#635

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

TRAVIS CATES, et al.,

Plaintiffs,

-vs- CASE NO. 167835

CLEVELAND METROPOLITAN GENERAL HOSPITAL, et al.,

Defendants.

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Deposition of PHILLIP I. LERNER, M.D., taken as if upon cross-examination before Aneta I. Fine, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the Mt. Sinai Hospital, One Mt. Sinai Drive, Cleveland, Ohio, at 3:30 p.m. on Tuesday, September 3, 1991, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Defendant
Mary-Blair Matejczyk, M.D.;

PHILLIP I. LERNER, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF PHILLIP I. LERNER, M.D.

BY MR. KAMPINSKI:

Q. Would you state your full name, please?

A. Dr. Phillip I. Lerner.

Q. Doctor, I'm going to ask you a number of questions this afternoon. If you don't understand any of them, tell me, I will be happy to rephrase any question you don't understand. When you respond you have to do so verbally. She can't take down a nod of your head, okay?

A. Okay.

Q. All right. Doctor, I just received your CV. It indicates that you're an assistant visiting physician at Cleveland Metropolitan General Hospital from '68, presumably to the present. Is that accurate?

A. Probably no longer active.

Q. Okay. How long was that true?

A. Well, it's hard to say. For many years but I

just don't know when. I haven't received -- the reason it's hard to say is that those of us who are on the faculty have certain appointments that don't have to be officially reestablished each year. It's sort of like a teaching category.

Q. All right. Let's go slow. When you say on the faculty you are talking about Case Western?

A. Yes.

Q. And when you are on the faculty that requires you to provide teaching to various residents?

A. Well, medical students and residents throughout the system, throughout the whole system.

Q. When you say the system, do you actually go to Case Western to teach them?

A. Yes.

Q. Or are these residents?

A. No. I go there. I go there for medical students. The residents usually are taught here or at one of the affiliated hospitals.

Q. And is it part of those teaching responsibilities that would have been --

A. That particular one, definitely was strictly a teaching as opposed to say the university where I have admitting privileges and I renew these

every year.
Q. Okay. So you don't have admitting privileges?
A. No.
Q. At Cleveland Metro?
A. (Indicating).
Q. When's the last time that you taught anybody at Cleveland Metropolitan?
A. Well, I go over and give conferences.
Q. I see.
A. That's still on an ongoing basis.
Q. And when would the last time that you would have done that be, just roughly?
A. A year ago perhaps.
Q. And when you say you give them, you are talking now about residents?
A. Well, no, faculty and residents.
Q. And this would be on infectious disease?
A. Yes.
Q. Okay. And have you given them to any of the physicians that are involved in this particular case?
A. I doubt it.
Q. Why do you doubt it?
A. Because of the year. It was back in, what was it, '86?

Q. '86, '87.
A. '86, '87, no.
Q. You wouldn't have been giving conferences at that time?
A. I would have been but the people, the only one that I would have had contact with would have been the infectious disease people.
Q. Yes. That's what I mean.
A. Yes. Well, I have ongoing contact with them all the time.
Q. Would that be true of the residents in this case, too, Dr. -- testing my memory here, Drs. --
A. Blinkhorn.
Q. Yes.
A. I know Dr. Blinkhorn, of course.
Q. How do you know Dr. Blinkhorn?
A. Because he is part of the infectious disease community.
Q. Two of you belong to the same societies?
A. No. I don't know what he belongs to but he is part of the Cleveland infectious disease community and we are a group that knows each other, gets together for conferences and things of that nature.

Q. Okay. Did the two of you discuss this case before your getting involved in it?
A. No.
Q. How about since you have been involved in it?
A. No.
Q. All right. And the other doctor --
MR. MELLINO: Bender-Persaud.
THE WITNESS: She is not infectious disease, is she?
MR. MELLINO: Yes.
THE WITNESS: Then I don't know her.
Q. How about Dr. Matejczyk, the orthopedic surgeon?
A. As far as I know, I have never met.
Q. Okay. Is that your file in front of you, doctor?
A. Yes.
Q. Okay. Can I take a look at it, please?
A. Yes.
Q. Has anything been taken out of here before your coming here today?
A. What do you mean?
Q. Well, letters?
A. This is the file.
MR. ALLISON: I think the only

thing that would not be in that file is the copies of the depositions and the medical records which I sent to Dr. Lerner which are reflected in the correspondence from me to him.

Q. Okay. And where would those be?

MR. ALLISON: In his office.

Q. All right. Here in the building?

A. I am not sure if they are.

MR. ALLISON: I'm sorry. In the office or at home?

MR. KAMPINSKI: Why don't you let the doctor answer?

A. I don't know whether the records are here or at home.

Q. Did you make notes on any of the depositions or the records?

A. Originally, yes.

Q. All right. Before we leave here today, can you check to see if they are here in the hospital?

A. I don't have them any longer.

Q. What would you have done with them?

A. After I dictated my letter I would have discarded them with the exception of one sheet.

Q. Okay.

A. Which summarizes the key points.
Q. All right. I didn't make myself clear. Did you make notes on the depositions?
A. No.
Q. Or the --
A. On the deposition, no.
Q. So whatever notes you made you would have discarded them once you dictated your report?
A. Right.
Q. And your report was dated -- it's in there. Okay. I'll find it. October 8, 1990.

Was that the only report you generated in this case?

A. Yes.
Q. There were none before and none subsequent?
A. No.
Q. All right. The letter from Mr. Allison indicates that he will have a copy of the deposition of Dr. Levine for you to review. Did you have a chance to review that?
A. Yes.
Q. All right. Before today?
A. Today, yes.
Q. Okay. Is there anything else that you reviewed after preparing your report but before today

other than the deposition of Dr. Levine?
A. No.
Q. All right. Doctor, the notes on the yellow legal sheet of paper, when did you prepare those, sir?
A. Whenever I summarized the case.
Q. That was initially. I mean this is not something you did before today, for example, I mean sat down today and wrote these out?
A. No. As I said, when I write my report and discard the notes that I write the report from, I usually summarize those things that I want to contain, that may not be stated in the report, but are key points to recall. Saves me the necessity to review records again.
Q. All right. If these are key points, and when I say these, let's refer to them as the legal sheet, why would they not be set forth in your report?
A. Because my report states my position, it doesn't necessarily entail all the reasons for my position.
Q. All right. Well, the reasons set forth on this yellow sheet of paper --
A. These aren't reasons.

