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

IN THE COURT OF COMMON PLEAS

Travis Cates, et al.,)
Plaintiffs,)Case No,
-vs-)**167,835**
Cleveland Metropolitan)
General Hospital, et al.,)
Defendants,)

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Deposition of PHILLIP LERNER, M.D., a witness herein, called by the Defendant, Cleveland Metropolitan General Hospital, as if upon direct examination under the statute, and taken before Luanne Protz, a Notary Public within and for the State of Ohio, pursuant to the agreement of counsel, and pursuant to the further stipulations of counsel herein contained, on Friday, the 6th day of September, 1991 at 3:30 o'clock P.M., at Mount Sinai Medical Center, the City of Cleveland, the County of Cuyahoga and the State of Ohio,

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APPEARANCES:

On behalf of the Plaintiffs:
Charles I. Kampinski, Esq.
Christopher Mellino, Esq.

On behalf of the Defendant,
Metropolitan General Hospital:
Arter & Hadden, by:
Thomas Allison, Esq.

On behalf of the Defendant,
Dr. Matejczyk:
Jacobson, Maynard, Tuschman
& Kalur, by:
Robert Seibel, Esq.

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P R O C E E D I N G S

PHILLIP LERNER, M.D., being of lawful age, having been first duly sworn according to law, deposes and says as follows:

DIRECT EXAMINATION OF PHILLIP LERNER, M.D.

BY MR. ALLISON:

Q Doctor, would you please state your full name and your professional address for the ladies and gentlemen of the jury?

A Phillip R. Lerner, Mount Sinai Medical Center, Cleveland, Ohio.

Q And what is your profession, Doctor?

A I am a specialist in infectious diseases.

Q At my request did you review certain medical records and other materials concerning the medical care and treatment of Travis Cates by Dr. Matejczyk and the physicians in the infectious disease service at Cleveland Metropolitan General Hospital?

A Yes, I did.

Q Have you reached certain opinions about the care and treatment provided to

Mr. Cates by the infectious disease physicians and fellows and residents, and the other personnel at Cleveland Metropolitan General Hospital from November 13th, 1987 through January 3rd of 1988?

A Yes, I have.

Q Doctor, do you hold all of these opinions to a reasonable degree of medical probability?

A Yes.

Q And are all the opinions that you will express here today, will those be to a seasonable degree of medical probability?

A Yes.

Q Now, before we get to your opinions, Doctor, I'd like you to just tell the jury a little about your qualifications. First, could you tell us about your educational background?

A I'm an undergraduate -- I went to what was then called Western Reserve University, Adelbert College, and, then, the medical school, which was then called

Western Reserve University School of Medicine, graduated in 1958, and, then, went for postgraduate studies to Boston, first the Beth Israel Hospital for two years, and, then, I trained and joined the staff of the New England Medical Center, also in Boston, affiliated with Tufts, for the following six years, and, then, I returned to Cleveland.

Q When did you return to Cleveland, Doctor?

A In 1966.

Q And, what -- what did you do when you returned to Cleveland?

A I was the chief of the infectious disease section at the VA Hospital.

Q Here in Cleveland?

A Here in Cleveland.

Q And how long did you hold that position?

A Seven years,

Q And, then, after your term as chief of infectious diseases at the VA Hospital, what did you do?

A I came across the street to this

institution, the Mt. Sinai, then called Hospital now called Medical Center.

Q Now, Doctor, have you been here at Mt. Sinai, then, ever since?

A Yes.

Q Have you held any teaching positions?

A I teach both here at the hospital and at the medical school.

Q And, could you just describe for us, briefly, the nature of your teaching responsibilities?

A This involves the teaching of residents in the hospital, both the medical and surgical, the teaching of medical students rotating from Reserve through our institution, and there are students also from other medical schools, and going over to the medical school, and teaching at the -- in the first two years at the medical school.

Q Do you hold any faculty positions with the medical school?

A Yes, I do.

Q And what position is that, Doctor?

A I'm a professor of medicine at the

medical school,
Q And when did you obtain that position?
A I was promoted to professor eight or nine years ago.
Q Are you licensed to practice medicine in Ohio, Doctor?
A Yes.
Q And do you have privileges at other hospitals besides Mt. Sinai?
A I have admitting privileges at University Hospitals as well, and I have courtesy or consulting privileges at a number of other institutions,
Q What does consulting privileges mean, Dr. Lerner?
A It means that, if some physician on the staff would like me to participate in the care of a patient in that institution on an irregular basis, on an occasional basis, that I'm permitted to do so.
Q Are you a member of any professional organizations?
A Yes.
Q And what might some of those be,

Doctor?
A Infectious Disease Society of America, American Society of Microbiology, Ohio Thoracic Society, American Federation for Clinical Research, several others. Offhand, I don't recall.
Q Have you published any articles in the medical literature?
A Yes.
Q About how many; do you recall?
A Somewhere in the range of three or four dozen original papers, case reports, and clinical and laboratory research, perhaps several dozen chapters in textbooks.
Q What -- basically, if you could describe for us the subject matter of your articles and book chapters, in a general sense.
A Most of my writings have been based on bacterial infections and treatment with antibiotics,
Q Doctor, what per cent of your professional time do you spend in the active clinical practice or teaching of

medicine?

A Somewhere around 85 to 90 per cent.

Q Is your practice limited to the specialty of infectious diseases?

A Pretty much so.

Q Is there something else you do as well as that,. then?

A Occasionally, I make rounds on the medical service, and, so, there is some internal medicine teaching at that point.

Q What is the specialty of infectious diseases, Dr. Lerner?

A It's the study, diagnosis and treatment of infections.

Q And, how long have you actually been engaged in this specialty of internal -- of infectious diseases?

A Since 1962 or '63.

Q Perhaps, if you could for us, just describe a typical day in your practice as a specialist in infectious diseases.

A My day begins at 8:00 in the morning with rounds on the floors with my sicker patients. At 9:00 o'clock, I break off and go down to the cafeteria where the

medical staff holds its morning report with the house staff, going over the overnight activities. That's held for an hour and, then, from 10:00 until noon, we make rounds again, seeing patients, going to the X-ray department and laboratories, checking out tests, examining patients, setting up new tests.

We, again, reconvene sometime in the early afternoon for additional rounds, and on certain days, there are conferences. On other days, there are laboratory conferences. And, a small percentage of my time is devoted to seeing patients, out-patients in the office.

Q Doctor, in addition to your practice of infectious diseases, do you also, from time to time, receive requests from attorneys to review cases like this case that is in litigation?

A Yes.

Q Approximately, if you could, tell us how many cases you've reviewed per -- in the last five years.

A Well, I don't keep track of this, and

every time I get asked, it's an approximation, but I receive somewhere around a dozen to a dozen and a half calls per year from lawyers who are seeking my expertise. Out of that number, I may review about a dozen cases, most of which are malpractice, but some are product liability.

Q Doctor, do you review cases for plaintiffs as well as defendants?

A Yes.

Q And, could you give us an approximation of what percentage of the cases might be for plaintiffs, and what per cent might be for defendants?

A A few years ago, it was around 50/50. I would estimate now it's a little less than that, probably 30, 40 per cent for plaintiffs, and the rest for defendants.

Q Doctor, why do you review cases?

A I feel very strongly that it's important that medical malpractice cases be settled on the basis of the medical facts and not on the basis of legal contortions.

Q Doctor, are you -- you were engaged in the full-time practice of infectious diseases in 1987.

A Yes.

Q And, you are familiar with the standard of care required of infectious disease physicians in 1987.

A Yes.

Q How does an infectious disease physician generally become involved in any patient's case?

A Most of the time, it's in response to a request from a physician to see a patient.

Q Is that a consultation?

A Yes.

Q Is that what they call that?

Now, when you are called as an infectious disease specialist by another physician to consult on a patient's condition, what professional service is it that you and other infectious disease specialists provide?

A In general, the expertise revolves around the question of diagnosis,

differential diagnosis, interpretation of culture results, access to specialized test material or techniques, and recommendations for therapy, which recommendations may include which antibiotic to use, the dosage of antibiotic and things of that nature.

Q Doctor, what is an infection?

A An infection is an encounter between a host and an organism. Now, an organism in layman's terms is a germ. It can be a virus or a bacteria or a fungus or a parasite, but it's an encounter between two living species, one of whom is trying to do something to the other.

Q As an infectious disease specialist, when you are called by another physician to -- to see a patient as a consultant, how do you determine whether that patient has an infection? Are there factors or things you consider or do, or how do you go about doing that as a specialist?

A Well, the encounter between the organism and the host can produce a variety of signs or symptoms. The

encounter may be completely silent and generate no abnormality, visible or demonstrable abnormality on the part of the host without some specialized tests, looking into the blood or something like that, for a marker for the encounter.

The encounter may result in a mild disease, a moderately severe disease, or something that's aggressive and life-threatening. The physical examination, evaluation of laboratory findings put together with the history of the patient, the type of patient and the evolution of the symptoms, forms the basis for the specialty.

Q What type of -- of laboratory evaluations would be involved, generally?

A The most important laboratory evaluations are smears; that is, taking a bit of the material, if there is some material available, and looking at it under a microscope with appropriate stains; cultures of the material, seeing if you can grow an organism or a bacteria.

There are other techniques for

identifying the presence of an organism without -- other than by growing it, and these would be specialized blood tests or examination of fluids in areas of the body where there normally is no fluid or no significant fluid.

Q If there was a possibility that an infection involved a joint, such as a knee joint, are there other procedures that are specific to determining whether there's an infection within a joint?

A Well, one would concentrate one's activities on the integrity of the joint, By physical examination and specialized X-ray studies, one would -- if fluid was available or material was available, one would examine that material by culture and smear techniques, analyze it.

Q How -- how would one obtain fluid from a joint for that type of laboratory analysis?

A Usually through an aspiration of a needle into a syringe. It may also be available at the time of an open operative procedure.

Q If you were able to obtain that type of a material, a fluid from a joint by aspiration, what are the various types of tests as an infectious disease specialist that you would want to do on that fluid to determine whether or not it had -- there was a presence of infection in the joint?

A You would send it to several different laboratories in the institution, one of which would count the number of cells and determine the proportions of cells present to see if you could quantitate the inflammatory response. You would send some material to the chemistry laboratory to measure for protein and sugar and other factors that would reflect inflammation. You would send some of the material to the microbiology laboratory and ask them to culture it.

Q Is there a test called a gram stain, Doctor?

A A gram stain is a relatively simple test in which you take some of the material you obtained, place it on a clean glass slide, fix it, dry it and stain it

with some readily available stains, and, then, examine it under the microscope.

Q Could you explain for us how these -- these various tests that you've just talked about aid you or any infectious disease specialist in determining whether or not there's an infection in a joint? Let's just start with the culture.

A Well, the culture, obviously, is a key test in determining whether or not someone is infected. If you obtain the growth of an organism from an area of the body where there are normally no bacteria, this is obviously a very strong point in favor of an infection. However, a report from a laboratory indicating that something is growing must be interpreted in light of the source of the specimen, because we are colonized with bacteria from the moment of birth throughout our entire lives, and there are organisms in -- in our bodies, on the surface of our body, and many of these are there permanently, and many of them are there only transiently, and sometimes these are

organisms that can cause a lot of trouble, but they're just sitting around in a colonizing form waiting for an opportunity, if the opportunity presents itself, to take advantage of the host. Therefore, there's a great deal of interpretation necessary in the results from the microbiology laboratory.

Q Okay. How about the cytology, Doctor, that you talked about determining the number of different, I think it was, white blood cells, and the different kinds of cells? How is that involved in aiding in the determination of whether or not there's an infection in a joint?

A When the body responds to any type of insult or injury, there is a response called inflammation. Inflammation is the marshalling of cell substances in the -- in the bloodstream to fight off the infection. The cells that are mobilized or marshalled are characteristically called forth in a specific pattern.

When there's an acute infection present, one will see mostly

polymorphonuclear leukocytes, These are the acute cells that respond to infection. The chronic cells of inflammation are macrophages and lymphocytes which are easily and readily distinguished under the microscope,

Q How about the total number of cells, Doctor? Is that an aid in determining whether there's an infection in the joint?

A Yes. The higher the number of cells, the more significant it is.

Q You talked about chemical laboratory tests. I think you mentioned protein and glucose or sugar. How are they of benefit in determining whether or not there's an infection?

A Again, as a measure of inflammation, and there are many types of inflammation, the level of the glucose in a -- in a fluid can point you in the direction of certain types of infection. The height of the protein elevation can likewise indicate a certain type of infection, as opposed to other types of infection.

Q On the basis of these types of tests

that we've just discussed, the culture, the cytology and the fluid analysis, if you had an infection within a joint, what -- what type of results would you expect to see from those tests?

A An acute infection or a chronic infection?

Q You -- let's talk about the acute infection first, and, then, we can talk about the chronic infection, if there's a difference.

A In an acute infection, one would expect to see a large number of white cells in the range of thousands, and most of those cells would be acute polymorphonuclear leukocytes, and we're talking in the range of 75, 80, 90 per cent, even 100 per cent polymorphonuclear leukocytes. The sugar or protein could be elevated or decreased, depending on the duration of the inflammatory process. And, in a chronic process, one tends to see higher protein levels, lower sugar levels, and lower cell count levels with a shift to what we call the right, rather

than the left, more chronic inflammatory cells than acute cells.

