgery.

Q Tell me why.

A I think in saying why, we can go to the other methodologies and show why not and then the reasons why in terms of the direct inoculation.

Q okay. why not bacteremia?

A Bacteremia implies a focus of infection elsewhere. secondly, that focus has to seed the brain, and in this case, we have a singular abscess of which that is not impossible, it occurs with some areas of seeding. There are many reasons why there's no evidence of a peripheral foci. Most common areas to go from central foci to infect the brain are lung, usually those are upper lobe of the lung, frequently in otherwise ill patients, drunks or such, and may frequently involve mixed anaerobes. odontogenics is a common source, either by bacteremia or by direct spread. odontogenics being dental and the like.

The other is endocarditis. This lady was picked up by the infectious disease consultants to have a very low grade murmur. A murmur is always significant for the, issue of endocarditis, but it was an unimpressive murmur to them. They followed it, never felt there was endocarditis. There was no

evidence of endocarditis. The dominant areas that you would seed the lung in the system -- or excuse me -- seed the brain, there is no evidence of infection. Now, there is talk about

she had some incontinence of stool periodically and alluding to there may have been a di -- enteritis or such with this lady. I see no true evidence of that in the chart. The Klebsiella oxytoca most certainly can cause diarrhea. The staph aureus would be very uncommon from that source. The other part that's very much against a foci of infection causing bacteremia seeding the area of the brain and causing the abscess is these three infectious disease doctors are all excellent. I know of all three of them. I know McHenry very, very well. He's been at this job for years. what's interesting is they brought up that as one of the issues of a potential etiology.

Q Brought up what as one of the potentials?

A The bacteremia. A very telling feature is look at what they did. They did not seek actively within the clinical record an alternative foci. Because a very intense, very thorough examination, they were not concerned about an alternative foci causing a bacteremia, seeding the brain abscess. Sort of from the academic perusal of what areas cause a seed to the brain, and secondly, reviewing the work of, bluntly, excellent infectious disease people not pursuing that area, I don't think it's just my opinion that it was not

a bacteremia. secondly is the site of a wound infection going deep to cause the abscess.

Q okay. so let me just to interpose a question here. I take it that you're about to tell me why you don't believe it was secondary to a wound infection track down?

A Yes.

Q okay.

A And let me tell you, this is the longest answer I've ever given in 20 years to a legal question. why not a wound infection going deep to cause the brain abscess? And this is where I -- the concerns I mentioned earlier, some of the review of the medical record, I have questions about.

And the reason this comes up, I think to any significance, is that various people talk about this lady potentially picking at her wounds. And that is mentioned once by physicians within the record. It's mentioned in a deposition by, I believe it's the chief neurosurgical resident goes on actually for some time about that potential. And others talk about it. one of the individuals giving expert opinion talks about it. But nowhere in the record do I ever see a physician state that she was picking at her wounds.

And I believe only one day postop, it may have mentioned that, that she had her arms sort of up, but otherwise when you review the nursing notes and they do the gradation of neurological assessment, they assess her at a

point where she is not raising her arms and such above gravity, which you cannot be doing this (indicating) and picking -- excuse me, I realize you can't write doing this -- arms above the level against gravity and picking at your scalp.

And so there's comment on this, and a lot is made of it by various people. But detailed review of the nurse's notes would tend to indicate that that is highly, highly unlikely. So I take significant exception to the issue that

she may have caused this in any way by picking at her wound, That does not imply it could not occur the other way. Lack of sterile technique on staff handling the wound postop could be a cause.

But I very much doubt it, because if a wound infection occurs, you're stating that your primary infection is a wound infection. Your wound is not going to heal beautifully. For the most part, neurosurgery states they have a clean, dry wound, and it looks good. In fact, to the extent that on the neurosurgical note of October 2nd --

MR. RUF: You can look at the records if you need to.

THE WITNESS: Yeah, I would like to look at the record on that date. can we break just for a second?

MR. PARKER: Yeah, why don't we take a minute.

(A break was taken.)

Q Let's go back on the record, you were continuing to explain why you believe this was not a wound infection that tracked down and you wanted to make reference to a notation of October 2.

THE WITNESS: Can you read me at least the last 20 seconds of what I was saying?

(The court reporter read back the record as requested.)

A on that, and I don't profess this to be absolutely God's truth on what they're saying, but on the physical exam, I do believe I can read this. Neuro unchanged -- it's the short form with the pi -- wound C and D -- which I'm assuming

at Cleveland clinic is clean and dry -- one stitch placed at right. And I believe that's frontal. That's -- that is a very weird note. And we have clean and dry, clean and dry and such from neurosurgery all along. Then we have on the 2nd, a stitch placed, but no explanation of why. I mean that's a very difficult note, because I'm left, why did they place the stitch.

YOU go back and review the nurse's notes and you see that periodically there has been crusting. There has been serosanguinous drainage. And it appears this stitch was placed because of drainage. So these wounds were not overtly purulent. They were healing, but they were never free entirely from drainage, and when I say wounds, I cannot say

all four. At times it is not totally clear which exact wound they're talking about.

But there is a disparity between the nurse's notes and the neurosurge notes pertaining to the wound. The stitch is placed. what's very interesting is that stitch is placed, within about 36 hours Ms. zimmerman exhibits the signs and symptoms of significant infection: Fever's up, chills, And on the 4th overt pus, drains, I believe, from the left and I believe it's the 5th from the right. Now the placement of that stitch is fascinating. Because did that close out the site which was relieving the pressure internally. And what placing that stitch did was manifest perhaps a little bit earlier and forced the manifestation of her infection by causing lack of drainage, higher pressure, and now a bacteremia from the brain abscess.