Q. What are they?
A. They're details, they're data.
Q. Okay. Do these details support or detract from your opinion?
A. Well, they are obviously in support.
Q. Well, the fact that, for example, on the first admission, is that was or was not a suggestion of loosening of the prosthesis?
A. I'm giving the x-ray report.
Q. Yes.
A. No suggestion of loosening of prosthesis.
Q. All right. So that supports it then, correct?
A. (Indicating).
Q. You have to answer verbally.
A. Yes.
Q. Okay. What significance is there that there was bone cement interfaced but not involved on January 5th of '88?
A. You want to get into the issues? I mean let's get into the story.
Q. I'd like you to answer.
A. I mean this is all in relationship to the details of the case. I have reviewed the case, there are medical facts and there's a sequence of events that support the position I have taken

in the letter.

Q. I understand. These materials are not --

A. If you want me to elaborate on these statements I'll elaborate them extensively, I will not answer single questions about them because this is a sequence, a flow of medical information that represents the facts in the case and my opinion about it.

Q. Doctor, you just told me that -- why don't you make this Plaintiff's 1.

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(Thereupon, Plaintiff's Exhibit 1, notes, were mark'd for purposes of identification.)

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Q. All right. Doctor, I have marked as Exhibit 1 the yellow piece of paper that you wrote down details. And when I asked you before you indicated that these details were not supportive of the conclusions set forth in your report, they were just details that you wrote down?

A. That's not what I said. That is not what I said and I resent your twisting the words here and that's why I'm very annoyed at what you're doing.

You're trying to trick me here and I don't like that. I know exactly what I'm here for and what I want to say and I will not say things out of context, I'll not say them the way you want me to say them. I'll say them the way I want to say them.

Q. Are you done?

A. Yes.

Q. You want to answer my question now?

A. What is your question?

Q. My question is the finding set forth on Plaintiff's Exhibit 1 where it says bone cement interface not involved, of what significance, sir, is that as it relates to your opinion?

A. I'd like to have my letter.

Q. Sure.

A. Paragraph two states as follows: This gentleman was first admitted on 11-13-87 and treated for a superficial wound infection of the right knee. Appropriate studies to rule out concurrent infection of the right total knee prosthesis were performed. He was discharged shortly after completing a 14 day course of I.V. Vancomycin.

He was next seen in an ambulatory setting on 12-22-87 for debridement and closure of the

right knee wound.

The tissue submitted to pathology at that time revealed no evidence of acute infection or active vasculitis but rheumatoid nodule formation was noted.

Next paragraph, patient was next admitted to the hospital on 1-3-88 with acute staphylococcal septicemia and multiple foci of metastatic infection including meningitis, endocarditis and bilateral septic knee effusions.

Prompt and appropriate medical and surgical therapy was forthcoming and the patient ultimately recovered and was transferred for further rehabilitation to Highland View Hospital on 1-28-88.

The expert witness that you have employed suggests that the total right knee was the site of infection at the time of the first admission and the cause for the widespread infection at the second, at the time of the second admission.

And the point that I'm bringing out here is that there was no evidence on the readmission to the hospital that the wound sutured on 12-23-87

had broken down or failed to heal. That biopsy showed a rheumatoid nodule and no acute, and I underlined acute, changes histologically despite the positive culture.

Q. Is that why you put down bone cement interface not involved? I mean that was my only question, sir.

A. That's simply additional supporting evidence that there was no infection inside that knee for the eight to nine weeks that your expert claimed that there was infection in that knee.

Q. Okay. And if there would have been infection, you would have expected then for there to have been involvement of the bone cement?

A. Well, you are claiming that this knee was infected from the beginning of November, this is roughly nine weeks or so, and for this to have been the site of a staphylococcal infection for that period of time with absolutely no loosening of the knee prosthesis and no involvement of the bone cement interface is strong evidence to suggest that your position is incorrect.

Q. When you say there's no evidence that the wound suture on December 23rd had broken down or failed to heal, when you say no evidence, do you

mean that none was provided to you, that you saw none in the medical records?

A. Those --

Q. Let me finish my question. That you saw on this in the deposition, that you have just seen nothing that would support that proposition?

A. These are excellent medical records. There's excellent documentation of everything that went on. There's a description a week after the wound was sutured by whoever saw the individual in the clinic that the wound was in excellent shape. At the time the patient was readmitted a week or so later to the hospital, there's no description of that particular site showing any signs of breakdown.

Q. Okay. So it was then not done based on the medical records?

A. Yes.

Q. The biopsy that you referred to showing a rheumatoid nodule and no acute changes histologically despite the culture. I don't --

A. Yes.

Q. I don't want to paraphrase. I'm trying to read it exactly as you wrote it. Was there any culture from that biopsy?

A. It says there was a culture.
Q. There was. And what was the culture?
A. The surface culture grew MRSA.
Q. That's --
A. Methicillin Resistant Staph Aureus.
Q. I see. So would that support the finding that there was no infection or detract from that finding?
A. Well, taken together with the histology, the microscopic appearance of the tissue itself, it suggests that that wound was colonized but not infected.
Q. Well, what is the difference between colonization and infection?
A. Colonization is the presence of bacteria simply growing on the surface of an area and infection is an interaction between the tissue and the organism.
Q. Could the specimen itself have been cultured?
A. It's possible to culture the specimen, yes.
Q. Was that done?
A. No.
Q. Why not?
MR. ALLISON: Objection.
A. I have no idea. I wasn't there.

Q. Should it have been done?
A. In light of what we know now, no, it wasn't necessary.
Q. Can it still be done?
A. At this point in time?
Q. Yes.
A. No.
Q. Why not?
A. There's certain things that can't be done.
Q. Okay. But why?
A. Huh?
Q. Why?
A. The specimen's no longer in a position to be cultured.
Q. How do you know?
A. Because it was fixed in appropriate fixing tissue in order to have a histologic preparation made of it and that kills any opportunity for bacteria to grow.
Q. In formaldehyde?
A. Whatever was used to fix it.
Q. Well, if one were concerned with whether or not an infection were colonizing or I'm sorry, whether or not the staph were colonizing or a deep infection, would one want to do a culture

on the tissue that was excised?
A. If it was necessary to do so, yes.
Q. How do you determine if it's necessary, doctor?
A. By the appearance and the circumstances in an individual case. A culture was sent from the area before it was excised.
Q. All right. And that culture was positive?
A. The surface culture was positive.
Q. Well, so that the evidence you get back from the culture indicates that there is an infection present, correct?
A. No.
Q. Or that there's staph present?
A. That's exactly right. That's all that it indicates is that there's staphylococci on the surface of the lesion.
Q. That doesn't tell you anything then about what is below the surface?
A. What is below the surface is below the surface and you find out what is below the surface by submitting the specimen of tissue to the microbiology laboratory, to the pathology laboratory and examining it under the microscope which was done here.
Q. Well, if you don't ask for a culture on that

specimen, how do you know whether or not the staph is in the infection or below the surface or not?