Q Doctor, are you familiar with a condition known as rheumatoid arthritis?

A Yes.

Q Have you ever treated patients with chronic rheumatoid arthritis?

A Many.

Q What is rheumatoid arthritis, just briefly for us?

A Rheumatoid arthritis is a chronic, very often disabling, inflammatory process that destroys joints, primarily, but is also involved in alterations and abnormalities in the soft tissues surrounding and supporting the joints.

Q Does the condition of rheumatoid arthritis have any effect on these tests that we've just discussed?

A It certainly does, because it is basically an inflammation, and we've been discussing the manifestations of infection, which is also an inflammation, and it may be very difficult to distinguish at certain stages of the

illness between the inflammation caused by rheumatoid arthritis and the inflammation caused by an infection that also happens to be present.

Q Doctor, in your practice experience, have you ever had occasion to treat a patient who had chronic rheumatoid arthritis and also had an infected superficial wound over a joint containing a prosthesis like a total knee arthroplasty?

MR. KAMPINSKI: Objection.

THE WITNESS: Yes.

BY MR. ALLISON:

Q From an infectious disease standpoint, is it -- is the possible involvement of a joint, when you have an infection over a joint in a patient with chronic rheumatoid arthritis and a total knee arthroplasty, is that something that should be considered by the infectious disease consultant?

A Always, yes.

Q When you're called as an infectious disease consultant by another physician,

for instance an orthopedic surgeon, to examine and treat a patient who has such a condition we've just described, a chronic rheumatoid arthritis with an infected superficial wound over a joint containing a prosthesis, after you were called in as a consultant, who becomes responsible for the care of that patient?

MR. KAMPINSKI: Objection.

THE WITNESS: You --

MR. KAMPINSKI: Just so there's no confusion, are you asking about his personal practice or in general?

MR. ALLISON: In general.

MR. KAMPINSKI: All right.

THE WITNESS: In general, when people are called in consultation, it is a joint effort on the part of the consulting and referring physician.

BY MR. ALLISON:

Q Doctor, you've reviewed certain medical records and other information concerning Mr. Cates and his treatment by the infectious disease physicians at Cleveland Metropolitan General Hospital in

November and December of 1987, and in January of 1988; is that correct?

A That's correct.

Q What records have you reviewed, Doctor?

A I reviewed the hospital records for the admission beginning November the 13th, 1987. I saw the record for the ambulatory surgery admission on, I believe it was, December the 22nd or 23rd, and, then, the record when the patient was readmitted on the 3rd of January, plus I reviewed several depositions.

Q Who asked you to review that information?

A You did.

Q And, did you know me before that time?

A No.

Q All right. Did you know any attorney at -- at my law firm, at Arter & Hadden, before that?

A Yes, I have had contact with other members of your firm.

Q How many, if you recall?

A I don't know, four or five.
Q Did you know, when I sent you the medical records and other information for review, that I represented Cleveland Metropolitan General Hospital and its infectious disease physicians and fellows and residents and other personnel?
A I believe you made me aware of that.
Q What was it that I asked you to do when I sent you that information, Dr. Lerner?
A To review the records in the case in question, and determine whether or not appropriate -- in my opinion appropriate medical and surgical care had been rendered.
Q Did the knowledge that the fact that I represented Cleveland Metropolitan General Hospital and its infectious disease physicians influence in any way your review of the materials in this case or the opinions that you formed?
A No.
Q Doctor, have you, or do you have any relationship with Cleveland Metropolitan

General Hospital?

A Yes, I do,

Q And, what is that relationship?

A Well, when it was still a city hospital, I was a medical student there, when it still rained in through the roof, and, so, I have an emotional attachment to the institution. But, that's about the extent of it, except that when I first returned to Cleveland in the '60's, I did make rounds on the infectious disease pavilion for a couple of years; I believe it was called the Toomey Pavilion, until things got too busy, and I was no longer able to do so, I do go over there for conferences from time to time, as I do for all hospitals in the area.

Q Doctor, does the relationship that you have had with Cleveland Metropolitan General Hospital influence in any way your review of this case or the opinions that you formed?

A I --

MR. KAMPINSKI: I'm going to object, That's up to the jury to decide.

THE WITNESS: Absolutely not.

BY MR. ALLISON:

Q Dr. Lerner, from your review of the information you've been provided in this case, what was Mr. Cates' condition when he presented at Cleveland Metropolitan General Hospital on November 13th, 1987?

A He presented with acute pain and swelling and inflammation of his knee.

Q That was his right knee?

A The right knee, the site of a prosthesis. There was also an area of skin breakdown and drainage.

Q Do you have a recollection of how long this wound over Mr. Cates' knee had been present prior to that time?

A It was present for a brief period of time, a week or so, I believe.

Q Now, as an infectious disease consultant involved in Mr. Cates' case, would there be anything in Mr. Cates' past medical history that would be important in evaluating Mr. Cates and in treating Mr. Cates during that admission in November of 1987?

A Yes.

Q And what would that be, Doctor?

A Well, this is a man with a long-standing history of chronic rheumatoid arthritis on much medication, on steroid medication, a patient with a known history of staph infection, a chronic carrier of staph.

Q Is the fact of the prosthesis something that would be important to total knee arthroplasty?

A Yes.

Q Did Mr. Cates have any other types of draining wounds or sites of the skin being disrupted at the time of his admission in November of 1987?

A Well, there was -- one examination by, I believe, one of the infectious disease people noted a small abscess on his buttock in addition to the draining lesion, and there was a story that in the preceding two weeks he had been -- he'd had small furuncles or abscesses on other locations on his body; his foot, I believe his ear, perhaps one of his toes,

Q Doctor, why would these things that we've just talked about: his history of rheumatoid arthritis and steroid treatment, and the prosthesis, the staph carrier status, and multiple sites of wounds, why would those things have been important to an infectious disease specialist in evaluating and treating Mr. Cates?

A This is a reflection, if you will, a map to the fact that this man is heavily colonized with staphylococci on the surface of his skin.

Q Do you recall what the admitting diagnosis for Mr. Cates was on November 13th?

A There was an appropriate suspicion of an infected knee prosthesis.

Q Doctor, is an admitting diagnosis a tentative diagnosis which is subject to change based on further evaluation and testing of a patient?

MR. KAMPINSKI: Objection, leading.

THE WITNESS: It has to be

tentative because you haven't got all the information you need to make it definitive.

BY MR. ALLISON:

Q After Mr. Cates was admitted to the hospital on November 13th of 1987, what should have been done to further evaluate his condition as to any possibility of infection of his right total knee arthroplasty?

A Appropriate studies to determine the extent and nature of his infection.

Q And what would those -- should those have included, Doctor?

A Careful physical examination, smears and cultures of any obvious draining fluid, examination of the fluid within the joint, X-rays, other blood tests,

Q What type of examinations of the fluid from the joint would have been indicated, Doctor?

A Smears and cultures and the appropriate laboratory analysis that I had mentioned before.

Q What was done to evaluate Mr. Cates'

condition, the possibility of any infection in his right knee, at the time he was admitted?

A Fluid was aspirated from the knee and sent for the appropriate studies.

Q And that, again, on --

A It included culture, cell count, gram stain, protein and sugar analysis.

Q Do you recall what the results of those tests were, Doctor?

A There were several hundred cells in the fluid. Most of these were lymphocytic or mononuclear cells. The sugar was low, and the protein was several hundred, around 230. The culture was negative.

Q Doctor, are those items that you've discussed indicative of an infection in Mr. Cates' right knee joint?

A They are indicative of inflammation.

Q Were any other cultures done on Mr. Cates?

A He had blood cultures drawn. He also had a culture of the material that was discharging from the surface of the knee.

Q Do you recall whether they did any

cultures of any of those other draining areas that you mentioned, Doctor?

A I believe there was a lesion in the ear that was cultured, and he also had some cultures of his nasal cavity.

Q Were X-rays performed?

A Yes.

Q Do you recall what the results of those X-rays were?

A The X-ray of the right knee showed no evidence that the prosthesis was loosened or in any way displaced.

Q Doctor, would the standard of care for an infectious disease physician in 1987, in a case such as Mr. Cates', have required that anything else be done to try and determine whether or not that knee was infected? Would the standard of care have required anything else should have been done?

A No.

Q Was the diagnosis, the admitting diagnosis in Mr. Cates' case of -- of a possible infected right knee joint, was that ever changed during the course of his

hospitalization?

MR. KAMPINSKI: Objection.

THE WITNESS: Yes.

BY MR. ALLISON:

Q Is that change documented in the medical records, Doctor?

A I believe it is.

Q And do you recall where that change is documented?

A A day or so after he was admitted to the hospital, they began calling it a wound infection.

Q Do you recall who made that change? And perhaps you could even refer to the medical records and find that notation.

A There's a note by Dr, Meyer, I believe, or is that -- yes, an orthopedic resident, on 11/14/87 --

Q What --

A -- calling it, "A/P wound infection, patient on nafcillin."

Q What does the "A/P" indicate, Doctor?

A Let's see; that's the soap --

MR. KAMPINSKI: What page are you on, Doctor?

THE WITNESS: This is on --

MR. ALLISON: Mine aren't numbered.

THE WITNESS: These aren't numbered. This is a progress note dated 11/14/87. It's just before the first entry of 11/15 in the middle of the page.

MR. KAMPINSKI: Oh, okay.

THE WITNESS: Assessment -- the "A" stands for assessment. The "P" escapes me for the moment.

BY MR. ALLISON:

Q Could it be plan, Doctor?

A I think so.

Q And, that assessment and plan --

A "S" is subjective; "O" is objective; "A" is assessment; and "P" is plan.

Q And that indicates that the assessment and plan was wound infection and continue antibiotics?

A Yes.

Q And that was written by S. Meyer?

A Correct.

Q And that's the same individual that

wrote the initial admitting diagnosis of a possibility of a knee infection?

A That's correct.

Q Doctor, as a result of the testing and evaluation that was done initially on Mr. Cates when he came into the hospital, was any treatment instituted?

A Yes.

Q And what was that?

A He was placed on an intravenous anti-staphylococcal antibiotic.

Q And, do you recall what that antibiotic was?

A Initially nafcillin, and, then, when the culture results became available, he was switched to a different drug called vancomycin.

Q Now, what is this organism that Mr. Cates had a positive culture for from the superficial wound over his right knee?

MR. KAMPINSKI: Objection.

THE WITNESS: Staphylococcus aureus is a common bacteria in our environment. It's found on the surface of our body transiently. It's

also found in the nasal pharynx, the nasal and throat tissues quite commonly. It is an aggressive organism when it has an opportunity to breach the body's natural defenses. If there's a break in the skin, it will take advantage of it, particularly in people who have an underlying problem in fending off infection. It's also an organism that is commonly a colonizing organism, and, therefore, it presents difficulties in interpreting the results of a culture of a material sent to the laboratory which is strictly a qualitative test. It in no way can tell you whether or not the organism growing is causing an infection or just sitting on the surface as a saprophytic colonizer.

BY MR. ALLISON:

Q Was it appropriate to start Mr. Cates on nafcillin when he came into the hospital?

A It was mandatory.

Q And was it appropriate to start him on vancomycin when the results of the culture from the wound came back?
A Once the nature of the organism was recognized, it was, again, mandatory to switch him to a different anti-staphylococcal drug, because the so-called methicillin-resistant Staphylococcus is resistant to all of this category of semi-synthetic penicillins.
Q Dr. Lerner, how did Mr. Cates' wound over his knee progress during his hospitalization?
A There was slow but definite improvement in all the objective signs of infection in the tissues surrounding his knee.
Q What were some of those objective signs, Doctor, that showed improvement?
A One thing that happened is that his low grade temperature, which was present for most of the first week, had disappeared by the second week, and as one reads through the -- the notes each day, very careful notes I might add, there's a

very clear description of the nature of the drainage, the amount of the drainage, and this changed from a thicker material that had some characteristics of -- associated with infection such as pus, into a thinner material, much more characteristic of the serum drainage simply of an unhealed wound. In addition to that, the swelling and the redness and the edema and the tenderness of the area receded.

Q How long was Mr. Cates on IV vancomycin?

A I think he received antibiotics for a total of about ten to 14 -- ten to 12 days. The vancomycin I think he got for about 14 days.

Q Dr. Lerner, can you have a superficial infection in a wound over a joint without the joint actually being involved?

A Yes.

Q Based upon your knowledge and training and experience as an infectious disease physician, and your review of the

materials in this case, do you have an opinion to a reasonable degree of medical probability whether Mr. Cates had an infection within his right knee joint at any time during his hospitalization from November 13th through December 2nd of 1987?

A I do have an opinion.

Q And what is that opinion, Doctor?

A There was no infection in that knee joint at that time.

Q And what is the basis of your opinion, Dr. Lerner?

A Well, the studies that were carried out clearly indicate -- and fluid was sampled at a time of an acute inflammatory process. He was -- he had fever and swelling and redness and pain. I believe he even had an elevated sedimentation rate, and, yet, fluid that was taken from inside the joint reflected only a mild inflammatory response and did not reflect an acute bacterial infection sitting in that joint.