Q well, do you believe that happened or are you just raising that as an issue and you don't know whether that happened?

A I believe that happened. And the other part is then the timing and the scans and looking at the brain abscess. If you go through the pathophysiology of a brain abscess, normally it has four phases, there's an early cerebritis, a late cerebritis usually the first few days, the next four to five days. Between about nine and eleven days, nine and 13 days, you'll get early capsulation, and 12 and on and 14 and

on, you'll get light capsulation. well, if you go to surgery on the 22nd and the scan that is taken with contrast, which is I think about the 6th or 7th, you have a very nicely defined enhanced encapsulated abscess. YOU have on scans prior to that strong indication of probable abscess. The timing fits beautifully with the known pathophysiology of the formation of brain abscess, even with the Decadron on board, which can delay some of these classical signs and symptoms appearing. It does not fit with a wound infection occurring later, tracking down then to form the abscess.

Q why not?

A Because the -- it would -- it should take considerably longer if you evoke a wound, especially a wound that never showed overt evidence of infection at the site.

Q Are you telling me that if this was a wound abscess that tracked down, then we should not have seen a brain abscess until even later?

A It's whether or not she would have had brain abscess,

whether you would have had another form of infection. But she could have an abscess by tracking down. But I feel it would have been later than this.

Q How much later?

A That's totally hypothetical, And the issue that I feel there's not a wound infection, you know, that's -- I'm not going to get into trying to split hairs as to timing,

because what I'm saying is there was no wound infection. The wound was evident of drainage, yes. Neurosurge notes say no problem. I believe there was a problem and symptoms with those wounds earlier, by reviewing the nursing notes, that's why neurosurge placed a stitch for no apparent reason on their notes. obviously they had a reason. I think the reason was, there was egress allowing it to maintain a lower pressure state that they closed off.

Q Do you acknowledge the stitch may have been placed simply because there was wound dehiscence?

A Well, of course wound dehiscence has to have a reason, and at that late stage post op, I suspect the reason given, neurosurge is quite unimpressed by the wound was not an overt evident wound infection, but there was continued drainage that was not healing.

Q where was Mrs. Zimmerman's brain abscess?

A It was frontal right, and we've not seen all her scans. we are going purely by reports.

Q okay. can you describe for me the structures that it involved or was next to?

A No, I'm not going to portend to.

Q Have you basically outlined for me the reasons that you do not believe that her abscess was a consequence of bacteremia or a consequence of wound infection that tracked down?

A Yes.

Q All right. So that leaves you with the opinion that it was inoculated at the time of surgery?

A Yes.

Q In what manner?

A My personal opinion is that it was inoculated with the probe. one, for the reasons that I feel strongly it was not bacteremia or a superficial surface wound infection tracking deep, therefore, that has to be the modality by which the infection occurred. And I believe it was both staph aureus and Kleb oxytoca -- Klebsiella oxytoca that were infiltrated directly to the area of the abscess. And I feel that occurred through what, in my opinion, is a clear breach of the standard of care in contamination of that probe.

Q oak. what did the clinic do wrong in its sterilization techniques?

A The use of ethylene oxide is fully appropriate. Ethylene oxide when the testing is properly done is an excellent methodology. However, there are -- this is a mammoth organization, huge number of surgeries, and an incredible number of surgical instruments that go through this procedure.

what is not known is, was everything properly free of debris, cleaned properly before it was in the ethylene oxide.

25 It has to be to be properly sterilized. secondly, with the

1 numbers that go through and the crowding, the number of
2 instruments they try to get into those machines, I'm always
3 concerned that individuals may not separate the probe from the
4 sheath.
5 And if you leave the probe in the sheath, then the
6 humidity, the penetrance of the ethylene oxide, that is all
7 going to be distorted from what the ideal is, and you may well
8 not get appropriate sterilization of the probe within the
9 sheath. It needs to be separate. And the other is in the
10 post ethylene oxide. Was there a process by which there was a
11 break in steri1e technique.
12 once you get to the OR, with the probe was there a
13 break in sterile technique. The other is the actual prep of
14 the scalp and the wound area. And the staphylococcus aureus,
15 very uncommon in stereo tactic type procedures, but is a true
16 surgical risk. That is an endogenous flora of the skin. That
17 can occur.
18 Kleb oxytoca may be present on the skin. If present,
19 it is a transient. And a transient should be removed by the
20 prep, if the prep is done properly. And were this to have
21 been acquired from the skin of the patient that contaminated
22 the probe, then you have, I feel, a clear break in the
23 preparation of the patient.
24 Q I have just heard you raise a number of
25 possibilities. I don't know that I got them all down or not.

43

Let's see if I understand some things a step at a time. First of all, ethylene oxide is an appropriate method for sterilizing surgical probe?

A Yes.

Q All right. You have raised the possibility that there was too much in the way of surgical instruments run through the sterilizer. Did I hear that correctly?

A well, I know what busy ORs do because this is one of the things I follow, and one of the problems we have often is just overcrowding because the ORs are busy and surgeons are demanding their instruments.

Q so an overcrowding of the sterilizer is a possibility?

A Not the overcrowding that concerns me. The issue would be would that cause somebody to have a greater likelihood of leaving the probe in the sheath to save room.

Q That's what I was trying to understand was whether or not those were related or unrelated. So one possibility is that a technician may not have separated the probe from the sheath?

A correct.

Q Do you know if that happened?

A I do not.

Q Another possibility is that, post sterilization, there was a breach in sterile technique in handling the probe,

44

do you know -- is that correct?