A. Histology tells you that.

Q. Histology means what?

A. The microscopic appearance of the tissue.

Q. And you can tell whether or not there is an infection or not?

A. I can tell from the report here that there was no infection in that tissue.

Q. How about within the, within the prosthesis, how can you tell whether or not the infection had seeded in the prosthesis on December 23rd?

A. There was no studies done of the prosthesis on the 23rd.

Q. So you can't tell?

A. I can't tell from anything that was done on the 23rd. I can tell from other data in the records.

Q. Why did he return on December 22nd?

MR. ALLISON: If you know, doctor.

THE WITNESS: Pardon?

MR. ALLISON: If you know, doctor.

MR. KAMPINSKI: All my questions to the doctor are if he knows. If he doesn't

know he'll tell me he doesn't know.

A. I assume this was a follow-up visit.

Q. And what was the reason for her having removed tissue on that day?

A. It was a further attempt to close the wound.

Q. Meaning the initial attempt had not been successful?

A. An attempt just before discharge had apparently not succeeded.

Q. And do you know why it hadn't succeeded?

A. I do.

Q. Why?

A. Because there was a rheumatoid nodule at the area and that's the reason that the lesion wouldn't heal up.

Q. What is a rheumatoid nodule?

A. It's an area of inflammation related to rheumatoid arthritis.

Q. And was that area present when he was discharged after his November 13th admission?

A. Presumably, yes.

Q. And why wasn't something done about it then?

A. An attempt was made to close the wound with a suture and see what happens. It didn't hold so the next time they attempted to close it they

excised the inflammatory tissue.
Q. Is there --
A. We don't excise every tissue specimen that we attempt to close when sealing a wound.
Q. Was there documentation of this rheumatoid nodule being present at the time he was discharged?
A. There was no tissue sampled at that time.
Q. Why not?
A. Pardon?
Q. Why not?
A. I just told you why not. You don't biopsy every tissue specimen of a wound that you're suturing closed.
Q. When do you do a Gallium scan?
A. When do you do a Gallium scan?
Q. Yes, sir.
A. When it's appropriate.
Q. When's that?
A. Whenever you are looking for some information that the Gallium scan can provide you.
Q. What can it provide you?
A. Information.
Q. What information?
A. Whatever information you are looking for.

Q. I mean are you being intentionally obtuse? I mean don't you want to answer my question?
A. I'm not being obtuse. I'm answering specifically your question and when I get a specific question about the Gallium --
Q. I asked you a specific question. I asked you what information it can provide you. You answer me nonsensically by saying whatever answer you are looking for. Is that a responsive answer?
A. Yes, it's a responsive answer because you are not asking me a question.
Q. What information can the Gallium scan provide you, question mark?
A. In what setting?
Q. In the setting of a potential infected knee?
A. Okay. What is the information that you're looking for?
Q. You're the doctor, you tell me.
A. No, you are asking me a question.
Q. Please, sir. And I'm trying to get an answer from you as a physician.
A. You are not asking me a question that I can respond to. When you ask me a question that I can respond to in relationship to this case, I will be happy to answer a question.

MR. ALLISON: Is your question, Chuck, what information would there have been with regard to Mr. Cates' situation? Maybe that would help.

MR. KAMPINSKI: No.

Q. First I'd like to know the parameters of when a physician would order a Gallium scan, what information you'd be looking for. I don't understand why you don't want to answer that.

A. I have answered it.

Q. Have you ever ordered a Gallium scan?

A. Yes, of course.

Q. What is it?

A. What is what?

Q. A Gallium scan?

A. A Gallium scan is the injection of nuclear material into the bloodstream followed by at an appropriate interval a counting machine over a specific tissue to indicate whether or not there's uptake of the nuclear material in that area.

Q. And if there is uptake, what does that tell you about that area?

A. That there's inflammation.

Q. Okay. Potentially infection?

A. There's inflammation.
Q. Well, can that inflammation be potentially infection?
A. One of the causes of inflammation is infection.
Q. Okay. Do they have the capability or did they have in 1987 the capability to do a Gallium scan at Metro?
A. I'm sure they did.
Q. Is that one of the tests you use as an infectious disease specialist to ascertain whether or not an infection exists in someone who has prostheses where you suspect there may be infection?
A. Now, when you use the word prostheses I'm going to answer quite specifically that Gallium scans in general are not of much help in differentiating various types of infection in association with prostheses.
Q. Okay. Let's eliminate the requirement of a prostheses then.
A. Okay.
Q. In an individual who you suspect as having an infection, is that one of the times where you might use a Gallium scan?
A. The value of a Gallium scan is in a highly

selected group of patients where the presence of an abscess or an inflammatory process is suspected but cannot be pinpointed. That's one area. You go looking blindly throughout the body for some inflammation that you suspect that you can't pinpoint geographically.

The other instance when a Gallium scan or similar nuclear studies are indicated, is when you are trying to determine in a quantitative fashion whether there's more inflammation present in a given location than you are clinically aware of.

Q. Okay. So, for example, if you knew there was some inflammation, you didn't know the extent of it and you were concerned about that, that might be a time when you would use a Gallium scan?

A. Exactly.

Q. Okay. And your answer, and please understand, I don't really want to paraphrase you, your answer presupposes that you can't clinically determine that, correct, and I think you said that?