Furthermore, the subsequent

course of events, the response to the antibiotic was appropriate and timely and complete. He was left with a tiny, little opening in the skin over the joint which stubbornly refused to close.

An attempt was made to mechanically close that area with a suture, and that didn't work; that didn't hold. So, when he returned to the hospital about a week later, a more aggressive attempt to close that area was undertaken, and he had an excision of this little open area, and, now, a suture was placed, and this successfully closed off the area.

The specimen was submitted to the laboratory, and it came back with an explanation for why this lesion had failed to heal with the previous attempts to close it with a suture. There was an inflammatory nodule, a rheumatoid nodule sitting smack in the middle of this tissue, and this was the reason that it was unable to heal in the normal course of events.

Q At the time Mr. Cates was discharged

from the hospital on December the 2nd, was he on antibiotics at that time?

A At what date?

Q When he was discharged from the hospital after the first admission.

A No, he was not sent home on antibiotics.

Q And the wound in his knee had been sutured at that time in the hospital?

A Yes.

Q And what was the condition of the wound at the time he was discharged?

A Well, it still was draining a little serous material, I understand.

Q Is that an indication of infection?

A No.

Q Doctor, was it appropriate in this case for the infectious disease physicians who were taking care of Mr. Cates not to recommend further antibiotics at the time of his discharge on December the 2nd?

A It was appropriate to the -- to the diagnosis and course of treatment that had -- they had undertaken. There was no suggestion or proof at that time that this

man had a deep infection in that knee prosthesis.

Q And was it appropriate for the infectious disease physicians not to recommend that Mr. Cates" knee be surgically opened and debrided or that prosthesis be removed?

A Anybody who would recommend that at that point in time would have been out of his mind.

Q Now, Doctor, there's been some discussion in this case that there was a sinus tract present involving Mr. Cates' knee, Briefly, if you could for us, what is a sinus tract, first of all?

A As it -- as it is used to describe draining areas in the skin, it represents a break in the skin with a -- a pathway down to a deeper structure. In the particular instance that we're talking about here, this would be a tract of a defect in the skin leading all the way down to a deeper structure, such as the total knee prosthesis.

Q Is there any indication that Mr.

Cates had a sinus tract leading from the wound in the skin over his right knee to any deeper structure?

A None whatsoever.

Q If there had been a sinus tract, would the course of Mr. Cates' condition of his -- of his right knee have been any different during that hospitalization from November the 13th to December the 2nd?

A It probably would have been a great deal different. It might have been only minimally different, but the key point that leads me to say -- to state unequivocally that there was no sinus tract is what happened from the time of the excision of the open area in the clinic on the 22nd of December of 1987 until the week, or eight days later when he came back on the 30th.

This man had been off of antibiotics for several weeks, and he came into the clinic with this still little bit of serous drainage from this open area. It was cultured on the surface, and the sinus -- the tissue was excised and a suture was

placed. He returned eight days later, and this area was healed over.

If you were to take a suture, and attempt to close a sinus tract from a deep structure such as a total knee prosthesis containing methicillin-resistant staph organisms without any antibiotic activity in the environment to suppress those bacteria, it would be like trying to cap a volcano. The body simply doesn't react that way, and there's no way that that lesion would have healed had there been a deep sinus tract.

As a matter of fact, one would expect and anticipate an explosive inflammatory response at the area of the opening with a very dramatic, acute recrudescence of inflammation around that knee.

Q Doctor, there's also been some discussion in this case that, based on the results of certain tests called erythrocyte sedimentation rate, that other tests should have been performed or conducted on Mr. Cates during that hospitalization.

First, are you familiar with the test known as an erythrocyte sedimentation rate?

A Yes, I am,

Q What is that for, Doctor?

A This is a nonspecific but sometimes helpful measure of inflammation. It relates to the rate, rapidity, actually, with which red blood cells settle out in plasma.

A specimen of blood is obtained, put into a tube, and allowed to sediment for an hour, and the rate at which that sedimentation takes place is the end result, This test, the end result of the test is a response to inflammation. It has no specificity 'whatsoever in terms of infection, and, unfortunately, in this case, because of Mr. Cates' rheumatoid arthritis, it had no value whatsoever,

Rheumatoid arthritis is a disease that is characteristically associated with an elevated sedimentation rate, and, therefore, in this man, it could not be followed in any way as a measure of

response to treatment,
Q So, in your opinion, it wasn't of value in determining whether he had an infection or in monitoring his response to treatment?
A It's just of no value in this particular case. It can't be used.
Q Now, it's been stated that, because of the fact that Mr. Cates had this erythrocyte sedimentation rate level, that repeat aspirations or taps on the right knee joint itself should have been performed in this case, My question, Doctor, is: Would the standard of care for an infectious disease specialist in 1987 have required repeat knee taps or aspirations in this case?
A The standard of care in 1987, or '86 or '88 or '89, it doesn't matter when it was; anybody who would have put a needle back into this man's knee when it was responding so nicely to the intravenous vancomycin would have been guilty of very poor judgment.
Q Are there any risks to repeated knee

aspiration in a patient in the condition that Mr. Cates was in?

A There's always a risk of putting bacteria into an area where you don't want to, and this man was a recognized skin and nasal carrier of Staphylococcus, and in him, therefore, an even greater risk.

Q Doctor, if a reaspiration or retap would have been done, do you have any reason to believe that the results would have been any different than those which were obtained the first time that the knee was aspirated?

A No.

MR. KAMPINSKI: Objection. Move to strike.

BY MR. ALLISON:

Q Are you familiar with a test known as a Galium scan?

A Yes.

Q What is that, Doctor?

A This is the injection into the bloodstream of a nuclear tracer which goes to tissues that are inflamed. It is taken up by the inflammatory cells in an area of

inflammation.

Q Would a Galium scan have been of any value in this case in determining whether Mr. Gates had an infection within his knee joint?

A Absolutely, unequivocally, no.

Q And why is that, Doctor?

A Because the Galium scan in the setting of prosthetic devices; in fact, all nuclear scanning techniques in the presence of prosthetic devices have an inherent shortcoming, which is that the body is responding at a chronic, low-grade state to the presence of the foreign body. So, there's always some degree of an inflammatory response.

If you are interested in finding out if there's infection deep in the prosthesis, there is no tissue inside the prosthesis for you to have a marker as an indication of the -- of the inflammation.

The presence of the soft tissue inflammation around the knee also would tend to pick up the Galium. So, if it was positive, it wouldn't tell you anything,

and if it was negative, it wouldn't tell you anything.

Q Would the standard of care of infectious disease physicians have required a Galium scan be performed in this case?

A Absolutely not.

Q Was two weeks of vancomycin therapy appropriate to treat Mr. Cates during his hospitalization from November 13th to December the 2nd?

MR. KAMPINSKI: Objection. Asked and answered.

THE WITNESS: It appears to have responded to that course of therapy in terms of their -- their evaluation of the objective signs of inflammation.

BY MR. ALLISON:

Q Now, we've talked, Doctor, about the surgical revision that was done on December 22nd of 1987. Could you be a little bit more specific as to what was done at that time?

A He was taken, I believe, to the -- in

an ambulatory surgery setting, and had an anesthetic applied. A surface -- a culture of the surface of the wound was sent to the laboratory, and, then, the open area of the skin was excised. It was what we call, probably, saucerized. It was just removed. And, then, the uninvolved skin was sutured together.

Q Besides the culture that was conducted on the surface of the wound, were there any other tests done on the tissues that were removed?

A Yes,

Q What was that, Doctor?

A The specimen was sent to the microbiology lab -- to the pathology laboratory, and it was fixed in, presumably, Formalin or some other fixative, and, then, stained and sliced into thin slices, placed on a microscope slide, and examined under the microscope.

Q Doctor, was there any evidence of infection in Mr. Cates' right knee joint on December 22nd of 1987?

A You're talking about the joint?

Q Yes, sir,
A We're getting away from the skin?
Q Yes, sir.
A Okay. There was no evidence of any infection inside the joint.
Q How do you know that, Doctor?
A By the total constellation of information that we have now gathered.
Q What about the fact that there was a positive culture of the wound's surface? Does that indicate any deeper infection or infection in Mr. Cates' knee joint?
A It indicates that the surface of this open wound in this man who was chronically colonized with Staphylococcus was growing a Staphylococcus, which is what the Staphylococcus does best; takes advantage of breaks in the skin.
Q Now, you mentioned the term colonized or -- what is that, Doctor?
A Colonization simply means that the organism is on the surface of a structure. It is multiplying, but it's not invading and harming the deeper tissues.
Q How do you know that this was just a

colonization of the surface of this wound that was excised?

A Because the tissue that was excised showed no evidence of any acute inflammation. Furthermore, it gave a perfect explanation for why it had not healed previously. There was a rheumatoid nodule sitting in the middle of it.

Q And, this tissue examination is that microscopic examination you explained to us just before?

A The histologic examination where the tissue is fixed and examined under the microscope.

Q As an infectious disease specialist, is it routine to treat colonization?

A It's not only not routine to treat colonization unless there's a reason to do so; it's very difficult to treat colonization.

Q Is there any reason to treat the colonization in this case?

A No.

Q Is there anything else about Mr. Cates' continued course from September the

22nd, 1987 to the time of about December the 30th of 1987 that indicates that he did not have any infection within this joint?

A Well, he returned for a follow-up visit, and a note indicated that the wound had healed, and he was not offering any new complaints; that is, the little wound that had been excised and, then, sutured,

MR. KAMPINSKI: I'm sorry. When was that question about -- directed?

THE WITNESS: On the 30th.

MR. ALLISON: The 30th.

MR. KAMPINSKI: I'm sorry.

BY MR. ALLISON:

Q Doctor, at the time that Dr. Matejczyk saw Mr. Cates for his wound check on December 30th, 1987, there's been testimony that she contacted someone in the infectious disease service about whether to prescribe antibiotics for Mr. Cates and was told, essentially, that no antibiotics would be necessary if the wound was fine.

My question for you, Doctor, is:

Is it within the standard of care for an infectious disease physician to provide that type of information to an attending orthopedic surgeon in the situation that we have present in this case without seeing the patient?

MR. KAMPINSKI: Objection.

THE WITNESS: Yes, perfectly adequate.

BY MR. ALLISON:

Q And why -- why is that, Doctor?

A Well, this is a joint effort on the part of physicians caring for the patient, and one arrives at a data base where it is possible to react to a query without a formal examination of the situation.

The fact of the matter is that one of the chief functions of an infectious disease specialist is to interpret to the nonspecialist the significance of a positive culture. As I stated at the outset, there are many situations in which pathogens are colonizing on the surface causing no problems and need not be the object of an antibiotic attack prescribed

by the physician. Not only is it unnecessary and expensive; it is potentially dangerous, and very likely to be unsuccessful.

The antibiotics that treat infection are notoriously inadequate for clearing the colonization of an organism. The reason for this is: There's no real interaction between the host and the organism.

Q So, it was appropriate to provide that advice in this case?

A The wound had healed up completely, and there was nothing to treat.

Q Now, Doctor, in your practice of the specialty of infectious diseases, have you had occasion to work with orthopedic surgeons?

A Frequently.

Q And, in your experience, are orthopedic surgeons qualified to determine whether a surgical wound is healing without signs of infection?

A I believe any surgeon is qualified to estimate whether a wound is -- a given

wound is healing, be it an orthopedic surgeon or any other surgeon.

Q And why was it that you believed this wound didn't heal and had to be reclosed on December the 22nd?

A The excised tissue revealed a rheumatoid nodule sitting right in the middle, apparently, and once that was removed, the tissue healed over.

Q What is a rheumatoid nodule, Doctor?

A Rheumatoid arthritis, as we mentioned before, is an inflammatory process that affects the cartilage of joints and the soft tissue structures supporting joints, and it represents an -- an abnormality or a defect in the skin because of the inflammation.

It's -- it's just like -- it behaves like an infection, if you will, because it produces abnormal tissue that represents a -- a barrier to the normal functioning of that tissue. If you were attempting to close a defect in the skin, and you were closing an inflammatory -- or if you were bringing normal skin in contact with an

inflammatory nodule, you don't have two healthy pieces of tissue to stick to each other, and that's why the first suturing failed, and the second one worked perfectly.

Q Now, Doctor, you know that Mr. Cates returned to the hospital on January the 3rd, 1988, and he had an infection in his bloodstream and other areas, and also infections in both of his knees. Do you have an opinion to a reasonable degree of medical probability whether the origin of all of these infections was the right knee?

A I have an opinion.

Q And what is that opinion, Doctor?

A The knee was not the source of this infection.

Q And what's the basis for that opinion?

A Again, we have both the systemic information and the knee information. We now have new information. This knee was opened up 48 hours after Mr. Cates reentered the hospital in January, and

this was now the 5th of January, and his symptoms had begun at the beginning of November, because he came in on the 13th of November complaining of two weeks of difficulty and swelling in that knee.

So, we now have a nine-week period of time where the question of an infected knee is being raised. The examination of the knee at the time it was drained of pus from the acute process that was involving the other knee, his heart, his nervous system, the systemic infection revealed no evidence of loosening of the prosthesis, no inflammation of the bone cement interface. Furthermore, there's no description whatsoever of a sinus tract going into the knee.