A correct.

Q Do you know if that happened?

A I do not know with certainty that that happened.

Q Another possibility is that in the operating room there was a breach in sterile technique in the handling or utilization of the probe, correct?

A correct.

Q And do you know if that happened?

A Nobody wrote that.

Q And then another possibility is inadequate surgical site preparation?

A correct.

Q And do you know if that happened?

A I wasn't there.

Q Do you know which of those different possibilities is most likely as compared to the other possibilities, or is it just not knowable?

A I'm not going to put a statistical risk of each, because I really can't do that. I guess what's most important to me is the Klebsiella oxytoca should have not have gotten where it got.

Q And is it fair to say that you're drawing the conclusion that because the Klebsiella oxytoca got to where it shouldn't have been, that there was a deviation in standard of

care in some respect?

A Yes.

Q Among those possibilities that we just outlined?

A Yes.

Q okay. can you tell me any specifics as to how the surgical site preparation was inadequate for this patient?

A I can only raise concerns, and actually this was a question I asked Mr. Ruf last night, because it wasn't clear to me, and still is not totally on review of this record, was whether the entire head was prepped, which I get the sense it was not versus four distinct areas. And I would have concern if we had four distinctive burr holes, maybe not with the amount of hair I have but the amount of hair you have, show that he's thick headed, I would have concern over --

Q I would hope I'm thick haired, but maybe I'm thick headed as well.

A Thick hair headed.

My concern would be with the probe and there still being hair. So it seems highly unusual to me to try to prep four individual areas, you've then covered as much as you can with just those areas exposed but if you're brushing up against the head or other things, you can, if you've got a lot of hair there, you can get organisms moving about the base of the hair. I mean, if you look at transient organisms on the skin, they're there. And they're just lying loosely. The

other endogenous flora, which you can accept the infection occurring are deeper often along the sebaceous gland and things like that, which is why shaving too early can be a problem because you can get inflammation and get those up.

So I'm not entirely clear exactly how they prepped. Assuming that the prep, everything is done the way I like, then you have to be very careful that you allow everything to

dry. Because only upon fully drying has the bacteriocidal effect of the solution had its maximum benefit. And it's a very good prep if done properly. I cannot tell you where it wasn't done properly. I wasn't there.

Q Okay. Have you reviewed any of the radiology films themselves in this case?

A No, we have not been sent those.

Q okay.

THE WITNESS: I hope they were not sent, Mark, because if they were, they're lost.

A I don't believe that any were sent.

Q You told me a few minutes ago about some stages of brain abscess development. If I wrote them down right, I think the first stage I think you called early cerebritis?

A Right.

Q what is that?

A That's the earliest part of infectious process where you develop inflammatory cell reaction. That usually goes on

for a few days. Then you have what's termed the stage of later cerebritis.

Q And when does later cerebritis set in?

A well, when the first stage ends, which goes from maybe zero to three, four days, so now you're talking three to four days to maybe eight or nine days. You have to realize these are not God defined absolute definitions of time, but reasonable and approximate. That stage would have continued inflammation, but now you start getting some necrosis and debris within the area. Then you get the early capsulation

phase where you start forming a defined entity. But --

Q what's the typical onset of the early capsulation stage?

A Eight or nine days, going to perhaps 11 to 14.

Q okay.

A And that's the phase where you're starting to get your abscess, it's starting to define itself, starting to early define margins to it, starting to necrose internally and develop a thicker capsulation. Now the virulence of certain organisms may go through this process more quickly than others. The use of the Dexamethazone, which she was on, can retard it somewhat. But those generally are the phases, and it's looking at that, and the fact that she's on Dexamethazone, that I feel very strongly ties this into direct inoculation and not secondary to a localized wound infection.

Q Your final stage was late capsulation?

A Right.

Q what are the characteristics and what's the typical onset?

A That is usually anywhere between 12 to 14, 11 to 14, or 14 days up.

Q And what is its characterization?

A It's more what you would see with that final scan where you have a clearly defined area that enhances on contrast being given. *Not* only infection enhances, a tumor can enhance. But tends to be enhanced around the rim and have -- to the radiologist, especially nuclear radiologist -- a fairly classic opinion or appearance of abscess. And that is

a totally mature abscess at that point.

Q Is there any medical literature that you're familiar with that sets forth the stages and their times of onset and their characteristics?

A That's been defined for some time in the medical literature.

Q And can you point me to any specifically?

A I could.

Q Can you as you sit here?

A I can't just give it to you off my head, but I could give it to you pretty quickly.

Q Is there any literature that you have reviewed in

connection with your preparation for this deposition, or preparation of giving your opinions in this case, on this subject matter?

A Not in giving my opinions. once my opinions were made, I have gone back and reviewed some areas. So in terms of making my opinion, that was purely based on my years of experience, education, and that type of thing. The staging of brain abscess, while I know it, I had to go back and review it, because that's something I hadn't looked at in probably ten or 15 years.

Q okay. where would one likely go to look for it?

A I think a generic review that you can find in the major textbooks of infectious disease. Mandel is the one I use.

Q Let me ask you some questions about medical literature. Is there any medical literature that you have

reviewed in preparation for giving testimony in this case?

A In the sense of my opinion?

Q Yes.

A No. In that sense for giving this deposition, no.

Q Is there any medical literature that you anticipate telling a jury is authoritative?

MR. RUF: objection. He doesn't know until he's asked.

A Authoritative for what?

Q On any of the issues that you anticipate testifying on?

A well, that's pretty broad.