A. Yes.

Q. Okay. Is there, or are there books, literature, that delineate the type of treatment by antibiotic of an infection such as Mr. Cates

had?
A. Which infection are you talking about?
Q. The infection that he had on November 13, 1987.
A. You are talking about the superficial infection that the doctors were treating him for?
Q. Well, did he have a superficial infection on November 13?
A. That's what they -- that's what they concluded after they did appropriate studies.
Q. Okay. I'll get back to this question in a second. When you say appropriate studies, I assume you are referring to the aspirate?
A. Yes.
Q. Any other studies?
A. Well, they did a variety of studies. They got cultures from his blood and from his nasopharynx and from the wound and they did laboratory counts and they got x-rays and they did a whole variety of things.
Q. Well, some of the laboratory counts didn't cause you to conclude that this was or cause them to conclude that this was a superficial wound, did they?
A. Well, in the aggregate that was their conclusion. There were signs of inflammation

around the knee, in fact, around both knees when he came in.

Q. What about the sed. rate?

A. It was elevated.

Q. And what was the reason for an elevation, sedimentation rate?

A. We're going to get into trouble again.

Q. I hope not.

A. Inflammation.

Q. Which could be as a result of infection?

A. That's one of the causes of inflammation.

Q. Is the extent of the increase in the sed. rate of assistance to you as a physician in determining whether or not you have a superficial wound or a deep infection?

A. If there is no other reason for the sed. rate to be abnormal, than the extent of the elevation can be useful.

Q. Okay. Useful in telling you that it's one versus the other?

A. No, useful in telling you in a quantitative fashion how much inflammation you have.

Q. All right. Would it make you more suspicious then the higher it was of a deep infection as opposed to a superficial?

A. If I saw very little evidence of inflammation on the surface of the wound and the sedimentation rate was spectacularly elevated I would suspect there's a lot going on deeper than I could appreciate.
Q. What do you consider spectacularly elevated?
A. Over 75, 80, in the ranges, close to a hundred.
Q. And you just told me earlier, I thought, that they found that there was not a great deal of evidence of infection, superficially, when he was discharged, correct?
A. No.
Q. I think you said it looked excellent?
A. No. When he was -- I said, I used the word excellent specifically in relationship to the follow-up visit on 12-30 in the clinic.
Q. How did it look when he was discharged?
A. Offhand, I don't recall at this point.
Q. If you need to look at the record go ahead.
A. This was a day or so after the wound had been sutured.
Q. Why don't you take a look at the record?
A. There was some drainage.
Q. I beg your pardon?
A. There apparently was some drainage at that

point.
Q. Drainage of what, pus?
A. No, there was no pus.
Q. What does pus tell you?
A. Pus tells you that you have destruction of tissue by an infectious process.
Q. And do you need to be a physician to be able to determine whether there's pus coming out of a wound or can an average person tell that?
A. There's some situations in which nonphysicians can recognize pus. There are some situations in which that which appears to be pus is not really pus.
Q. If Mr. Cates had a deep knee infection as opposed to a surface infection, was his treatment appropriate in your opinion?
MR. ALLISON: At what point in time, sir?
MR. KAMPINSKI: Between November and January, November of '87 and January of '88.
A. If he had a deep knee infection.
Q. Yes, sir.
A. Then the treatment he got was not appropriate.
Q. Okay.

A. In fact, I stated that somewhere. Maybe I just told Mr. Allison.
Q. I don't see that in your --
A. Okay. It wasn't in the letter.
Q. Okay. So you would agree, then, the issue as it relates to the liability as to the physicians here is whether or not it was a superficial infection or a deep knee infection?
A. Yes.
MR. ALLISON: Objection.
MR. SEIBEL: Objection.
A. Absolutely.
Q. Okay. Why did he return to see Dr. Matejczyk on December 30th?
MR. ALLISON: If you know the answer to that question.
A. I assume it was a follow-up visit, scheduled follow-up visit.
Q. Could you tell me what she observed at that time?
A. She observed that the wound apparently had healed.
Q. Could you point that out in her records, if the records are here?
A. Wound check excellent. Path report, rheumatoid

nodule, exclamation mark. No treatment with antibiotics per I.D. if wound fine.

This is written on a laboratory report of the result of the culture from the previous week.

Q. Do you know why that's not in her medical record?

MR. ALLISON: Objection.

MR. SEIBEL: Objection. You know it is, Chuck.

MR. KAMPINSKI: It is?

MR. SEIBEL: Yes.

MR. KAMPINSKI: Would you point that out to me?

MR. SEIBEL: Point what out? You mean in Dr. Matejczyk's chart?

MR. KAMPINSKI: Sure.

MR. SEIBEL: You were given her original chart in her deposition. It's right in there. The original report is right there.

MR. ALLISON: I believe that's why this was marked Defendant's 2 from Metro on 10-3.

MR. SEIBEL: You had it marked as

an original exhibit in Dr. Matejczyk's deposition.

MR. KAMPINSKI: You are saying there's a note from this?

MR. SEIBEL: That note with that notation is in the original chart.

MR. KAMPINSKI: Mr. Seibel, if you listen to my question you see we're not at odds here.

MR. SEIBEL: You are asking the doctor why it's not in her chart and I'm just telling you it was.

Q. Do you know why her writing that's set forth on the lab report of presumably her findings of a December 30th visit are not set forth in her office records as well?

MR. ALLISON: Objection.

MR. SEIBEL: Objection.

A. I have no way of knowing this.

Q. In these excellent medical records that you referred to I assume you saw where various physicians did, in fact, describe this as a deep knee infection?

A. At what point in time are you referring to?

Q. Well, both November 13th and December 5th.

A. December 5th?
Q. Yes, sir. I'm sorry, January 5th?
A. Well, those are two completely separate circumstances. December 5th the knees were --
Q. You mean January?
A. January, on January 5th both knees were opened and drained and pus was present.
Q. How about November 13th?
A. On November 13th there was no evidence that the knee was infected and an aspiration of that knee supports that position.
Q. All right. So whoever put that down was wrong then, is that correct?
A. What they put down and why they put it down at the beginning of a hospitalization --

MR. ALLISON: You are speaking of November the 13th, doctor?

MR. KAMPINSKI: Yes.

A. I'm talking about November the 13th, it may have been appropriate to the circumstances and the information they had at a specific point in time before all the necessary information had been gathered.
Q. Well, is one aspirate sufficient for you as a physician to rule out a deep knee infection?