Now, I don't know what else we need to establish the fact that this was not infected, and if there's any question, all you have to do is go back and look at the tissues.

Q Doctor, is there any way to say where this infection in his bloodstream came from?

A It's almost certain that it came from another focus of infection on the surface of his body. Whether it got in through one of these little abscesses that he had on his skin or his foot, or got in through the respiratory tree, it's difficult to say, but it did not get in through that right knee, because this would not be the pattern of -- of pathology or evolution of the infection.

If the right knee was the source of the infection, it would not have healed at the end of December. It would have exploded by itself and been a primary focus of infection in and of itself when he came back into the hospital. It was part and parcel of a generalized septic picture.

Q Doctor, do you have an opinion to a reasonable degree of medical probability as to whether the care rendered to Mr. Cates by the infectious disease physicians and fellows and residents and all of the other personnel in the Cleveland Metropolitan General Hospital, from

November 11th, 1987 to the time that he was readmitted to the hospital on January 3rd of 1988, was appropriate and in accordance with the acceptable standard of care?

A I have an opinion.

Q And what is that opinion, Doctor?

A It was completely appropriate at every step of the way.

Q And the basis for that opinion, Doctor?

A Is the -- the situation that we have described is a patient with a significant underlying inflammatory disorder of his joint; comes into the hospital with a superficial infection of the knee, appropriately suspected at the beginning of representing something more serious and deep, deeper than what the surface appeared to show; following which appropriate studies to investigate whether or not there was infection within the knee were carried out. He was treated for a superficial infection, which was then the appropriate diagnosis, and he responded to

that treatment. Because there was a small area of open skin that continued to drain some serous material, an attempt was made to close that with a suture. That failed. When that failed, a further attempt was made to close this, this time by excising tissue, getting a culture, and trying to explain why this wouldn't close.

It then closed over very nicely, and the tissue submitted to the bacteriologist -- to the pathology laboratory showed no evidence of acute inflammation, and it showed a rheumatoid nodule which explained why this superficial lesion was open in the first place and didn't close on the first admission.

Q Doctor, would you agree with the plaintiffs' expert, Dr. Levine, that the care provided to Mr. Cates during his hospitalization which began on January the 3rd of 1988 by the -- all the personnel at Cleveland Metropolitan General Hospital, including the infectious disease service, was exemplary?

MR. KAMPINSKI: Objection.

THE WITNESS: From which date?

BY MR. ALLISON:

Q From January 3rd.

A Yes, I would agree.

MR. ALLISON: Thank you. I have nothing further at this time.

MR. KAMPINSKI: Go off the record for a moment.

CROSS-EXAMINATION OF PHILLIP LERNER, M.D.

BY MR. KAMPINSKI:

Q Doctor, my name is Charles Kampinski. I represent Mr. Cates, sir. Did you indicate earlier, Doctor, that you did not have any connection currently with Metropolitan General Hospital? Was that what you said?

A I have no official connection with the hospital,

Q All right, because you had given me your CV the other day when I took your deposition that had an open-ended reference to Metro. It indicated you taught there; is that correct?

A The Metropolitan General Hospital is one of the teaching hospitals affiliated

with the medical school. I'm on the full-time faculty at the medical school.

Q At Case Western?

A At Case Western Reserve University.

Q I see,

A There are five full-time affiliated hospitals, and I do teaching at each of these hospitals. In 1968, I had an official appointment for my teaching purposes when I went over there on a regular basis to teach one month out of the year on the infectious disease pavilion.

Q Uh-huh.

A Somewhere over the years that faded away, and I don't know the termination date. Currently, credentialing requires a reappointment each year if you are -- have an active staff appointment. I continue to have an active staff appointment, for example, at University Hospitals because I teach over there on a much more regular basis. I *go* to the Metro for conjoint conferences. I occasionally give a grand rounds discussion.

Q But you don't teach there on any regular basis, then?

A No, no.

Q You do affiliate, however, with people in the infectious disease department there; would that be a fair statement?

A The infectious disease community in the entire city is a close-knit group and we work together at many levels, both clinically and in research.

Q Okay, and that would be yourself with the attendings at Metro?

A It could depend on various levels. There may be fellows who have a research project that might fall within my area of expertise; so, they might contact me.

Q All right. The infectious disease individuals, physicians, and I think they -- were any of them, by the way, anything other than residents and fellows during the November hospitalization?

MR. ALLISON: I'm sorry. What was the question, Chuck?

BY MR. KAMPINSKI:

Q During the November hospitalization, were any of the infectious disease people taking care of Mr. Cates anything other than residents and fellows?
A I'm sure at some point in time, there was an attending.
Q Could you show me a note by an attending in November?
A I don't recall. Do you remember where Dr. Tomford's note was? There was at some point in time, I believe Dr. Tomford wrote a note on this patient.
Q In November?
A I don't remember when it was.
Q Well, I mean, if it's there, I'd like you to tell me.
A Well, I'd be happy to go through the chart.
Q Sure, because I couldn't find anywhere where there was an attending who saw him in November of '87.
A There's a note on November 17th by Dr. Bender: "Will discuss culture results with Dr. Tomford."
Q So, he's saying he'll talk to

Tomford.

A Well, there's a mention of Dr. Tomford there.

Q When you see a patient as an attending, by the way, you put a note in; don't you?

MR. ALLISON: Objection.

THE WITNESS: Yes.

BY MR. KAMPINSKI:

Q I'm sorry. You were looking to see if he saw him.

A I don't see a note by Dr. Tomford, no.

Q So, you were mistaken when you thought there was?

A No, I didn't say -- I didn't say I knew which admission he had signed the note.

Q Okay. Well, certainly, it wasn't the November admission.

A It does not appear to be,

Q And, who were the attending infectious disease physicians at Metro in 1987?

A Well, Dr. Tomford was one. Dr.

Spagnuolo was another. Dr. Wolinsky; I think Dr. Frengley, Dermit Frengley was still attending on infectious disease.

Q Okay, and by the way, there's no notes from any of the others in there?

A No, I didn't see any,

Q You're -- you're friends with all of these individuals?

A I know them all, yes.

Q As a matter of fact, you have even written papers with some of them; haven't you?

A As I mentioned before, we have done cooperative research,

Q And these have been published together with you and they as the authors on them?

A We've published papers in order to publish large series of cases sharing the experiences of the different hospitals.

Q So, if I were to look a paper up, for example, on the CV, it would have your name and their name as authors?

A There are papers that include the authors of these other institutions, yes.

Q Are you also involved in this close-knit community with some of the residents or fellows who were involved in the care of Mr. Cates?
A I know Dr. Blinkhorn.
Q Okay, and he was one of the infectious disease what? Fellows at the time?
A I assume he was a fellow at the time.
Q All right. When you indicated earlier that, and I think you said that you had had contact with other members of the firm of Arter & Hadden, what you meant was you had testified for other members of that firm, correct?
A Again, I don't keep a specific record of every encounter I have with a lawyer. I will tell you that I have reviewed cases for members of the firm.
Q Of Arter & Hadden?
A Of the firm. I don't remember whether I've testified for them, written reports, given depositions. All I'm telling you is that I have reviewed cases for them.

Q Okay. You indicated, Doctor, that, and you were very careful in your wording throughout your testimony, direct testimony, indicating that the treatment was appropriate if, in fact, this particular infection was superficial in nature; is that correct?

A Correct.

Q All right. Now, if, in fact, it was a deep knee wound; that is, in the prosthesis, into the knee joint itself, then, the treatment would have been inappropriate; would that be a fair statement?

A It would have been incorrect.

Q Well, and inappropriate.

A No, it would have been incorrect. There's a difference between inappropriate and incorrect.

Q All right. We'll do it your way, then. It would not have been correct?

A That's correct.

Q All right, and it would have been below the standard of care; wouldn't it, to treat this particular problem --

16:53:55

16:54:43

Stop

A No. What would have been below the standard of care would have been to knowingly treat a deep wound infection -- a deep knee infection the way it was treated.

Q Okay, so, even if you don't know but you should know, that's okay; is that what you're saying -- telling this jury?

A Could know.

Q All right, well, in terms of could know, that would require one to have a high level of suspicion and to do the correct tests, right?

A At all times, gather the appropriate information and act upon that information.

Q All right, which is, by the way, what you tried to do after the fact by going through the records and the depositions, correct?

A It's the only way one could reach a conclusion.

Q Right, because you weren't there; you didn't see him; you don't know what the knee looked like.

A None of us were.

16:55:03

Start

Q All right, so, how do you gather that information? I mean, you look through the records?

A Well, you look through the records, and you hope that you find enough information in the records to permit you to reach a conclusion. Now, there are many records that are incomplete, and many times I will tell a lawyer who asks me to review a record: I cannot answer your question for you either way, In this particular instance, this is a superbly documented, daily chronicle of everything that happened to this patient.

Q Okay, and when you look at this information, you look at all the information; don't you, not just part of it?

16:56:16

A Correct.

Q And you don't just look at the information that might be helpful to reach, or to assist you in reaching a certain conclusion.

A You can't --

Q Let me finish. I mean, you would

look at all information, even if it was harmful to the conclusion that you would want reached; would that be correct?

A The facts cannot be changed.

Q Right.

A The facts are the facts.

Q And, that's -- you're talking now about medical facts.

A Well, we're dealing with a surgical case. So, we're talking about medical and surgical facts.

Q All right, and that's, as you described earlier, what you want the case to be decided on as opposed to what you called the legal contortion, correct?

A I think I used a different word.

Q I think you used legal contortion.

A Well, all too often, the process by which these cases are adjudicated is an attempt to distort the facts or make capital of small, isolated bits of information which to the laymen appear to be inappropriate to a given argument.

Now, obviously, each side is trying to make a point, and the fact that I am

16:56:5
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willing to stake my reputation on this case that there was no infection in this knee joint means that I am 100 per cent certain, and I wouldn't be here today if I didn't think so.

Q Do you ever lose in cases where you've testified?

A I have no idea.

Q You mean, you're not told afterwards?

A Well, lawyers are notorious for not following up sometimes with physicians.

Q So, you --

A I do know that cases have been settled inappropriately from my point of view --

Q Well --

A -- because -- because they didn't feel that it was fiscally appropriate to proceed with a trial.

Q Well, even if you lose, Doctor, or if you have lost in the past, I mean, I assume you still have your reputation.

16:58:48

MR. ALLISON: Objection. Objection to this whole line of questioning. This whole line of

questioning is absolutely --

THE WITNESS: First of all, I'm not the one to lose --

MR. ALLISON: Excuse me one moment, Doctor.

MR. KAMPINSKI: You just said --

MR. ALLISON: I --

MR. KAMPINSKI: -- you objected to this whole line of questioning. If you've got an objection, make it.

MR. ALLISON: This whole line of questioning is absolutely irrelevant. It has absolutely nothing to do with any of the issues in this case, and I mean any of them. I will lodge now a continuing objection to any further questions along this line, and if at some point it continues to go on, I will just simply instruct the doctor to quit answering the questions.

BY MR. KAMPINSKI:

Q All right. So, a legal contortion,

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16:58:06

as you referred to it in the direct examination, is what? The jury being wrong?

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q Is that a legal contortion?

A A jury is not a legal entity. The jury is part and parcel of the process by which a decision is reached.

Q Okay, and you are here to assist them in assuring that no injustice occurs, and that they decide the case based on the medical facts as you perceive them, correct?

MR. ALLISON: Objection,

THE WITNESS: I am here to try and point out to a group of laymen what the facts are in a complicated, scientific arena in which they have no basis whatsoever on their -- in their background for reaching a decision except by the contortions of the lawyers on either side.

BY MR. KAMPINSKI:

Q Okay. One of the things jurors can

do --
A And I --
Q -- is look at records, right, just like you did?
A No, jurors cannot look at records the way I can because they don't have the experience and the background and the expertise to interpret what they see.
Q Okay. They can interpret whether or not somebody is being honest and fair and forthright, though, right?
MR. ALLISON: Objection.
THE WITNESS: I have no way of knowing what a juror can divine from someone's motives, which you're implying, if they're being honest and correct.
BY MR. KAMPINSKI:
Q Sure. Whether they're just picking and choosing facts to support an opinion or whether they're analyzing all facts in an effort to be fair, that's something that you would expect they could do.
MR. ALLISON: Objection, this case is not about the jury. If you

want to continue this line, I'm going to tell the doctor not to answer. If you would like to call Judge Bernside right now, then do it.

BY MR. KAMPINSKI:

Q Good. Go ahead, Doctor. Go ahead, you can answer.

A Answer what?

Q My question.

A I'm not going to answer your question because I've been instructed not to do so.

MR. KAMPINSKI: And under what authority do you tell a nonparty witness not to answer a question, sir?

MR. ALLISON: When the questions are absolutely and totally irrelevant.

MR. KAMPINSKI: Who decides that, you or the judge?

MR. ALLISON: Which is why I asked you to please pick up the phone.

MR.KAMPINSKI: Excuse me. Without a ruling from -- without an

11:01:11

answer from the doctor, how is the judge going to decide? I mean, one of the nice things about video is that, if it is an inappropriate response or question, it can be excised.