Q well, it is broad, something that lawyers sometimes do with their experts is use them in order to establish a foundation to put some particular articles or portions of article into evidence. Are you anticipating being used in that manner?

A I don't believe I can answer that because that response would be, if an opinion of mine is contested, then most certainly my opinions, which may be my opinions, are based on not only experience but a very broad reading over the years and education and teaching, bluntly.

Q And that's fair enough.

A So at that point -- go ahead.

Q But here's what I'm getting at, I didn't see any medical literature in the file that you brought here today?

A NO.

Q And so I'm simply trying to protect myself in the

sense of whether or not there's any medical literature that has been pulled for this case that you anticipate you'll be going into trial and saying this literature is authoritative on this issue or this principle -- I understand things may come up and you may defend your opinions. That's not what I'm trying to do here. I'm trying to understand if you are

anticipating coming into trial with the intention of laying foundations for particular items of medical literature.

MR. RUF: I may ask him to review some literature at trial and state whether or not he thinks it's accurate and reliable.

MR. PARKER: Okay.

Q At the present time, do *you* -- is there anything that you have discussed or any material that you have reviewed in order to be able to do that?

A The answer is no, but if a comment I made were contested, then the answer would be yes. Because I could give you references.

Q okay. You have told me that Mandel is a textbook on infectious disease that you look to. Are there other textbooks on infectious disease that you think are particularly helpful and reliable?

A Mandel is, I think, the main one for infectious diseases, There's Hoeprich which is very good. I think there's Douglas, which has more pictures. We have Barrow, which is the clinical microbiology. For myself, Barrow for clinical microbiology and Mandel for infectious diseases, are the two big ones that I use.

Q Is Klebsiella oxytoca susceptible to sterilization by ethylene oxide?

A If all procedures are followed correctly, yes.

Q Okay. Do you have the understanding that the surgical site was shaved -- you don't know if the whole head was shaved, at least, but the areas surrounding the burr holes were shaved; is that your understanding?

A I think they shaved.

Q Do you know whether a presurgical antiseptic was used?

A It appears they did a Betadine prep.

Q And was that appropriate?

A The use of a Betadine prep is appropriate.

Q We began our discussion of Mrs. Zimmerman's infection by talking about three possible pathogenic sources for the infection. And you went on to tell me what you thought was most probable. Do you agree that it is at least possible that her infection could have resulted from bacteremia?

A No.

Q You don't believe that's even possible?

A NO.

Q And do you believe that it is even possible that her infection could have resulted from a wound infection?

A No.

Q Those are impossible scenarios, in your opinion?

A The clinical record does not support those in one instance. They're, in my opinion, not tenable.

Q Can operative infections occur despite careful use of

sterile technique?

A In many procedures, yes. This procedure, stereo tactic surgery, generally is usually an incredibly low rate of infection.

Q Well, the fact that the surgery is stereo tactic doesn't change the fact that it's invasive, does it?

A It's invasive.

Q The stereo tactic aspect of the surgery has to do with the location and direction of the incisions and insertions and the localization of the procedure --

A correct.

Q — is that correct? The fact that there's stereo tactic navigation involved in the surgery, does not in and of itself affect whether or not there can be infection, does it?

A No, the issue for infection is going to be the placement and entry of the probe.

Q okay. Can operative infection in stereo tactic neurosurgery occur despite careful use of sterile technique?

A Not due to Klebsiella oxytoca.

Q Can operative infections occur in stereo tactic neurosurgery with other organisms despite careful use of steri1e technique?

A Yes.

Q Tell me what's special about Klebsiella oxytoca.

A Klebsiella oxytoca is not an endogenous flora of the

skin. Various surgeries have various accepted levels of infection. And if you are within that statistical range after X hundreds of cases and such, you're going to have an acceptable rate and history for your procedure. But the anticipated organisms are going to be a coagulase-negative staphylococcus. A staphylococcus aureus, perhaps a strep viridans, diptheroids, endogenous flora that are deeper and have greater attachment, lichens and such, to the skin than what other organisms do, that can burrow and hide within the sebaceous gland and burrow down to the follicle of the hair. Klebsiella is not one of those.

Klebsiella, if it is on your skin, which it can be on the skin, is going to be sort of like light dusting. It's a transient. It doesn't want to be there. It actually -- the skin's a hostile environment. Klebsiella doesn't do well there. It does well in sort of moister areas, which is why we can colonize anywhere in our body with it, because underarms, groin areas, it can be anywhere. But when prepped it should readily be removed as are other nonresident flora. Non endog -- true endogenous flora of the skin. The presence of Klebsiella oxytoca, it should not be there. And to be there is a breach.

Q How many brain abscesses have you treated over your career?

A Over 100, under 200.

Q How many brain abscesses have you treated in your career that were secondary to a surgical procedure?

A over, probably over 30, under 100.

Q Of those that were secondary to a surgical procedure, how many were caused by negligence or a breach in the standard of care?

MR. RUF: objection.

A I can't state the exact number. I can recall a couple that I -- that was a concern of mine.

Q when you say you can recall a couple, that indicates to me a relatively small number, a single digit number?

A Yes.

Q Probably less than 10?

A Probably.

Q would it be fair to state that in most cases in which a brain abscess occurs secondary to a neurosurgical procedure, that abscess is not the result of negligence or a breach in standard of care?

MR. RUF: objection. That depends on the organism, based on his testimony.

Q Is my statement correct?

A I can't answer that yes or no, because it depends on what the surgery was.

Q Of those that you indicated you were concerned they were due to a breach in standard of care, how did you make

that determination?