A. If the rest of the clinical picture is appropriate and supportive of the results of that, of course it is.
Q. Okay. And when you say rest of the clinical picture and results, I mean we have already discussed the sedimentation rate?
A. If this had not responded to intravenous antibiotics that were given with the resolution of the soft tissue inflammation and the disappearance of the effusions, anything unusual about the response to what they were treating this man for, which was a superficial inflammatory process, if that had not responded to antibiotic, then one might have considered reaspirating the knee at a different location in order to try and explain why there was not a response to the antibiotic.
Q. Okay. When you say, hadn't responded, I mean the sed. rate didn't go down, it actually went up?
A. The sed. rate in this case is of no value whatsoever. The man has rheumatoid arthritis. Patients with rheumatoid arthritis have elevated sed. rates that could not fluctuate in relationship to secondary infection. There's a

background factor that you simply can't escape in this case.

Q. So that if we looked at another hospitalization of his we could expect to see the sed. rate around 75 as well?

A. Depending on what the activity of his rheumatoid arthritis was.

Q. What was the activity of his rheumatoid arthritis in November?

A. He was complaining a great deal of joint pains elsewhere besides his knee. So I assume it was active.

Q. The response that you're saying was favorable, when you give somebody antibiotics for an infection whether it's superficial or whether it's deep, you would expect some response, would you not, you would expect to see the antibiotics hopefully working, correct?

A. How do you measure that they are working?

Q. How do you measure they're working? You said you don't look at the sed. rate.

A. That's not what I said.

Q. You look at the sed. rate in this case?

A. Please, don't misquote me. I really don't like what you're trying to do.

Q. You said the sed. rates are of no significance in this case.
A. You are trying to trip me up by saying these things quickly and contradict myself.
Q. You know, doctor, I'm not smart enough to trip you up.
A. Stop trying.
Q. Nor am I trying to. You just told me the sed. rate was of no significance in this case.
A. I did not tell you that.
Q. What significance was it then?
A. I said that in the presence of active rheumatoid arthritis the sedimentation rate is not a parameter by which you can measure a response.
Q. Okay. And you just told me he had active rheumatoid arthritis?
A. It would appear that he had active rheumatoid arthritis at that point in time.
Q. So what significance did it have in this case, any?
A. It's not something that you can use as a monitor of a response to infection in the treatment of it.
Q. Okay. In the absence of using that, okay, what is it that you would, you would look at to

determine the response to the antibiotic?
A. You would look at the fever, the white count, the inflammatory process that you can see in front of you, the swelling, the redness, the tenderness, the erythema.
Q. Okay.
A. The amount of pain.
Q. All right. Anything else?
A. Those are the main things.
Q. All right. So basically other than the white count and the fever, these would all be clinical symptoms, correct?
A. Both objective and subjective, what the patient tells you and what you can see.
Q. Okay. The fever and white count are laboratory data that you can determine, correct?
A. Yes.
Q. Could you tell me -- well, all right, when you say both subjective and objective, it's then important to know what the patient says?
A. Correct.
Q. What did the patient say with respect to his complaints when he went in on December 22nd?
MR. ALLISON: If you'd like to refer to the records, doctor.

A. What did he say on the 22nd?
Q. Yes, sir.
A. I'd be happy to look this up.
MR. ALLISON: On the 22nd you said, Chuck?
MR. KAMPINSKI: That's what I said.
A. 53 -- we're talking about. Wait a minute. This is --
Q. What page are you referring to, please?
MR. ALLISON: He is, number one, looking at my notes and I am just referring him to the notes that we have of the 12-22-87 outpatient procedure which I believe is what you were concerned with. If you'd like to show him yours, that's fine.
MR. KAMPINSKI: He can look at anything he wants, it's just that I can't correspond if yours doesn't have the page numbers.
MR. ALLISON: I have no page number on mine.
MR. KAMPINSKI: Is it all right if I look along with him?

MR. ALLISON: Let me look since those are mine.

Why don't you show him yours. I have written all over mine.

MR. KAMPINSKI: Well, why don't you look at yours and tell me what it says. I don't want to see your writing and quite frankly I may not have the 22nd there so why don't you look at that one.

A. Would you read the question to me again, please.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. I don't see any statement on these pages indicating that the patient expressed any specific complaints.

Q. Who did the aspirate when he was in the hospital in November?

MR. ALLISON: If you recall, doctor. Please feel free to refer to the records.

A. I have to find out.

Q. I think it's on the November 17th entry,

doctor.

A. Okay.

Q. It actually refers to having been done on the 13th.

A. Here we go. Right knee aspirate under -- this is on the admitting note on 11-13. Right -- this is after the neurological exam.

Right knee aspirate under sterile conditions. Gram stain negative for organisms. Meaning white cells, and then later on the results of that were indicated and there's an arrow with a signature, or there is an arrow here with a signature. I assume it's there and so whenever that individual is there that apparently did the aspirate.

Q. Is that a signature or does that say no growth?

A. I don't know. I can't read it.

Q. Okay. The signature of the note is by S. Meyer?

A. Okay.

Q. Do you know who S. Meyer is?

A. No.

Q. Do you know what level of experience he was?

A. No.

Q. But would you have, I take it or do you assume that he did the aspirate apparently?

MR. ALLISON: Objection.

A. I have no reason to doubt it.

Q. Okay. Was there purulent drainage throughout his hospitalization in November?

A. Throughout the entire two weeks?

Q. Yes, sir.

A. No.

Q. All right. How about the first week?

A. I'd have to look at the notes for each day.

MR. ALLISON: Please do, doctor.

A. All right. Let's see on the 14th. Dr. Bender's note doesn't describe any drainage. Can't read the note on the next page. It's poorly reproduced so I don't know what that says. But there's one at 5 p.m. on the 14th, small amount of serosanguineous --

Q. What is that?

A. Serosanguineous means a mixture of a little bit of blood with some serum in it.

Q. Okay. Is that evidence of an infection or not?

A. It's just an evidence of drainage.

Q. Well, serous is what?

A. Serous refers to serum.

Q. Okay. What kind of serum?

A. Well, most tissue fluids from the body contain

proteins and are an ultrafiltrate of the liquid phase of the blood if you will and so the extracellular fluid with a high protein content is a reflection of that serum and most tissue fluid is called serous when it is just an ultrafiltrate of serum.

Q. Is that evidence of infection?

A. No. That's evidence of tissue fluid.

Q. All right. And would you expect that in the presence of infection?

A. Serum and serous drainage is a reflection of tissue fluid. If you have a defect in the skin, and until that defect is repaired with certain activities or motions or traumas, the body is repairative process as part and parcel of that process, a serum fluid will be extruded or appear on the surface until it organizes into a protective barrier that is part of the healing process.