MR. ALLISON: Like I said, if you would like to call the judge --

MR. KAMPINSKI: Sure, I'll be happy to call the judge. Let's go off the record.

(At this time a discussion was held off the record.)

MR. KAMPINSKI: Let's go back on the record.

MR. ALLISON: How long do you anticipate this particular line of questions to go on?

MR. KAMPINSKI: Until I'm done asking.

MR. ALLISON: Doctor, to the best of your ability to answer -- well, wait until we're back on the record.

MR. KAMPINSKI: First, let the

record show that, you know, I did attempt to call the court, and it's now 5:05, and of course there's nobody there,

MR. ALLISON: Actually, it's 5:02, which is about two minutes after we went off the record before, but I agree; there doesn't appear to be anybody there.

MR. KAMPINSKI: All right, Now, can we get an answer from the doctor so we can move on?

MR. ALLISON: Well, as I said, I totally object to this entire line of questioning. To the extent that the doctor is able to answer what I believe are totally irrelevant questions which I will move to be struck, he may go ahead and try to do so.

BY MR. KAMPINSKI:

Q Do you remember the question, Doctor? 17:03:41

A No, I don't.

Q All right. Would you read it back, please.

(At this time the previous question was read back by the court reporter.)

MR. ALLISON: Objection,

THE WITNESS: Are we talking about the jury now?

MR. KAMPINSKI: Let's go back on.

BY MR. KAMPINSKI:

Q Yes, we're talking about the jury.

A Could you ask me the question again, please?

Q Yes. In terms of what a legal contortion is as testified to by you on direct examination, Doctor, you wouldn't consider a legal contortion a jury being able to analyze whether or not a physician such as yourself was picking and choosing medical facts to support a particular opinion or whether he was basing his opinion based on all the evidence in the record? 17:05:35

MR. ALLISON: Objection.

THE WITNESS: You haven't asked me what I meant by -- when I used the

term, legal contortion.

BY MR. KAMPINSKI:

Q I think I did, and I think you told me, and I'm asking you if what I just asked you is part of that,

A No.

Q Okay. Doctor, a few moments ago, I was somewhat taken aback when you said that you did not agree that a deep knee infection, if, in fact, it was present in Mr. Cates -- well, let me withdraw that.

A few moments ago, I asked you, if Mr. Cates had a deep knee infection, would the treatment that was rendered to him have been appropriate, and you said you don't agree that it would be inappropriate; you agree it would be incorrect. Have I stated that correctly?

A More or less.

Q Well, I -- I don't mean to paraphrase you, because you made a distinction between appropriate and correct,

A Yes. The correct treatment would have been what was necessary for the condition that existed.

Q Okay.
A The appropriate treatment was the treatment that was rendered based on the information that the physicians were working with. Now, if the information that the physicians had didn't lead them to the proper diagnosis, then, their treatment was still appropriate, but it wasn't correct.
Q Doctor, we're here on September 6th, 1991, and your video deposition is being taken so that it can be shown to the jury. Now, I had an opportunity to take your deposition on September the 3rd, 1991, just three days ago. Do you recall that, sir? 17:07:24
A Yes.
Q And you were sworn in; you were put under oath at that time. Do you recall that?
A Yes.
Q You were sworn to tell the truth, the whole truth and nothing but the truth; do you remember that?
A Yes. I do.

Q Do you recall the following questions and the following answers?

MR. ALLISON: Page, please?

BY MR. KAMPINSKI:

Q Page 30, line 14. I asked you the following question: "If Mr. Cates had a deep knee infection as opposed to a surface infection, was his treatment appropriate in your opinion?"

Mr. Allison interjected and asked: "At what point in time, sir? "

I then said, "Between November and January, November of 1987 and January of 1988?"

Your answer was: "If he had a deep knee infection?"

Question: "Yes, sir."

Answer by you under oath three days ago, quote: "Then the treatment he got was not appropriate."

Do you remember that question, or do you remember that answer, Doctor?

A I remember it, and this is part of the legal shenanigans that I indicated to you at the beginning, an attempt to trap

me with a single word by asking a question in a different way. 17:08:48

Q You know, sir, I asked you the same question a few minutes ago. You're the one that made the distinction between appropriate and correct, not me. So, you're the one that's playing word games, Doctor.

A Please don't yell at me.

Q All right.

A I do not take lightly your yelling at me. I'm here to present the medical facts in a case. I'm not here to fall into one of your traps to attempt to get me to appear to contradict myself.

Q Well, you did contradict yourself, Doctor.

A No, I don't think I contradicted myself. You asked a question in a different format, and I responded appropriately to the question the other day, and I responded appropriately to the question today.

Q Well, was the treatment appropriate if, in fact, he had a deep knee infection 17:09:30

between November and January -- November of '87 and January of '88?
A I stand by the answer that I've already given you.
Q Which one?
A You can read them off the record.
Q Which record?
A She's got it on there.
Q I just read it off your other sworn testimony. Which one would you like us to use?
A I would like you to use the question -- the response that answers the question.
Q Which one is that?
A That's your problem, not mine. I know what I said. 17:10:05
Q Doctor, you also said under direct examination that there was no evidence of inflammation in the slide that was taken December 22nd -- or the smear that was taken December 22nd of 1987.
MR. ALLISON: Objection.
BY MR. KAMPINSKI:
Q Do you remember that testimony?
A What smear?

Q Well, during the operation on December 22nd. Well, you're right. There was no smear, right?
A There was a culture. There was no smear. There was a pathology specimen from the tissue.
Q Yes, and I think your testimony was that, based upon that pathology specimen, there was no evidence of inflammation.
MR. ALLISON: Objection.
THE WITNESS: There was no evidence of acute inflammation.
BY MR. KAMPINSKI:
Q Do you have that question and answer marked, court reporter? Could you read back that question, and could you read back that answer that the doctor gave under direct examination, please, on the record?
(At this time the previous question and answer were read back by the court reporter.)
BY MR. KAMPINSKI:
Q All right.. Would you point out to me, Doctor, where in the pathology slide

it says: No acute inflammation?
A I'll be happy to read it for you.
Q Well, it says that there --
A I will read you the report, okay? May I do that?
Q No, you don't have to read the whole report. It's going into evidence.
A Why can't I read the report in response to your question?
Q Does it show evidence --
A You are asking me the question, and I am attempting to answer it.
Q You want to read the whole report and knock yourself out?
A No, I'm going to read that part of the report that supports the response I'm giving you. Is that something I'm permitted to do?
Q Whatever is fair to you, sir, go ahead.
A But you don't object to that?
Q Would it matter?
A I don't think so. Have I lost it? Here we go.
Q Beg your pardon? Beg your pardon,

sir?

A Here, The description of the pathology report submitted on the 22nd of 1987 signed by the pathologist shows, "Fragments of skin, fibroconnective tissue and synovium with chronic inflammation, fibrosis, rheumatoid nodule formation, and mild perivascular mononuclear infiltrate. Note: No active acute vasculitis is seen." There's no evidence of acute inflammation, and there's no evidence of acute vasculitis.

Q All right. "Evidence of chronic inflammation."

A It says, "Chronic inflammation of the synovium."

Q Well, that means, and I think you testified that inflammation is a response to infection, or can be a response to infection.

A Inflammation is a response to injury. One of the things that causes injury is infection.

Q All right, So, that chronic inflammation can, in fact, be a sign of

the existence of -- of infection, correct?
A In a man with rheumatoid arthritis, it cannot be used as a sign of anything, because the basic process in this man's joints is inflammation, and that's exactly what is described here. There's -- no matter how you slice this, Mr. Kampinski, they are describing for you changes related to his basic disease.

Now, you claim that I am biased because I have a relationship with colleagues at the Cleveland Metropolitan General Hospital. I didn't write this report. I didn't do the biopsy. I'm attempting to interpret the results to a group of laymen. No matter how you slice it, this does not support your position. I'm very sorry.

Q You know, does acute -- the absence of acute inflammation prove something, then? Is that why you brought that up?

A Absolutely, absolutely.

Q I see. So, chronic inflammation means nothing?

A You are attempting to --

Q Is the answer yes or no? It means nothing; is that right?
A No, that's not -- you asked me a question, and I'm going to answer the question, You are attempting to link the surface culture with methicillin-resistant Staphylococcus to an active infection with that Staphylococcus in this tissue going into the total knee, and I am simply trying to point out to all of you laymen and to the jury that's going to witness this videotape, I hope, that if there was infection from that Staphylococcus through this tissue into the knee joint, there would be acute inflammatory cells present, polymorphonuclear leukocytes, and there is no evidence -- it doesn't even say acute and chronic. It says "chronic."
Q Where is the stain or the analysis that would tell us whether or not there's polymorphonuclear leukocytes?
A It's sitting in the pathology department of the Cuyahoga County Hospital.
Q No, I mean --

A Specimen number 10414 S87, and if you have any question about it, we can get some blown-up pictures made of that, and we can demonstrate that --

Q Excuse me.

A -- to the people who are interested in knowing the truth.

Q You know, I asked you that in your deposition, whether or not it would assist us to -- to get those cultures and to analyze them.

A No. We're not talking about cultures.

Q I'm sorry.

A I'm talking about the tissue,

Q Right, to get the tissue and determine whether or not we could culture the bacteria. You said we couldn't do it.

A You're talking about two different things, Mr. Kampinski, and I do not like your attempt, once again, to obfuscate the issues. In my deposition, the discovery deposition --

Q Yes, sir.

A -- which was taken three days ago,

you cited the date; you talked about an attempt to culture the bacteria from that tissue.

Q I asked if you could do that.

A I'm not finished with my answer.

Q Sure.

A And I responded to you that we could not do that because this tissue has been fixed, and it's not possible to grow bacteria. We are now talking about an entirely different test on this tissue, and that test would be to get these slides or the blocks from them, make pictures, and show the actual inflammatory response to the people at this trial, and show them that there is no acute inflammatory cell response in that tissue.

Q Could you have done a culture on December 22nd of that tissue?

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q I mean, could one have been done?

A It could have been done, yes.

Q Well, I mean, what would that have shown the physicians, assuming they wanted

the information? Would it have told them whether or not there was a --

A Do you want me to answer on the basis of what I know the specimen contained, or prior to that time? They took a culture from the surface.

Q And what did that show? What did that show?

A That showed that the organism, methicillin-resistant Staphylococcus, was growing on the surface of this open wound.

Q Well, how do you know the swab was taken from the surface?

A Well, I have no reason to suspect that it was anything other than what was described.

Q Okay, so --

A It was described as being taken from the surface of the wound.

Q Where is that described? It says "swab."

A It says "swab-skin." It doesn't say -- it doesn't say: swab from sinus tract. It doesn't say swab from the deep portion of this open area.

Q Okay. So, wherever it was taken -- I mean, you would have expected that it would have been taken from the opening, though; wouldn't you?
A Common sense would dictate that.
Q Yes, so that the result of that was MSRA; correct, and that's -- What is that, Doctor?
A Methicillin-resistant Staphylococcus aureus.
Q MRSA.
A I didn't correct you. I felt that was a minor point.
Q And is that difficult to treat, Doctor?
A Difficult in what sense?
Q Well, I mean, is it highly resistant to certain types of drugs?
A One has a more limited armamentarium of antibiotics to choose from.
Q And, by the way, what was the organism that was discovered to be existing on Mr. Cates in November of 1987 when he was in the hospital?
A As we have said repeatedly this

afternoon, this man was chronically colonized.

Q What was the origin?

A And infected with methicillin-resistant staph aureus.

Q I see. So, that was the same organism that was found on December 22nd, 1987; is that correct, sir?

A I can't say that with any degree of certainty. It was a similar organism.

Q Well, okay. I think other doctors have testified that it probably was the same. You wouldn't disagree with that.

MR. ALLISON: Objection.

THE WITNESS: I am responding to your question. Your question was: Was this the same organism, and I'm telling you: It probably -- it was a similar organism and probably the same organism, but without specific testing, there's no way to know that this man had not become colonized in the intervening period with a different organism.

BY MR. KAMPINSKI:

Q How about in January of 1988 when he came in with -- what did he come in with at that time, sir?

A He came in with an acute staphylococcal septicemia, endocarditis, meningitis and bilateral septic arthritis of the knees.

Q All right. Can you explain that in English to the jury, please?

A It meant that he had Staphylococcus growing in his bloodstream and on his heart valve. He had it growing in his nervous system, and he had it growing in both knees, and the category of infection was with this same organism.

Q All right. So, just so I understand, I mean, he had this organism when he came into the hospital November -- what was it, 3rd -- 13th, 1987?

A He had a methicillin-resistant Staphylococcus.

Q Sure. Okay, and he had it again when -- the only culture that they did do, the swab in December of '87, correct?

MR. **ALLISON**: Objection.

THE WITNESS: He had a methicillin-resistant staph aureus at that time.

BY MR. KAMPINSKI:

Q Sure, and, then, he had it ultimately in his blood in January of 1988, correct?

A He had a methicillin-resistant staph aureus in his blood at that time.

Q Well, it was probably the same organism in January as it was in November; wasn't it?

MR. ALLISON: Objection, Asked and answered.