A By unanticipated organism. And I was not seeing them for those issues, I was seeing them in consultation. These are ones that I was concerned about standard of care. unusual organism, unanticipated organism. And a surgery that generally it was nontrauma.

A lot of these that I saw were trauma, post surgical trauma where your risk of infection is significantly higher. So these were the clean neurosurgical surgeries where infection is very low. It was not back surgery. we're talking purely brain and is unexpected. So -- and then with that, we had an organism.

For instance, if this had been purely staph aureus, we may not be here talking, because even though this procedure should have a very low rate of infection, if it were one organism that was purely an endogenous skin flora, that is an acceptable risk. But that Klebsiella oxytoca is unacceptable. And that's the issue. The presence of that indicates to me, without doubt, a break in the standard of care the sterility of the products somewhere.

Q Is a Klebsiella oxytoca, is that a gram-negative organism?

A Yes.

Q Is it unusual to have a gram-negative organism associated with brain abscess?

A No, not necessarily. Again it depends on the source. If you have an abscess from prostate disease in men, you may very well have a gram-negative. If you have, from a lung abscess, you may have a mixed anaerobic/aerobic, but you may well have a Klebsiella and e-coli or such.

Q when surgical instruments are sterilized, we use the word sterilized, does the sterilization procedure leave them entirely without microorganisms, or is the goal to reduce to the extent possible the microorganisms that are on the

instrument?

A The intent is, it wouldn't be called a sterilizer if they weren't sterile. So the intent is to render them sterile. They can only be rendered sterile if the process is allowed to act on each instrument properly. I.e., if the sheath were left on, you're not going to get the proper humidity because of the sheath around the probe, you're not probably going to get penetrance of the side, or if the debris is not taken off, the cleaning pre-sterilization is critical. And you could have an error in those and your marker that would show it went through properly would still very well show it went through properly.

Q I guess what I'm getting at is whether or not sterility is something that is generally achieved, or whether when we talk about steri1izing instruments, steri1izing the surgical field, prepping the patient, whether what we're

really doing is reducing the microorganisms as much as we can?

A when we prep the surgical field, we don't use the term, we're sterilizing it. we are prepping it to maximally reduce load. The maximal reduction of load we're really talking about are those native flora. Those transient flora we should remove. when we're talking sterility, it's like you're -- a girl's pregnant. If I'm sterile, it's not going to be, no matter what. Sterile is an absolute. when we sterilize instruments, they are sterile.

Q so if I'm understanding you correctly, the instruments should be sterile, the surgical field is something where we're trying to reduce the microorganisms, to'reduce the

loading of the microorganisms?

A Dramatically, but we don't say we produced a sterile field.

Q okay. In the report that you and Dr. Martinelli prepared, you make note of some postoperative findings that Mrs, zimmerman was bradykinetic with decreased verbalization. Do you have an opinion as to whether or not that finding was infection related?

A No, we're more just describing what she was like post op and in terms of this or that symptom secondary to what.

Q Your report also describes an EEG finding showed epilepsy from the right frontal lobe in the left temporal region. were those findings infection related?

A No, I don't believe so.

Q okay. And your report also mentions EEG findings of encephalopathy, was that infection related?

A No.

Q can you tell me why there was a singular brain abscess as opposed to an infection of each of the locations of surgery?

A one — and I don't have an absolute. In fact, I've asked that question of myself. one, if the probe were inoculated after having already done one, two, or three of them, that could be one explanation. The other could be the probe was contaminated, this may have even been the first, and it may have in essence done its harm and she got lucky on the other three. It's hard to say.

I don't have a good answer for that, except in this

area where the infection occurred, there is evidence of what is termed -- they do a great number of scans on this lady post surgery, and I've never seen this number of scans done. The surgical note everything seems to have gone well, and yet, the lady does not do well postop. And the doctors are ordering enormous number of scans, and there appears to be evidence of hemorrhage.

If you have an inoculant bacteria, and you inoculate it into an area that has some hemorrhage, that is just like inoculating a blood broth that we do in the laboratory, to

enhance the growth of bacteria. This area may be where the abscess formed because this is where there was hemorrhage.

Q so the area of hemorrhage may be a particular suitable site for the development of the Klebsiella to cause?

A Right, just in the sense that you're almost -- it's like inoculating the plate. Blood is a wonderful media for bacteria to grow in.

Q when this kind of surgery is done and an area is ablated by radio frequency, does that produce necrosis?

A I'm going to stay away from answering that at all, because --

Q Defer to the neurosurgeons?

A Yeah.

Q That's fine. In Mrs. Zimmerman, there was positive urine culture for Klebsiella pneumoniae?

A correct.

Q Is that of any significance?

A Totally unrelated.

Q Can the risk of infection be eliminated from any invasive surgical procedure?

MR. RUF: objection. For any organism?

Q My question, if I can ask my questions, please, is: can the risk of infection be eliminated in any invasive surgical procedure?

A To the known endogenous skin flora, even where there

is minuscule risk, there remains minuscule risk. certain organisms, as I've said in this case, Klebsiella oxytoca is not acceptable. That risk should have been eliminated.

Q Have you ever met Mrs. zimmerman?

A No.

Q Have you met anyone in her family?

A No.

Q I take it then that you haven't examined her in any way, shape, or form?

A NO.

Q Do you have any plans to examine her before trial?

A NO.

Q I understand your opinions with respect to Mrs. zimmerman particularly, but let me ask a few general questions.

can a patient's urine be a source for organisms that cause bacteremia?

A The urine may be the source, but it would require a certain type of infection with urine.

Q what do you mean by that?