Q. Okay. And is the color of it significant then or does that incorporate color when you say serous?

A. When you say serous you generally mean it has a yellowish color that is characteristic of a normal serous discharge.

Q. So if you wanted to reflect an abnormal discharge, how would you, how would you put that down?
A. Seropurulent, serosanguineous.
Q. So the serosanguineous you refer to, that is the serum with blood interspersed?
A. With apparently some blood cells to give it a reddish tinge.
Q. That would indicate presence of infection?
A. No. That again can be part of the reparative process, tissues that are healing by small fragile blood vessels growing in to provide the nourishment to the healing process and these are easily disrupted and introduce red cells into the area.
Q. Okay. Well then how would you describe drainage that would be reflective of infection, purulent?
A. Purulent, seropurulent.
Q. Okay. Now, let me ask you this, doctor: If you had purulent drainage at some point in time, would that be an indication of a deep knee infection?
A. Not necessarily.
Q. All right. But that would be evidence of that or something that might concern you?

A. No. It would indicate that the tissue from which that purulent material emerged contained pus. That's all that it would tell you. It wouldn't tell you what part of the tissue, how deep, how superficial. It wouldn't tell you anything else.

Q. So all the descriptions of the drainage didn't assist you then?

A. They did assist me. They tell me that there was no additional pus coming out of this wound which was slow to heal. And we know why it didn't heal. It had a rheumatoid nodule smack in the middle of it.

Q. Could you show me where they indicate it is a rheumatoid nodule present at the time of his discharge?

A. They didn't indicate it at the time of his discharge because they didn't biopsy it at the time of his discharge, but they biopsied it a week later and it contained a rheumatoid nodule. And after they excised the nodule and sutured it closed it healed.

Q. I'm sorry, it healed?

A. Yes.

Q. When did it heal?

A. Subsequent to the procedure on the 23rd. 22nd. 23rd.
Q. How did his right knee become infected?
A. At what point in time?
Q. Well, when he came back in January.
MR. ALLISON: You are talking about within the knee joint itself?
Q. That's exactly what I'm talking about.
MR. ALLISON: Okay. Sorry.
A. It became infected as a result of a bloodstream infection.
Q. And how did his bloodstream become infected?
A. Start of stapylococci gaining entry into it from some location in his body.
Q. What location?
A. Anybody's guess.
Q. So you don't have an opinion then as to where it came from?
A. Yes. I just gave you my opinion. I told you it came from a bloodstream infection from some entry into the skin site in this particular patient.
Q. Okay. I didn't make myself clear. You don't have an opinion as to where it gained entry then into the bloodstream?

A. That is not what I -- there's no way to tell that.

Q. Of course, if, in fact, it was a deep knee infection in the prosthesis, that wouldn't give you an adequate explanation for where it entered the bloodstream, would it not?

MR. ALLISON: Objection.

MR. SEIBEL: Objection.

A. Well, if the knee had been the source of this infection, there's no way that the wound would have healed when it was sutured.

You are claiming it was a sinus tract, representing deep knee infection, it was sutured and it healed without any antibiotic whatsoever being given. There are things that are absolutes and there are things that are relative, and there's no way that a sinus tract representing a deep methicillin resistant staphylococcal infection would be excised and then sutured and heal over without some antibiotic being given.

Q. Sure, otherwise it would be red, it would be swollen, it would be pusy?

A. It would just break down. It wouldn't heal at all.

Q. Getting back to my question, if, in fact, it was a deep knee infection that would be an adequate explanation for where it got into the bloodstream from?

MR. ALLISON: Objection.

MR. SEIBEL: Objection.

A. That could be a source of bloodstream infection.

Q. And by the way, a prostheses is a foreign body in the body, correct?

A. Correct.

Q. And that certainly is a primary site for hosting a bacteria such as MRSA, correct?

A. Yes.

Q. And you would suspect that as an infectious disease physician, would you not?

A. It's always a point of suspicion.

Q. I asked you earlier, and we got away from the subject, if there is any publications or books that you're aware of that indicate how long one would treat a deep knee infection with antibiotics for this kind of infection?

A. Well, you wouldn't treat it, you would take out the prosthesis.

Q. All right. And would you also provide antibiotics in addition to --

A. Yes.
Q. And how long would you do that for?
A. Well, once you remove -- once you get the acute infectious problem under control with antibiotics, you would remove the prosthesis and then treat for many weeks to eliminate the infection before replacing it with a new prosthesis.
Q. Okay. And that would be I.V. or --
A. Intravenous, yes.
Q. And followed by oral?
A. If it were necessary.
Q. The absence of insurance coverage for an individual would not be an appropriate basis for not admitting someone to a hospital?
MR. ALLISON: Objection.
Q. Would you agree with that?
A. As a generic statement?
Q. Yes, sir.
A. Of course I would agree with it.
Q. Do you have any opinion as to what problems Mr. Cates had after January of '88 that were caused by the infection that he presented with at that time?
A. No.

Q. Haven't looked at any subsequent records?
A. Not in any detail.
Q. All right. You disagree with Dr. Levine's conclusion that he had a deep knee infection, correct?
A. Yes.
Q. Not to beat a dead horse, but if, in fact, I did you would then agree with his proposed course of treatment, which I think is basically identical to what you have indicated here today?
A. Yes.
Q. Do you agree that the -- it is or the burden is on the physician to rule out a deep knee infection in an individual such as Mr. Cates in November of 1987, in terms of the way he presented?

MR. ALLISON: Objection.

A. Yes, I agree.
Q. Okay. Is there a potential problem with suturing an infected wound?
A. Potential problem for what?
Q. Well, I am not sure. In a situation where you may have a deep knee infection and you suture the opening to that?
A. As I explained before, the body has its own

wisdom. The reason that there's drainage when there's deep inflammation or infection is to get rid of things that the body doesn't want inside of it, and if you put a suture in the pathway of the body's attempt to relieve itself of an adverse condition, the body is going to react then, it's going to react in very quick order and that's exactly why I feel that in this particular case the evidence is overwhelming that erythesis is completely incorrect.

Now, in most cases we don't have the kind of evidence that we have here, and that's why I'm taking the strong stand that I'm taking.