THE WITNESS: The only thing we know is that it was a methicillin-resistant staph aureus. It was not phage type. It was not in any other way pursued and identified as to its being the same strain of staph aureus. Now, the fact that it probably was is irrelevant. You are asking me to establish or to respond to your questions that this was the same organism throughout, and I'm simply telling you, based on the data

we have, we can only conjecture that it was.

BY MR. KAMPINSKI:

Q Doctor, there's a difference -- you've testified a lot; haven't you, sir? I mean, you gave --

MR. ALLISON: Objection.

THE WITNESS: I've given a number of depositions.

BY MR. KAMPINSKI:

Q Sure, and you know the difference between probabilities and possibilities; don't you?

A That's correct.

Q All right. Probabilities mean that something is probably more true than not?

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q Correct?

A Yes..

Q Possibilities are it's just possible; it's not probable. There's a distinct difference, and you are aware of that?

A Yes.

Q All right. My question, and it's a

very simple one: And is it probable that the organism in January of 1988 is the same as the one that was there in November of 1987?

A Yes.

Q Okay, and they treated him for that organism in November of '87 with two weeks of antibiotics; is that correct?

A Two weeks of IV vancomycin.

Q Sure, and, then, they stopped that, right?

A Correct.

Q Sent him out of the hospital without any antibiotics?

A That's correct.

Q You testified at great length in direct examination that he was getting better in the hospital in November of '87, right? Do you recall that?

A I testified that the condition for which he was receiving the antibiotics was responding appropriately.

Q Uh-huh, and if somebody is draining purulent liquid, does that indicate more probably that he has a -- if he's draining

it from -- from a knee joint, that he more probably has a deep knee infection as opposed to a surface infection?

MR. ALLISON: Objection.

THE WITNESS: That assumes things that were not true in this case.

BY MR. KAMPINSKI:

Q Well, what's purulent drainage?

A Purulent drainage means that the material, the liquid material coming from a defect in the skin has a yellowish color and represents pus.

Q And does that -- are you saying there was no purulent drainage in this case?

A No.

Q What are you saying?

A I'm saying that you're saying it came from a deep source, and that is not necessarily true.

Q Well, was there or wasn't there a purulent drainage?

A There was purulent drainage at the onset of this man's admission to the hospital.

Q And --
A Subsequently, the --
Q All right. Go ahead. Go ahead. Finish. Go ahead.
A Subsequently, as the notes clearly point out, this drainage changed in character, changed in amount, and became clear and no longer indicative of purulent material.
Q Well, once it's purulent, or purulent, however you would pronounce it, doesn't that tell you that it's probable that the infection is deep?
A No.
Q Okay. So, that was just an observation that one can look at and say: That doesn't prove anything?
A It doesn't tell you to any degree of certainty where it's coming from. It can be surface; it can be intermediate; or it can be deep.
Q Well, what if it comes when the patient flexes or extends his knee over the patella?
A Well, any time you flex or extend

tissue over a hard surface, any liquid material in the soft tissues is going to be extruded through a defect.

Q So, it could be deep; it could be superficial?

A It doesn't tell you anything.

Q All right. The initial analysis was that it was an infected right total knee, correct?

A The initial impression, quite appropriately, when the man was admitted to the hospital, was to be concerned about an infected knee prosthesis, and that's exactly what we have in this chart,

Q All right, You said a number of times on direct examination that it was a possible infected right knee. Do you recall saying, characterizing it as possible?

A No, what I've said repeatedly --

Q Do you recall that or not?

A What I've said repeatedly is that this man was admitted to the hospital with a presumptive diagnosis of an infected total knee, and an appropriate work-up was

carried out to decide whether that initial impression was correct.

Q You know, if at any time you don't understand my question I will be happy to rephrase it, and my question really was a very simple, straightforward one, not designed to trick you or embarrass you or do anything of that sort. It was: Do you recall characterizing the analysis, initial analysis, as possible --

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q -- right knee infection? That was my question.

MR. ALLISON: Objection.

THE WITNESS: That's not true at all. There's no point in time that I said that.

BY MR. KAMPINSKI:

Q You didn't?

A No?

Q How about suspected? You didn't say that either in your direct examination.

A I said -- the initial analysis --

Q Did you or didn't you say that?

A I'm going to respond to your question if you will permit me.
Q Either you said it or you didn't say it.
A You're using the term -- you're using the term, and this is again an example of your attempt to trick me up with words. There was no analysis made prior to the time that the presumptive diagnosis of an infected total knee was put down on the admitting sheet. The analysis that took place subsequent to that ruled it out, because nothing had been done prior to the time he was admitted. It was the testing and the information gathered after that point that led to discarding that diagnosis.
Q So, is the answer to my question: No, you didn't say suspected?
A I can't answer your question because it's a'non-question. You're asking me two things --
Q No, Doctor. I'm asking --
A -- at the same time.
Q You're concerned about my somehow

suggesting something inappropriate here, and my concern, quite frankly, is that you would do the same thing, and if, in fact, you testified on direct examination --

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q -- that they put down, suspected right total knee, and they didn't, I mean, that would be inappropriate on your part to try to sway the jury with adjectives that just don't exist.

A No. You are attempting to confuse the issue because, as is always the case, a physician is required to write down on a sheet of paper what he or she believes to be a working diagnosis that must be the foundation for the -- for the work-up, and that's what was done here. Once the information was gathered, another diagnosis was substituted.

MR. ALLISON: Let's go off the record for a second.

(At this time a short recess was had.)

BY MR. KAMPINSKI:

Q What was the discharge diagnosis and the discharge -- in the clinical resume', sir? Would you tell the jury?
A What page?
Q Well, yours aren't numbered the way mine are.
A Well, I will be happy to read your page, if you like.
Q Sure. Under "Impression," the part that's underlined there, do you see that?
Here's the first page of that, by the way, Doctor. And could you tell the jury the date on -- that that was dictated? It's on the first page.
A Well, here again --
Q Could you just tell the jury the date that it was dictated? That's my only question, Doctor.
A I will tell the jury that it was dictated on 12/2/87, and it is a resume' of the entire hospital admission.
Q Does it say, "Dictated January 14th," up on the top?
A Oh, this -- this one here,
Q Yes, sir.

A I didn't see that. Okay, 1/14/88.
Q All right. So, that was well after he was discharged, well after he was seen in December, even after he was seen in January of 1988, correct?
MR. ALLISON: Objection.
BY MR. KAMPINSKI:
Q Is that correct, sir?
A This, again --
Q Is that correct? Your attorney had an opportunity to ask you questions for over an hour. You know, I'm trying to ask you questions --
A You're trying to get me to make a statement at a point --
Q I just asked you --
A -- at a point in time that doesn't exist, and I'm recognizing what you're trying to do here.
Q Doctor, just answer the question, please.
A And all I'm trying to do is point out that you're trying to trick us again.
Q Just answer the question, please.
This was done -- this was dictated at a

time after he was discharged. It was dictated at a time after he was seen in December. It was even dictated after he was already seen in the hospital in January of '88. Isn't that true?

A Yes.

Q Okay, and in the analysis -- I'm sorry; the -- did you find that in your own records, by the way? Do you have that, so I can look at mine and you can look at yours? And you reviewed these records before testifying; didn't you?

A Yes, yes, I did.

Q Sure, and under "Impression," would you please tell the jury what was dictated as the impression?

A That is the impression --

Q Just tell them what it was -- what it was. I mean, these are medical facts.

MR. ALLISON: You're asking the doctor to read the sentence that occurs after "Impression"?

THE WITNESS: I am going to read the sentence that represents a resume' of the patient's hospital

admission. The impression at the time of the admission, that's not what this says --

BY MR. KAMPINSKI:

Q Oh.

A But that's what it implies. The impression was an "infected right total knee admitted for possible removal. ID will be consulted. Cardiology will be consulted."

We then see "Hospital Course" following after that. "Hospital Course" follows after "Impression." If this was the final impression in this discharge summary, it would appear after the "Hospital Course."

Q After the "Hospital --"

A Not before. That is the format --

Q I see.

A -- for discharge diagnoses.

Q All right. Then, why don't you, Doctor, go to the discharge order in this case. Did you do that?

A Yes.

Q Okay. Now, would you indicate to the

jury -- there's a difference there, admitting diagnosis, correct?
A Admitting diagnosis says, "Infected total knee arthroplasty."
Q Sure, and, then, would you read what it says under, "Principal discharge diagnosis"?
A There are two things here.
Q Sure, read them all.
A There's a statement, "Infected total knee arthroplasty," and that's crossed out, and a diagnosis of "Superficial wound breakdown" is then --
Q Written in by somebody?
A Then written in.
Q Who wrote that in?
A I have no idea.
Q When did they write it in?
A I have no idea.
Q Well, when the man was discharged, apparently, somebody wrote in, "Infected total knee arthroplasty"; isn't that true?
MR. ALLISON: Objection.
THE WITNESS: Someone did.
BY MR. KAMPINSKI:

Q And that was before there was a lawsuit; isn't that true?

MR. ALLISON: Objection.

THE WITNESS: I assume so.

BY MR. KAMPINSKI:

Q Did you ignore that particular fact when you reached your --

A No.

Q -- conclusion?

A As a matter of fact, I did not ignore it. It was one of the things that I noticed early on.

Q Okay. Dr. Meyer, whom you referred to earlier, on his assessment and plan on November 13th when -- when Mr. Cates was admitted, he put down that his impression was, "Infected right total knee," correct?

A Correct.

Q All right. The next day, there's a -- November 14th, there's a note written, and to be honest with you, Doctor, I'm not sure who -- who it's written by.

A The one in the middle of the page or afterwards?

Q No, this one here.

A The bottom one.
Q I think that's Dr. Bender. Do you see that note?
A Yes.
Q I'm not sure we have the same one.
A Yes, I think we do.
Q Okay
A The last word is, "Will check cultures."
Q Yes, right. And he's got -- 'let's see.
A "Assessment."
Q "Assessment."
A "Probable septic prosthetic right knee with superficial furuncle over right patella.
Q It says, "Probable septic prosthetic right knee," not possible but probable and, then, he's got some suggestions, right?
A Yes.
Q What's the fourth suggestion there, Doctor?
A "Will require --"
Q "Repeat aspiration"?

A "-- repeat aspiration of the right knee."

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q Now, an aspiration is the removal of liquid from the joint, correct?

A Yes.

Q A removal of material from the joint for analysis?

A Yes.

Q Okay. Now, that was done the day before by this Dr. Meyer; wasn't it, on the 13th?

A Yes.

Q And that's what you referred to as coming back as negative.

A That's correct.

Q All right. Now --

A Well, I don't know if he knew it was negative at that time, because he says right at the bottom, "Will check cultures.

Q Okay, but we can't tell which cultures he's referring to. He may be referring to the ones he wants repeated.

A If he had known the results of the cultures prior to this time, I think he would have mentioned it in the note. He may well have mentioned some -- some -- something in the note. I haven't read this note at this point in time.
Q Uh-huh, but it depends where you do the culture or the aspiration to analyze the appropriateness of the results of -- of that culture; wouldn't that be a fair statement?
A I'm not quite sure I understand.
Q All right. If somebody doesn't do the aspiration in the right place, they may not get the right result.
A It's possible that an aspiration from a different location would have different results.
Q And what was the level of experience of Dr. Meyer?
A I have no idea, but he obviously succeeded in removing fluid from -- from the prosthesis.
Q Well, from somewhere.
MR. SEIBEL: Objection.

THE WITNESS: He put a needle in and he got fluid out.

BY MR. KAMPINSKI:

Q Why is it that Dr, Bender wanted it repeated, then?

MR. ALLISON: Objection.

THE WITNESS: These are suggestions that Dr. Bender is offering as part of the work-up.

BY MR. KAMPINSKI:

Q Uh-huh, Well, was it done?

A They're not cast in stone.

Q Was it done?

A As far as I know, it wasn't done.

MR. ALLISON: Objection,

BY MR. KAMPINSKI:

Q These references that you made earlier -- by the way, no additional cultures were done of the knee joint during that hospitalization for the remaining two weeks that he was there; isn't that true?

MR. ALLISON: Objection.

THE WITNESS: That is correct.

BY MR. KAMPINSKI:

Q And your suggestion that Mr. Cates had some other -- how did you characterize them? Problems with his ear and his foot and his buttocks; abscesses on the buttocks, foot, ears and toes, and you thought some of them might have been a couple weeks before he even came in.

A It's not my suggestion; it's my review of the record.

Q Yes.

A Someone's history contained evidence that Mr. Cates had experienced furuncles elsewhere on his body prior to coming in, and at the time he was admitted, someone described a furuncle somewhere on the buttock.

Q What did they do about that? Did they take care of those?

A I have no idea.

Q Well, I mean, he was in the hospital. If that was a problem, wouldn't they take care of them?

A If it was necessary to take care of them, they would have been taken care of.