A well, a cystitis, a routine cystitis in a woman, is

not going to cause bacteremia. Hemorrhagic cystitis, which is just bladder inflammation, but dramatic due to a cis-platinum or radiation therapy, could cause bacteremia in the face of a urinary tract infection. So the answer is yes, but not just a

routine UTI.

Q Generally speaking, can a patient's intestines be a source of organisms causing a bacteremia?

A As we walk about from day to day perfectly healthy, very rarely, but one can have periodically a potential for a transient bacteremia that immunologically would just clear, but incredibly rare.

Q Was there ever a culture done of Mrs. Zimmerman's abscess material?

A No, not in this hospitalization. Later I believe there was and that culture was negative.

Q Okay. without a culture, do we definitively know that the abscess organisms were staph aureus and Klebsiella oxytoca?

A Yes.

Q How do we know that?

A Put it this way, if a student of mine were to argue that question, I would fail them. It's a matter that you have a patient who by all clinical and physiological factors has a brain abscess. she is bacteremic, the same two organisms that are in the blood, same susceptibility are in the wound. she responds to therapy in a manner with purely medical therapy that is not inconsistent with the diagnosis of brain abscess. So everything says she has a brain abscess. She has a brain

abscess, period. And I won't -- that is absolute. To say

otherwise is looking for zebras.

Q Do you recall which incision sites were noted to have pus or discharge?

A I would have to go back, because we've got four sites theoretically, and go back. Sometimes they don't state exactly, they'll say left of right, they won't say anterior or posterior. I would have to go back and look at each, except on the fourth, it was from the left, and it was the fifth that the right started to drain, I actually believe it was the family that told the nurses first it was draining. And then the nurses note of it.

Q And what you do specifically recall raises this next question. can you explain why there would be discharge from an incision site different side of the head than the abscess?

A Interesting question. And again, there's got to be a connection somewhere. But you won't see on your scans and such tracks. So I don't have an answer for that.

Q when you say there must be a connection, you're saying there must be a physical way for the fluid to communicate --

A There has to be, and, you know, you've got four probes coming down, I think because of her postop status mentally and such how she was, but I've -- leave that out.

Q I'm sorry. I'm lost.

A I just, I don't know the answer to your question,

64

okay. I wonder if the answer lies maybe in something within the OR, but the OR notes don't reveal any problems, but I've never seen a patient get so many scans after surgery.

Q But, ultimately, you don't know why there's discharge at a side other than the side of the --

A No, there has to be communication,

Q In connection with your expert witness work, have you ever advertised?

A Yes.

Q Do you still?

A No.

Q when did you last advertise?

A last paid for advertising October of 2001.

Q And where did you advertise?

A Trial Magazine.

Q Anywhere else?

A I believe just Trial.

Q Trial Magazine is the magazine of the Association of Trial Lawyers of America; is that correct?

A I'm not sure. That's the one I was told to advertise in.

Q who suggested that you advertise in Trial Magazine?

A I actually phoned a lawyer that had done'defense work with.

Q okay. Do you list with any services that provide

65

expert reviews?

A No.

Q Have you ever?

A Have ever?

Q Yes.

A No.

Q You have pretty extensive medical records and I only glanced through them before we started the deposition. I didn't study them in detail, but it appeared to me as though the medical records you have are those of the Cleveland Clinic?

A Yes.

Q Do you have what appears to you to be a complete set of records from the Cleveland clinic, in other words, as you looked through those records, did you say, geez, we don't seem to have nurses notes, or we don't seem to have these kinds of reports or those kinds of --

A No, on the body of this admission, I'm comfortable. There's nothing I did not have except the live films. I had to rely on the reports.

Q And there are pages that are tabbed. who did that tabbing?

A All this, that's all Dr. Martinelli. It makes him sleep well at night.

Q Have you reviewed those tabs to see how they

correlate with the record or what it is that they are particularly marking?

A No, it drives me nuts.

Q Do you have records from any other health care

providers other than the Cleveland clinic? As I looked through there, I didn't see Menninger records and I didn't see --

A If there are, they were not reviewed. I know there was some rehab in here, which I'm not sure if that's Cleveland clinic.

Q Did you review the rehab records?

A very briefly. I mean, once the infectious disease side was over --

Q was there anything from the rehab records that would have bearing upon your opinions as to the standard of care issues and infection issues that you addressed?

A No.

Q Your box of file materials contains a number of depositions. Did you review all of the depositions?

A Yes.

Q when I'm done asking you questions, I'll read through the depositions that are in the file and I'll read through the other materials that are in the file, understanding that you're telling me you have read all of those depositions?

A Yes.

Q There is a binder that is dated September 11th, 2000, it says Bob Linton. If we could find that binder?

MR. RUF: Is that it there?

MR. PARKER: That's not it.

MR. RUF: They're all marked the same date.

THE WITNESS: That has to be the date was sent to me, I'm sure. This is probably it.

Q We're looking at a binder dated 9/11/2000 Robert Linton volume 3 of 4, and I want to point you to a subdivision six, there's a chronology at subdivision six. Do you know who prepared that?

A I'm not sure who prepared this. It was not prepared by myself.

Q Do you know if it was prepared by Dr. Martinelli?

A It's something that he would love to do, but I don't believe so. I believe this was part of what was sent to us. My assumption it was a paramedical of the law firm.

Q Did your -- do your opinions, are they based in part on that chronology?

A Well, I hate to say this in front of Mr. Ruf, but I don't read these chronologies until I've reviewed the record.

Q okay. But I guess my question still stands though, is your opinion based upon that chronology in whole or in part?

A NO, it's based entirely upon my personal opinion and

review of the record.