Q. Have you testified before, doctor?

A. Yes.

Q. For plaintiffs and defendants?

A. Yes.

Q. How many times would you say percentage-wise you have testified for plaintiffs?

A. It used to be 50-50 but it's down about 35-40 for plaintiffs, that I review cases for plaintiffs.

Q. Percentage-wise how many times have you testified for the plaintiff versus the defendant, in a lawsuit?

A. Again, I would imagine it breaks down to the same percentage if it ultimately gets to that point.
Q. Okay. Do you have a list of cases that you have been involved in?
A. No.
Q. There's no way you can reconstruct that?
A. Yes, but I am not going to. I'll give you the name of lawyers if you want.
Q. Okay. Could you do that?
A. I will be happy to give you names of lawyers.
Q. Go ahead, shoot.
A. I will go to my files and give them to you.
Q. Okay. If you provide those to Mr. Allison, he can give them to us.
A. How far back do you want me to go?
Q. Five years.
A. Okay. You want both plaintiffs and defendants?
Q. Please. Have you testified for Arter Hadden before?
A. Yes.
Q. For Mr. Allison?
A. I don't remember.
MR. ALLISON: (Indicating).
A. I don't think so.

Q. Mr. Zellers?
A. Zellers, yes.
Q. How many times?
A. I don't know.

MR. KAMPINSKI: Okay. Tom, you would have the information on those cases, wouldn't you?

MR. ALLISON: I honestly don't know. You know, I have not ever utilized Dr. Lerner's expertise to review any case on behalf of defendant and Michael's no longer here as you know so I don't know what information might be available.

MR. KAMPINSKI: Okay. Whatever you have you will provide then?

MR. ALLISON: What is it that you would like to have?

MR. KAMPINSKI: Well, the names of the cases he has been involved in, the names of the attorneys. I mean the doctor's going to try to find --

MR. ALLISON: The doctor said he was going to give you, give me the names of the attorneys to give to you.

MR. KAMPINSKI: Right.

MR. ALLISON: Fine.

Q. Would you agree that if you have a staph infection of the sinus tract that that causes concern for the infection being deeper?

A. If you have a deep sinus tract, yes.

Q. Well, how can you determine whether you have got a deep sinus tract?

A. By studying it.

Q. How would you study it?

A. You can inject some die into it and take some x-rays.

Q. Gallium scan?

A. No, not Gallium scan.

Q. You wouldn't have to do that?

A. No. It's a waste of money.

Q. Okay. Was the positive culture on the 22nd something that in your opinion required any follow-up at all?

A. Yes, of course.

Q. What follow-up did it require?

A. An evaluation as to its significance.

Q. You mean right then and there?

A. I am not sure I know what you mean.

Q. All right. She got a culture on the 22nd?

A. She took a culture.

Q. Right. And it proved to be positive?
A. It was sent to the laboratory and processed and ultimately proved to be growing MRSA.
Q. All right. And is there a way that you can determine whether that's the same MRSA that he had in November?
A. No. Probably is but you can't.
Q. And when you say probably is, why is that?
A. Well, most of these people retain the same organism.
Q. Okay.
A. When they're colonized.
Q. All right. So what he had in November was probably the same thing he had December 23rd.

All right. When you say, I'm sorry, you said you analyze it afterwards or evaluate it afterwards?

A. Well, you take the result in the context of the case.
Q. When you say the context, you are talking about clinical context?
A. Yes.
Q. How it looked?
A. How the wound looked.
Q. So that you wouldn't necessarily have to have

any additional studies done other than just looking at the wound?

A. Depended how the wound would look. If the wound looks fine then that's the end of the problem. If the wound doesn't look fine then you might want to do additional study, rebiopsy, reculture, reevaluate.

Q. Is it appropriate for an infectious disease specialist without seeing a patient to indicate in the presence of a positive culture that no antibiotics need be initiated if, quote, "the wound looks fine," end quote?

A. One of the chief functions of an infectious disease specialist is to interpret the results of cultures for noninfectious disease specialists.

Q. Okay. So I don't quibble with what you just said.

A. It's my answer to your question.

Q. So that is appropriate then?

A. Yes.

Q. Okay. So that by being told the results of a positive culture on the phone, that's sufficient to tell you or to tell an infectious disease specialist that he can then leave it up to the

clinician in terms of the clinician's observations?

MR. ALLISON: Objection.

A. No. That's not what I said.

Q. Okay. Well then maybe you better say it so I understand it?

A. That's not an interpretation.

Q. Well, how do you interpret a positive culture as being something other than a positive culture?

A. Well, you interpret it in the context of the circumstances under which it was taken and its results.

Q. Who interpreted it in this case?

A. Both the orthopedics individual and Dr. -- whoever the I.D. fellow that was called.

Q. Who was that?

A. I don't know.

Q. Well, one of the things you did is I guess you read both depositions, correct?

MR. ALLISON: Which both depositions?

Q. Of the infectious disease fellows?

MR. ALLISON: Which one?

MR. KAMPINSKI: Gee, what did you provide him?

Q. I assume you read them all?
A. I read what was sent me.
Q. Dr. Battersby, Dr. Bender, right?
A. Okay.
Q. Were you provided with Dr. Blinkhorn's deposition?
A. Is it listed?
Q. Well, I don't know, doctor. I mean I haven't had a chance to study these.
MR. ALLISON: I believe he was, Chuck.
Q. I am not trying to play games with you. If you were, you were, if you weren't, you weren't.
MR. ALLISON: He was.
Q. Persaud, Blinkhorn, Battersby and Matejczyk?
A. Okay.
Q. Which of them were, or was the individual that Dr. Matejczyk spoke to?
A. I don't know.
Q. Isn't one of the things you teach residents is to put notes in the chart with respect to consults that they do, whether it be by phone or by own person, however they consult?
A. Making a notation for every phone call you get?
Q. Well, if you're consulting somebody about

whether to give or not give antibiotics in the face of a positive culture isn't that something that ought to be noted?

MR. ALLISON: Objection.

A. If you're performing a formal consultation which involves your examination of the patient, and specific input, then a note is appropriate. If you're responding to a phone call providing you with information and asking for your input as to follow-up based on that information and your expertise, the answer to that is we simply can not write a note every time we get a phone call asking for information.

Q. Okay. So this would be an informal consult?

A. It would be, whatever you want to label it, it would be.

Q. What would you label it?

A. Well, a consultation implies a specific isolated event. This is a phone call asking for information.

Q. Well, when you, as an infectious disease specialist give your opinion to an attending, I mean how do you call that anything other than a consult? I mean that's why you are being called, correct?