Q Do you see any mention of that being

a problem when he was discharged?
A Obviously, there wasn't,
Q Then, why did you suggest that those could have been the sites of the subsequent infection, Doctor?
A Because this man has clinical evidence of a state of chronic colonization. He's a nasal carrier of the organism, and his history suggests that at various parts -- surfaces -- parts of his skin and the surface of his body, staphylococci are gaining entry into the tissues,

He has a little abscess here, a little furuncle here, and that is a characteristic pattern of an individual who is chronically colonized on the surface of his skin with Staphylococcus.
Q So, he got it from his nose, then, and it got into his blood?
A The nose is the main reservoir for chronic staphylococcal colonization. You can clear up every single organism on the surface of the body by one of a variety of techniques. If you don't eliminate the

nasal carrier, it comes right back.
Q So, and when you say chronic, he's had this for what? Ten, 15 years?
A I have no idea how long he's had it. I only know that at the time of this admission, he had a positive -- he was a positive carrier for staph aureus in his nasal culture.
Q So, you don't necessarily know if it was chronic. He just had it when he was in the hospital in November of '87?
A The history suggests that it was chronic.
Q What history?
A The fact that he had several small abscesses on his skin in the two weeks prior to his coming into the hospital.
Q Does that mean that they were infected with staph, those abscesses?
A More than likely.
Q Oh, and you can say that as an infectious disease specialist without looking at a culture or hearing anything other than he had an abscess?
A Given this scenario, yes, it is

almost certainly the etiology of those organisms or those lesions.

Q I thought you told me in your deposition that you had no idea where the January infection came from, but now -- now you do?

A Once again, you're attempting to trip me up on something I might have said in response to a given question three days ago that may or may not relate to what we're talking about now. As I recall, you asked me if I had an opinion as to where the infection came from, if it didn't come from the knee. Am I correct?

Q Yes, I don't have a quarrel with that, Doctor.

A And I said: It's more than likely that it came from some focus on the skin, because this man had demonstrated that he was a chronic carrier and was having multiple skin infections with this organism.

Q But you didn't know from where, and you still don't.

A I didn't know which precise part of

his body there was a break in the skin that permitted this organism to get into his bloodstream.

Q Okay, we know there was a break in the skin at the knee; don't we?

A Yes.

Q And, yet, you've ruled that out as the site, correct?

A I ruled it out as the --

Q Is that correct?

A Yes.

Q Why don't we change the tape now, if you want to take a break for a minute.

(At this time a short-recess was had.)

BY MR. KAMPINSKI:

Q All right. Doctor, throughout his November hospital stay, there was drainage noted. I think you testified that it either got better or decreased as his hospitalization went on. Would that be correct?

A That's correct.

Q All right. The -- and he was discharged on December 2nd. On December

lst, there was a note; it's actually in the progress notes, where there's a statement by the patient himself at 1:30 P.M. Do you see that, sir? Are we on the same page, December lst?

A Okay.

Q It says, "Bad news. It started draining." And the analysis was: "Wound drain small clear sanguinous drainage." That's written by a nurse.

A Okay, Yes, after they closed it with a suture.

Q So, they closed it what? That day?

A They attempted to suture, I think, the day before he left.

Q Okay, and that would have been the lst?

A Yes.

Q And is that why it started draining; because the suture was put in, or --

A Well, I assumed that they -- yes, it says, the day before at 8:00 in the evening, "No drainage was noted. Suture in the middle of the incision." Okay, that's on the progress note from the 30th, and,

it says, "Incision dry and healed." And, then, the following day at 1:30 P.M., it says that it started to drain again. So, the suture didn't work.

Q But, I mean, they didn't take the suture out and put it back in. He was just discharged the next day; is that correct?

A Yes. It says, "Wound drain small clear sanguinous drainage."

Q Well, I mean, if the suture wasn't working, why -- why wouldn't they fix it?

MR. ALLISON: Objection.

THE WITNESS: I have no idea.

BY MR. KAMPINSKI:

Q Okay. When was he seen --

A Here's the discharge summary on the next page. It says something different.

Q By another nurse or the same nurse?

A Yes. It says, "Wound in knee with one suture intact well proximated without drainage." That's at the time of discharge.

Q So, depending upon when we read a note, we may see different information,

then?
A I would say it a little differently. Depending on when the note was written, we may have different information.
Q Okay. He was then sent home, right, without any antibiotic therapy, correct?
A That's correct,
Q All right, Now, if, in fact, he had a deep knee infection, Doctor, when he was in the hospital on November 13th as various physicians, at least initially, thought he had, and as some described even after he was discharged; if he had that --
MR. ALLISON: Objection.
BY MR. KAMPINSKI:
Q -- I know you disagree that he had it, but if he had it, it would not have been appropriate to discharge him at that time; would it?
MR. ALLISON: Objection.
THE WITNESS: That's correct.
BY MR. KAMPINSKI:
Q All right, and the appropriate treatment would have been to remove the prosthesis; isn't that true?

A Ultimately.

Q Yes, because a prosthesis is a foreign body or a foreign item within the body, and it can, in fact, act as a host for infection.

A In point of fact, what would have been tried before the prosthesis would be removed would be a more extended course of antibiotic therapy.

Q How many weeks?

A Six to eight weeks.

Q Not just two weeks?

A Correct.

Q And that would have been IV?

A There are situations in which oral antibiotics could be used for part of that time.

Q Okay, but it would have been much longer than what he got?

A The period of time was inadequate to treat an infected knee.

Q All right, and even with trying just antibiotics, the probability is that the prosthesis would have to be removed to insure that the potential infection site

was removed.

A It is uncommon to cure these with antibiotics, but it depends on how long they've been infected. If it's an acute infection, there have been some of these that appear to have responded to prolonged antibiotics without removal of the prosthesis.

Q Okay, *so* that would have been possible, and maybe even the prosthesis removed, but under any circumstances, he would not have been discharged when he was under the circumstances that he was?

A If there was a deep knee infection, yes.

Q All right. Now, when did he, then, see the doctor next? Do you know?

A The discharge note says, "Follow-up at Ortho Clinic in one week. Patient discharged to home with brother."

Q All right. One week would have been what? Approximately December 10th?

A Something like that.

Q Was he seen in the clinic then?

A I don't know. I don't recall.

Q Well, I mean, did you review those records, sir?
A I may have. I don't recall at the moment whether he came in on the 9th or the 10th.
MR. ALLISON: Please feel free to look at the records, Doctor.
THE WITNESS: Do we have an out-patient -- is there an out-patient section here? I don't see any notes that he was seen on the 10th. There's a stamp that a visit was set up, but there's no note there.
BY MR. KAMPINSKI:
Q Well, when was he seen in the out-patient clinic?
A As far as I can tell, the first notation in the out-patient clinic is when he comes in for the -- for the operative procedure and ambulatory surgery.
Q Well, all right. He -- he apparently, then, was seen on the 22nd at the out-patient clinic for surgery?
A Well, I don't know. There's no --

there is no entry here at all between the second and the time he has the surgery. so --

Q Well, how much --

A -- somebody had to at some point in time decide that he had to come in for that surgery.

Q Sure.

A And there's no documentation of that in these records.

Q Well, I mean, does that mean there's something missing here?

MR. ALLISON: Objection,

THE WITNESS: It's possible.

BY MR. KAMPINSKI:

Q Well, how do you as a physician, then, know what the situation -- I mean, reviewing this after the fact, know what the situation was with his knee between his discharge on December 22nd -- I'm sorry, December 2nd and December 22nd?

A I don't know what went on in that interval of time.

Q Okay. Well, he shows up on the 22nd apparently for a scheduled surgery.

A Correct.
Q Do you know who scheduled it?
A I would assume the surgeon.
Q Who was that?
A The orthopedic surgeon, Dr. Matejczyk.
Q Okay, and having been in the hospital for a period of what? Two, three weeks in November being treated for infection, I assume that one of the focuses that you would have anticipated of hers would be to determine or to insure that there was no reoccurrence of the infection.
A Her responsibility would be to follow up the patient, yes.
Q Yes, and when she took this piece of tissue that was sent to the pathology lab, were the instructions -- well, how does that work? I mean, do you as a physician, when you send tissue to a lab, tell them what it is you want them to find or to look for, rather?
A No. As a rule, the -- you have to instruct them, if you want the material to be cultured, either if -- for example, if

you only get tissue --

Q Uh-huh.

A -- then you say: Please culture for the following. If you don't want the tissue cultured, then, the specimen gets processed in the standard way, and after an initial examination in pathology, one may order special studies or special stains to be carried out if the initial impression warrants it.

Let's say, for example, that they saw some little pockets of acute inflammation. The pathologist might automatically do a tissue gram stain in response to that without being asked. On the other hand, it might be something that the physician would request after reviewing the specimen with the pathologist.

Q Well, could you tell me -- well, one of the way5 that you or any physician, or even an individual who is not necessarily a physician, can determine if something is potentially infected is by the way it looks clinically, correct?

A Well, that's one of the ways, yes.

Q Yes. I mean, you take that in conjunction with your laboratory tests.
A Correct.
Q All right. And, I think you told me that what you look for -- let's see. You look for fever. You look for inflammation. You look for swelling. You look for redness. You look for tenderness. Those are signs to you as a doctor that would make you suspicious of infection.
A Correct.
Q Is there a -- a physical exam that you can show me here with respect to this December 22nd surgery?
A The only note we have is by -- let's see if we can find something here. An operative note from the surgeon, Dr.. Matejczyk, indicating that this -- giving the history and, "A wound that communicates with the fascial space that has been nonpurulent and nontender but has not closed secondary to mechanical problems," and, then, she describes the surgical procedure.

Q Well, what was his fever, or what was his temperature? I mean, there's a place in the operating room for vital signs - isn't there? - on the sheet.

Q I'm looking for the OR sheet. I don't see any recording of his vital signs.

Q When it says, "Not closed secondary to mechanical problems," that infers what? Suture breakage or suture not holding?

A I have no idea what she means by mechanical problems, but she's suggesting that the tissue is not healing because the two ends are not proximating each other, and that they're being held apart by some mechanical force.

There are some vital signs listed at the bottom of the progress notes on the ambulatory surgery list.

Q Blood pressure?

A Blood pressure.

Q Heart rate?

A Heart rate and respiratory rate.

Q Okay, and what was his temperature?

A They did not record it.

Q Well, that's -- that's one of the signs, or one of the things that --
A There obviously was not enough information visible to raise the question of whether or not she had to take a temperature recording.
Q Sedimentation -- the specialty for rheumatoid arthritis is rheumatologist; is that correct?
A Yes.
Q And, that's not one of your Specialties, correct?
A I deal with infections in patients who have rheumatoid arthritis.
Q All right, but you don't deal -- in the absence of them having an infection, you don't deal with them, or do you?
A I'm sometimes asked to evaluate whether inflammatory changes are related to infection or to their arthritis.
Q You testified that the sedimentation rate was of no value in this case, correct?
A It was of no assistance.
Q No assistance. What was the value,

the sedimentation rate value?
A The number?
Q Yes, sir.
A Seventy-five millimeters per hour.
Q What's normal?
A Zero to ten, zero to 20.
Q And how many times did they do the test for sedimentation rate?
A I don't recall.
Q You can take a look if you need to. And we're talking now about the November hospitalization again?
A Yes, uh-huh. Okay. There's a sedimentation rate recorded on the 13th of November, the day he came in.
Q Okay, and that figure, I'm sorry?
A Is 75 millimeters per hour.
Q Uh-huh.
A And, then, there's -- oh, that's the preliminary report. Then, there's one on the 30th of November with a reading of 66.
Q Okay, and that's abnormal as well?
A Yes.
Q Okay, any others?
A There's another one on the 23rd that

I see here.
Q Uh-huh.
A That was 75.
Q Also elevated, abnormal?
A Yes,
Q Okay.
A Correct.
Q And, that's a sign of inflammation, I think you testified?
A That's correct.
Q And, inflammation can be something associated with infection.
MR. ALLISON: Objection. Asked and answered,
THE WITNESS: Yes.
BY MR. KAMPINSKI:
Q If it was of no value, could you please tell me why it was ordered on three occasions?
A You'll have to ask the people who ordered it.
Q All right. Shifting back, then, for a moment to the December 22nd procedure, Doctor, did Dr. Matejczyk order any type of culture to be done on the material that

was removed from his knee?
A The bio -- the tissue?
Q Yes, sir.
A No.
Q That could be done, though.
A Certainly.
MR. ALLISON: Objection.
THE WITNESS: Yes.
BY MR. KAMPINSKI:
Q All right, and the only evidence that she got back as to the existence of staph was positive from the swab, correct? I mean, she did -- she removed a piece of tissue. She also took a swab from the knee area.
A She took a swab apparently from the open area before she excised the tissue.
Q Well, how do you know it was before?
A She didn't do it afterward.
Q How do you know that?
A I think her operative note indicates that they prepped it and cultured it and, then, excised it. Yes. "Incision was made around the one centimeter open wound after cultures were taken."

Even if she had sent a piece of the tissue for culture, and it had grown, it wouldn't have meant anything.

Q Why is that?

A Because it was contaminated, colonized. The bottom line on whether the tissue was infected is the histology, not the culture, and, again, this is where interpretation of culture results is what --

Q Okay.

A -- we're talking about.

Q But the swab -- the swab did show the existence of staph?

A The swab grew the methicillin-resistant staph aureus.

Q All right. There was no treatment given for that, correct?

A There was no antibiotic treatment given,

Q Did Mr. Cates return again to see her?

A Mr. Cates came back on the 30th of November -- of December.

Q Okay, and I take it you reviewed Dr.