Q showing you what has been marked as Exhibit Two, can you tell me what that is?

A That's my curriculum vitae.

Q Can you tell me if it's current?

A Actually it appears quite current.

Q Are there any corrections that need to be made to it?

A I don't think so. We had already taken complete Practice Solutions off this. I must have updated this.

Q under certifications, one of the organizations that

you list is American college of Forensic Examiners. what is that?

A That is a college, one of many other medical colleges have one conference -- there's several conferences a year, there's one conference that's really very good that I enjoy, but it is not a board like internal medicine infectious diseases. It's a board that you're awarded because of publications and a point system on things that you have done. So you're a member of that board, but it's not a board that you've been examined for.

Q All right. And the American Board of Forensic Medicine, what is that?

A That's what we were just talking about.

Q oh, I asked before about the American college of Forensic Examiners; are they related?

A oh, yes. Yes, they're related.

Q And they are not board certification in the classic sense of something for which you have to hold very strict board qualifications and then undergo a board examination?

A No. The only reason you do the exam -- several do the exam, but they only do the exam because they did not qualify by other things they have done, which was board certifications in at least two other areas, X publications, teaching hours, things like that.

Q DO you hold yourself out as an expert in forensic medicine?

A NO.

Q And do you claim a certification, board certification

in forensic medicine?

A only always qualify it in the sense that you asked about it. I never allow it to be implied, it's something took three years of fellowship training for.

Q You list as a present appointment, director of employee health at Covenant Medical center; is that accurate?

A thought those were all knocked out now. Because all of that is finished as of April 2001.

Q okay.

A oh, assumed that was knocked out when saw CPS was off here. No.

Q so you are no longer director of employee health at

Covenant Medical center?

A No. Still have privileges and such there, but that is what I retired from April 2001.

Q okay. There's a listing of an assistant professorship with Texas Tech university Medical Center, is that current?

A That is current. Current does not mean I'm actively doing it right now.

Q Right. when did you last engage in any duties as an assistant professor? when did you last teach?

A Bioterrorism last year.

Q I'm sorry?

A Bioterrorism last year. Lecturing.

MR. PARKER: off the record.

(off-the-record discussion.)

Q You characterized me earlier in this deposition as

thick headed and it's showing now.

A I was talking about hair.

Q I really was not understanding your answer. You're telling me, I think, that you lectured on bioterrorism?

A Right.

Q On one occasion last year?

A Actually lectured over the last several years on bioterrorism a great deal.

Q okay. Are you currently engaged in any teaching

activities?

A Yes, in the sense that again we're getting back to what I just sort of put myself back open for, the outside consultation and the san Angelo contract will involve significant amount of teaching.

Q okay. Will you be teaching medical students through an accredited medical school program?

A Not at San Angelo. They do not have medical students,

Q Also on appointments, you've listed chief of hospital epidemiology and infection control at covenant Health System?

A No, those --

Q That --

A -- outside of privileges at covenant, April 2001 is the end of that.

Q okay. And that's true as well with the director of infection control at covenant?

A Right.

MR. PARKER: Doctor, I thank you for answering

my questions. I am going to go through on the record some of the materials that are in your file, and you're welcome to be present for that.

MR. RUF: Before we go off the record, I want to clear something up. I don't think it's clear on the record, and since we're approaching trial, I want to clear this up.

EXAMINATION

BY MR. RUF:

Q Doctor, I just have a few questions for you about your work at San Angelo community Hospital, I think you testified that you have reached an agreement with that hospital; is that correct?

A They have -- we have not signed contracts yet, but they have asked me -- when I left, they asked if I would take a contract and come back on a permanent basis in terms of infection control and -- I'm blocking on the word for — it's the quality assurance side, and review and continue to review that for them over the long term.

Q Is that something --

MR. PARKER: objection. And move to strike.

Q Is that something you have accepted, or are going to accept?

A I will accept that.

Q And does that work involve the active clinical practice in medicine?

A As far as I'm concerned, yes.

Q why does it involve the active clinical practice in medicine?

A Because you're reviewing the patient care records of, you're making critical assessment of that care in terms of the privileging for the physicians doing it.

Q So are you going to be engaging at 'least 50 percent of your time in the active clinical practice of medicine based upon the work you're going to be doing for San Angelo community Hospital?

MR. PARKER: objection.

A That and now that I'm going to get back into more of the clinical side, yes, it will be more than 50 percent.

Q why are you once again becoming involved in the active clinical practice of medicine?

A It's my first love. The big thing is my health is allowing me to by cutting back on so much else.

Q Now in the past, have you solely cut back on your involvement in clinical practice because of health reasons?

A Yes.

Q And as long as your health permits you, are you going to be engaged in the active clinical practice of medicine?

A I hope to be, yes.

MR. RUF: Thank you, Dr. Kerr.

Time 11:26.

MR. PARKER: Just a few questions.

EXAMINATION

BY MR. PARKER:

Q YOU told us just a moment ago that at San Angelo, to your way of viewing things, you'll be engaged in an active clinical practice. Let me ask a few follow-up questions.

Will you -- do you know if you will be doing hands-on examination or treatment of patients?

A Interesting question, because they have asked if I would do consultation over the phone, or when I'm down there, on patients. And I told them I will not do that any longer because I cannot be there on a daily basis. It's a liability I'm not willing to take. But I have agreed that I will go down on a regular basis and we will hold rounds where they can discuss patients with me. Or we may do rounds going around the ward. But I specifically will not take the responsibility for the direct patient orders.

Q Okay. So you won't be writing orders?

A NO.

Q Will you be performing patient examinations?

A I may be.