A. Because I could walk down the hall and somebody can button hole me and say let me ask you a question about a patient of mine and I will answer the question if it's a simple question and can be answered and is generic. If I decide that this is not a question that can be answered without seeing the patient or gathering more information --

Q. Okay.

A. -- then I turn it into a consult.

Q. All right. The inquiry that was made of somebody allegedly by Dr. Matejczyk, is that something that could have been answered in an informal basis such as walking down the hall or would that have required a further follow-up by the person being consulted?

MR. ALLISON: Objection.

A. There are several ways of doing this. You can increase the burden upon the patient and the economic system by having each consultant separately see the patient in follow-up and make a formal entry into the chart or you can work in concert the way doctors do and communicate with each other as to the results of an encounter, and in this instance as is true in so many

instances, one physician seeing a patient in the clinic called another physician and said this is the scenario, I have got a positive culture, I took out this wound, I sutured it, it shows a rheumatoid nodule, it's all healed up, what should I do about the culture. And the individual with his or her expertise said it is not necessary to do anything about it.

Q. And you agree with that?

A. 100 percent.

Q. Okay. Can you do Gram stains on an excised lesion?

A. You can do a Gram stain on anything you want.

Q. Okay. It wasn't done with the December 22nd --

A. There's no indication that it was.

Q. The physicians, the infectious disease physicians caring for Mr. Cates in the November hospitalization, were they all residents? Do you know?

MR. ALLISON: Objection.

A. At the time?

Q. Yes, sir.

A. I would have no way of knowing whether they had finished their fellowships. They would be fellows. The I.D. residents and fellows so some

could be, you now, rotating through as part of their internal medicine electives supervised by a fellow, a specific infectious disease fellow.

Q. Okay. Well, was Dr. Battersby a fellow at that time? Do you know?

A. I have no idea without checking the records.

Q. Dr. Myers? Do you know him?

A. Again, I know Blinkhorn. Blinkhorn was a fellow at that time, I'm pretty sure.

Q. And you don't know any of the others?

A. I may know them but I don't know them.

Q. Okay. Who were the attending infectious disease physicians at Metro?

A. At Metro?

Q. Yes, sir.

A. At that point in time?

Q. Yes, sir.

A. Dr. Walinski was there, Dr. Phil Spagnoto, Dr. Walt Tomford may have been there or he may have left to go to the Clinic at that time. There was another, there was another physician that makes infectious disease rounds there by the name of Dermot Frengley, F R E N G L E Y.

Q. Any others, sir?

A. There could have been others there that I don't

know about that were doing research.
Q. Did you see any of their names on this chart?
A. I don't recall offhand.
Q. Do any of your articles or books deal with the issues involved in this case, doctor? I mean are there any specific ones that you would say aha, I have written on this particular topic and that directly --
A. What topic are you speaking about?
Q. Any of the topics that we have discussed today, either the particular infection that we're talking about --
MR. ALLISON: Meaning the MRSA.
MR. KAMPINSKI: Yes.
A. MRSA --
Q. -- or staph, the treatment of that infection, how long one would keep an individual on antibiotics, how you determine a superficial versus a deep wound giving advice informally about a positive culture. I don't mean those to be exclusive, but -- I haven't had a chance to look at your CV, okay, and there's no way that I obviously have the knowledge that you have about what you have written, so if you believe that you have written something that impacts upon

these issues that are, that you believe were involved in this case, please let me know what those papers are and you can take a look at --

A. I don't have to.

Q. Here. Show him the CV.

A. Some of the papers would involve infected knee, prosthesis. Not necessarily with this particular organism. But in our reviews of streptococcal infections, for example, we would talk about infected prostheses.

In our reviews of endocarditis we would talk about methicillin resistant staph bacteria. Those would be the two categories of articles that might, you know, impact on some of the things we talked about.

Q. Okay. If you would indulge me then and tell me which particular articles you are referring to?

A. Okay. As I said, these types of cases would be mentioned in, let's see, reference 27, 29, 36, and 38. That's under the, let me give you the pages so you don't get confused. Those are on pages five and six.

Q. Okay. All right. Lastly, doctor, we're here on Tuesday, the 3rd. I have been noticed for your deposition for this Friday, I guess.

MR. ALLISON: That's correct.

Q. You are going to be out of town during the trial of this case?

A. Yes.

Q. And I would only ask that the information that you have indicated that you could provide me, that I be provided with that tomorrow.

MR. ALLISON: We'll get it to you as soon as we can.

Q. I mean otherwise it's going to be meaningless.

A. You mean the lawyer, the names of the lawyers? I can't do it tonight and I will do it tomorrow when I have the time.

Q. Okay. And you will tell Mr. Allison.

MR. KAMPINSKI: If you could just let Chris know tomorrow.

MR. ALLISON: That's correct.

MR. KAMPINSKI: That's all I have. Mr. Seibel might have some questions.

MR. SEIBEL: No questions.

MR. ALLISON: Doctor, you know you have the right to read and sign the transcript. I would suggest that you do not waive signature, that you read this transcript.

THE WITNESS: Okay.

MR. KAMPINSKI: The only other thing is if we could give the court reporter the two exhibits, 1 being the yellow page, 2 being the folder with the letters, if you can make copies, get it back to the doctor and get me a copy.

MR. ALLISON: Doctor, do you have any problem with them taking your original file, I mean the court reporter having your original file in this matter?

THE WITNESS: Yes. I'll send her copies.

MR. ALLISON: Okay. If that's acceptable there's no reason -- I mean you have seen what is in here, you have marked the one handwritten sheet as an exhibit, the rest are my correspondence to the doctor. I don't see why the doctor can't make copies of that.

MR. KAMPINSKI: Well, can we make them while we're here?

THE WITNESS: No.

MR. ALLISON: Would that be possible, doctor? Would there be any

problem if I take the original file and send you copies?

THE WITNESS: That's fine.

MR. ALLISON: I have not objected so far to Mr. Kampinski looking at my letters to the doctor but I do object to the fact that those are communications which really are not relevant to any of the issues in this case.

MR. KAMPINSKI: Okay. Very good.

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PHILLIP I. LERNER, M.D.

C E R T I F I C A T E

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

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named PHILLIP I. LERNER, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 __.

_____
Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 27, 1996