Q I'm sorry. I'm having trouble with "I may be". Do you know if you will or will not?

A They may request an opinion from me on an examination,

Q Will you be reviewing the record of the exam, or will you be performing the exam, or do you know?

A Most certainly I will be reviewing the records. If they request my opinion, I would do the exam.

Q okay. As you testify here today, are you on any medications?

A Yes.

Q okay. can you tell me what those are?

A There you go (indicating).

Q what are they?

A I am on Sinemet CR; Compton, Requip, Sinemet plain, aspirin, Aciphex. I think that's enough.

Q Do any of those have any impact upon your ability to comprehend my questions or to formulate responses to them or do they affect your cognition or understanding in any way?

A NO.

MR. PARKER: Okay. I'll be going through your records, but I think I'm done with questions for you.

THE WITNESS: Appreciate it. Thank you

MR. RUF: Doctor, do you want to read this transcript?

THE WITNESS: Absolutely.

(Off-the-record discussion.)

MR. PARKER: I'm just reading into the record materials that are in the file produced by Dr. Kerr: Deposition transcript of Martin McHenry, M.D.; deposition transcript of Mary Eleanor Reilly; deposition transcript of Richard schule; deposition transcript of Gene Barnett, M.D.; deposition transcript of Susan Rehm, M.D.; deposition transcript of Stephen M. Gordon, M.D.; deposition transcript of Robin Avery, M.D.; medical records of Trinity Lutheran

Hospital; medical records of Overland Park Regional Medical center; medical records of the Rehabilitation Institute; medical records of Shawnee Mission Medical Center; medical

records of Martin Buckman, M.D.; medical records of Neurology Consultants; charter Neurology Consultants; medical records of the Cleveland Clinic Foundation in five loose-leaf volumes. The way those volumes are bound they include interrogatories and a request for production of documents to the Cleveland Clinic, and the responses thereto, which includes various pages of policies and procedure manuals relative to sterilization procedures. The deposition of Penny sonters, R.N.; the expert report of Phillip Gildenberg; the expert report of Keith Armitage, M.D.; the expert report of william Rutala, Ph.D.; the curriculum vitae of Dr. Rutala; the report of Mark poznansky, M.D.; and Dr. Poznansky's curriculum vitae; the deposition of Dr. Poznansky; the deposition of Kristen Minnick; the deposition of Kathleen zobec, R.N.; the deposition of Mary Bertin, R.N.; the deposition of Georges Markarian, M.D.; the deposition of Michael Ryan, M.D.; the deposition of Sherman zimmerman, the deposition of Margaret Zimmerman-Rabe; the deposition of Janet Serkey.

And that concludes the contents of the file.

(Deposition concluded; time 11:43).

(signature by the witness required.)

CHANGES AND SIGNATURE PAGE
ORAL DEPOSITION OF DR. CLARK KERR
MAY 3, 2002

Page:	Line:	change:	Reason:

I, DR. CLARK KERR, have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

DR. CLARK KERR

THE STATE OF TEXAS)
COUNTY OF LUBBOCK)

Before me, , on this day personally appeared DR. CLARK KERR, known to me (or proved to me under oath or through an identifying document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same.

Given under my hand and seal of office this the day of , 2002.

Notary public in and for the state of Texas

My Commission Expires:

CUYAHOGA COUNTY COMMON PLEAS
CASE NO. 399411

MARY LOU ZIMMERMAN, ET AL

VS.

THE CLEVELAND CLINIC FOUNDATION

REPORTER'S CERTIFICATION
DEPOSITION OF DR. CLARK KERR
MAY 3, 2002

I, Linda York, Texas certified court Reporter, hereby certify to the following:

That the deposition transcript is a true record of the testimony given by the witness, after said witness was duly sworn by me;

That the deposition transcript was submitted on _____, 2002, to the witness or to the attorney for the witness for examination, signature and return to me within 20 days from today's date;

That the amount of time used by each party at the deposition is:

MR. PARKER: Two Hours, 30 Minutes
MR. RUF: Two Minutes

That appearances of all parties of record are as follows:

For the Plaintiff: MR. ROBERT LINTON
(via telephone)
- and -
MR. MARK RUF
Linton & Hirshman
700 W. St. clair Avenue
Cleveland, OH 44113
216.687.1999
fax 216.771.5803

For the Defendant: MR. ALAN PARKER
Reminger & Reminger
The 113 St. Clair Building
Cleveland, OH 44114
216.687.1311
fax 216.687.1841

That I am neither attorney nor counsel for, related to, nor employed by any of the parties or attorneys of record in this cause, nor do I have a financial interest in the action.

certified to by me on this the 6th day of May, 2002.

Linda York
Texas certified Court Reporter
Certificate Number 4899
Expiration Date: Dec. 31, 2003
P. O. BOX 86
Lubbock, Texas 79401
806.763.0036

FURTHER RULE 203 TRCP CERTIFICATION

( ) The above-described deposition was not returned to the offices of Cathy sosebee & Associates, and I have notified all parties reflected in this certificate.

-OR-

( ) The above-described deposition was returned to the offices of Cathy sosebee & Associates on and delivered to Mr, Parker, Custodial Attorney.

charges for the preparation of the deposition transcript and any copies of exhibits are:

Amount:

chargeable to: Mr. Parker

This certificate will be filed with the clerk of the court and served on all parties of record shown herein.

certified to by me on this the ____ day of _____, 2002.

Linda York
Texas certified court Reporter
Certificate Number 4899
Expiration Date: Dec. 31, 2003
P. O. Box 86
Lubbock, Texas 79408
806.763.0036