Matejczyk's office record as part of the records that you looked at; is that correct?

A Did I?

Q Do you have them here?

THE WITNESS: Do we have them?

BY MR. KAMPINSKI:

Q Well, I mean, do you have the record that you reviewed, sir? Is that it?

MR. ALLISON: That's mine.

THE WITNESS: This is his record.

BY MR. KAMPINSKI:

Q Well, where is yours?

A I don't have it.

Q Okay. Where is it?

A I don't know. I've been trying to find it. If it was sent to me, I reviewed it.

Q All right. Could you show me where her office record is for the visit of the 30th?

A That's in here. The recording of that encounter is a note written on a clinic copy of the culture result from the

time of surgery.
Q I'm sorry; the clinic copy?
A Yes. That's the title at the top of the page.
Q Well, if you --
A Defendant's Exhibit 2.
Q Sure. If you would back up, she does have entries for visits; does she not?
MR. ALLISON: I don't believe those records are contained in the volume that Dr. Lerner has in front of him. If you'd like to give him yours, I'm sure he can look through them.
BY MR. KAMPINSKI:
Q Well, were you provided with her -- her office records? Do you recall those, Doctor?
A No, I don't. I don't know that I ever saw these.
Q Okay. Is there any --
A In fact, I'm sure I didn't see these.
Q Okay. Those were provided to me, by the way, by Mr. Zellers, who is an attorney also at Arter & Hadden who is

also involved in the case, and you can see they're numbered there at the bottom --

A Uh-huh,

Q -- which reflects the numbering of the records that were provided to me. Okay. Now, if you look at -- what's the first numbered page on Dr. Matejczyk's office record? It's in that particular section, Doctor.

A Twelve.

Q Twelve, okay, and that starts with what date?

A 9/22/81,

Q All right, and, then, the next page is 13?

A Correct.

Q And that has what date on it?

A 2/9/84.

Q Okay, and the next page is 14. And that goes from when to when?

A 12/15/86 and 7/6/87.

Q All right.

A And, then --

Q And, then, there's a written entry saying what? 4/4 --

A "4/4/88, no show."

Q All right. So, there is no entry in there for any visit of December 30th; is there, Doctor?

MR. ALLISON: Objection

MR. SEIBEL: Objection.

THE WITNESS: Not recorded in there.

BY MR. KAMPINSKI:

Q Okay. Now, you just skipped page 15, and that is what, Doctor? Would you show that to the jury? Okay. What is that, Doctor?

A It's a copy of a path report, of a culture result.

Q All right.

A From the specimen taken on the 22nd, presumably at surgery, but the -- the report itself is dated 12/30/87 printed at that time.

Q All right. The computer printout is the 30th?

A That's correct.

Q Okay. When would the -- do you have any idea when the report itself would have

been generated?
A Well, it's --
Q There's a timeframe.
A There's a time -- there's a time listed.
Q Okay. Go ahead.
A The time says 5:42, 12/30/87.
Q Okay, but it's got different listings of the different pathology -- I'm sorry; different smears.
A Specimens.
Q Specimens, correct, all of them taken December 22nd?
A The first part is a description of the specimen. There's a specimen -- there is a specimen labeled, "time 12 --" no, "15:55."
Q 1:55 on 12/22?
A On 12/22.
Q And the result was reported when, Doctor?
A On -- well, this was printed -- this was printed on 5:42, 12/30/87.
Q No, sir. We're at cross-purposes.
A No. Okay, I'm --

Q If you look at --
A At the top --
Q No, no. If you look at where it says, "The specimen, 12/22, 15:55, miscellaneous pyrogen culture," do you see that?
A Uh-huh, okay.
Q Do you see "Date in lab" after that?
A 12/22.
Q There's a column saying "Result," right? Do you see that?
A Okay.
Q It says, "Result," 12/22 at 15:55?
A That's when it's checked into the lab,
Q It says "Result"?
A It can't be, The specimen is received at 15:55.
Q Okay.
A I mean it has to grow up overnight and be tested. There's no way that it was -- the result was known at that time.
Q All right. When did they know the result?
A Well, I don't know, because all I --

the only other date we have here is -- is 5:42 on 12/30/87. Now, I don't know whether this was printed up as part of an ongoing computer printout and somebody took this one page out of it. That sometimes is how hospital computers work. They print up new and old information at the same time. On the other hand, it's possible that this was printed up for the first time at that -- on that date, but I just -- I just don't know.

Q Okay. How many -- how many cultures were there for the swab? Were there two?

A This was --

Q There was one at 15:55, and one at 15:37?

A 15:37, yes.

Q So, she actually took two -- two swabs?

A Well, it says "Swab wound exudate." Maybe she took a second swab for some reason.

Q What does it mean, "wound exudate"?

A Exudate means drainage.

Q So, there was drainage from the

wound, and she took a swab from it?
A Well, she's calling it -- she's calling it exudate, which simply means there was some moisture there, some liquid material.
Q Sure, and that grew staph aureus?
A Yes.
Q The copy that I gave you, Doctor, that was provided to me by counsel for the defendant. Does it indicate anything about any communication that Dr. Matejczyk had with anybody?
A No.
Q And, if you show that to the jury just so they can understand, there's a time -- there's a circular stamp in that right -- bottom right corner, and there's nothing written there. There's nothing there at all; is there?
A There's nothing handwritten, no.
Q Can you tell what's on that stamp?
A Some -- there's a time and a date, but I can't read it.
Q You can't tell what --
A It says December, but I don't know

what the other numbers are.
Q Does it say "December 31st" on that stamp, Doctor?
A It's possible.
Q Well, if it does say "December 31st" on that stamp, could you explain to the jury how in the world it is that the copy you're looking at now, which has writing on it, could have gotten that writing on it on December 30th?
A No, because that was printed up at 5:12. The clinic copy has a time of 5:12, 12/30/87. So, it was printed up that morning.
Q I understand, but why don't you show the jury both copies, sir, that one and the one you're looking at.
A This one was printed up at a different time.
Q Okay. Fine. 'Show the jury both of them.
A This one went to the -- they have different titles on them, by the way,
Q Okay.
A This has got the name of the hospital

on the top, and it's at 5:42 A.M., Ward Orthopedics, and here's a report that has Clinic Copy, and it was printed up 30 minutes earlier.

Q Are these tear-away copies; do you know?

A These are copies of the original, I would imagine. These -- I mean, I don't know, because these are Xerox copies, so I have no idea what the original looked like.

Q Who did Dr. Matejczyk talk to?

A Someone in infectious disease.

Q I'm sorry. I -- I didn't make my question clear. Who specifically did she talk to?

A Someone in infectious disease.

Q Which individual in infectious disease?

A It's not designated in her note.

Q Well, nobody in infectious disease remembers talking to her.

MR. SEIBEL: Objection.

BY MR. KAMPINSKI:

A I mean, how are we supposed to

A Are you asking me is it possible for someone to write a note and predate it?

The answer, of course, is yes.
Q What did the wound look like when she discharged him on the 30th?
A Excellent.
Q And that's in that same note that you're referring to?
A It says "Wound check excellent." It means she checked the wound, and it looked excellent.
Q Excellent.
A So, I assume it meant that it was healed.
Q How many days after December 30th is January 3rd?
A Four or five, depending on whether you want to include the 30th.
Q Would you tell the jury what the wound looked like on January 3rd, please? Do you have that?
A The description of the admitting work-up by someone whose number was 42271, the house officer whose identification number was that, said under "Extremities," "Severe deformed or deformity of most joints noted. Ulnar deviation of hand and

foot, and --" something, a word I can't read, "with multiple scars secondary to orthopedic procedures,"

That's one house officer's description. The senior assistant, SAR, senior assistant resident, "Extremities, small amount of exudate from wound in left knee, Severe deformity of hand including" something "deformity, ulnar deviation."

And that's the extent of the description on the admission to the hospital.

Q Did he have infection in his right knee, Doctor?

A He had infection in both knees.

Q Did he have pus coming out of his right knee?

A No.

Q He didn't?

A There was no description of pus.

Q Under -- in the discharge summary, Doctor, under hospital course --

A For this -- are we talking about the second?

A No, for this admission.

A The second admission?
Q No, for January 3rd.
A That's the second hospital admission, The first was in November,
Q Right. Correct, In the middle of the paragraph where it said, under "Hospital Course," it says, "Knees were tapped and were found contained purulent pus of his right knee."
A Yes.
Q All right, So, there was purulent pus in his right knee on January 3?
A Yes. Yes.
Q By the way this summary was dictated January 28th, 1988, correct?
A Yes.
Q All right. And they reviewed his past medical history at that time?
A There is a review, yes.
Q And under "Past Medical History" in that first full paragraph, the following sentence is contained: "The patient has an infected right prosthetic knee which was infected two months ago which has grown methicillin-resistant staph aureus."

Did I read that correctly, sir?

A Yes.

Q Under "Hospital Course" on page 2, Doctor, in the middle of -- I see that you -- your copy also has the same thing highlighted as mine does, and that's -- that's Mr. Allison's copy that he gave you to look at?

A Yes.

Q Okay, and it's got the sentence that says, "His meningitis was most likely seated through the blood from his septic knee." Is that what that says, sir?

A Yes.

Q Doctor, could you please tell the jury what information you had to tell you what Mr. Cates' knee looked like on December 22nd and December 30th when he was seen by Dr. Matejczyk, other than what you've already told us? I mean, anything else?

A Well, I'm going by the records; that's all.

Q Okay.

A The records indicate that there was a

small area of open drainage at the site that they previously had sutured, and it did not appear to be acutely inflamed. So, she attempted to excise and suture it. If it had been inflamed and infected, she would have been a fool to do what she did.

Q So, there's no other information, then, other than what you've already told us?

A Exactly.

Q Okay. Can -- can a patient, or information from a patient assist you as a physician in analyzing and determining that patient's problems?

A Of course.

Q And, would you please tell the jury what depositions you were provided by Mr. Allison to review in order to give your expert opinion in this case.

A I reviewed Dr. Matejczyk's.

Q Okay.

A I recall reviewing that.

Q All right. What else?

A Dr. Bender's.

Q Okay.

A And I think those were the two main depositions that I reviewed,

MR. KAMPINSKI: Do you have the letter that sets forth the materials that you sent to him?

THE WITNESS: Okay. I reviewed originally Dr. Matejczyk's deposition and Dr. Blinkhorn's, and subsequently, I reviewed Dr. Battersby and Dr. Bender,

BY MR. KAMPINSKI:

Q Okay. Are those all the depositions that you then reviewed?

A I subsequently have reviewed Dr. Levine's deposition.

Q Okay. Does that, then, constitute all the depositions you've reviewed?

A Yes,

Q All right. Doctor, would your opinion in this case as to -- and really the difference between you and Dr. Levine is your belief as to whether or not this was a deep knee infection, Other than that, basically, you're in agreement with him.

MR. ALLISON: Objection,
BY MR. KAMPINSKI:
Q Would that be a fair statement?
A No, it's not true.
Q Well, I mean, without getting into all the specifics, if it was a deep --
A Specifics are important. We can't -- we can't ignore the specifics.
Q Okay. If it was a deep knee infection, then you would agree with his analysis of how it should have been treated,
MR. ALLISON: Objection.
BY MR. KAMPINSKI:
Q Correct?
A If this patient or any patient had a deep knee infection, then, there's a specific course of treatment. This patient did not get a course of treatment for a deep knee infection.
Q Okay. If at the time that he was discharged on December 2nd, 1987, he had a fever from that point through the time that he was hospitalized on January 3rd, 1988, if he did, would that affect your

opinion?
A Yes.
Q Okay. If the wound on his right knee was draining, sore, swollen, inflamed and red during that period of time, would that affect your opinion?
A Between the time he was discharged and the time he was readmitted?
Q Yes, sir.
A Yes.
Q And how would your opinion be affected by that?
A Well, I would be concerned that it was something other than what the records I reviewed indicated.
Q Well, Doctor, could you please explain to the jury why it is that you weren't given Mr. Cates' deposition to review?
A I have no idea.
MR. ALLISON: Objection.
BY MR. KAMPINSKI:
Q Well, are you aware of the fact, Doctor, that he testified that between the time he was discharged from the hospital

on December 2nd and the time he saw Dr. Matejczyk, it was draining, sore, swollen, inflamed and red, and that he had a fever? Were you aware of that testimony?

A No.

Q Well, I mean, is it a coincidence that you were not given that --

MR. ALLISON: Objection.

Q -- or is that something that wouldn't have been important to you?

MR. ALLISON: Objection.

THE WITNESS: I have no idea why I wasn't given it.

BY MR. KAMPINSKI:

Q And if those are the facts, Doctor, then, the treatment rendered to this man was inappropriate; wasn't it?

MR. ALLISON: Objection.

THE WITNESS: If those are the facts, then, the records that I reviewed would be considered incomplete.

MR. KAMPINSKI: That's all I have. Thank you.

MR. SEIBEL: Off the record.

(At this time a short recess was had.)

CROSS-EXAMINATION OF PHILLIP LERNER, M.D.

BY MR. SEIBEL:

Q Dr. Lerner, my name is Bob Seibel. I represent Dr. Matejczyk in this case. Were you able to locate any evidence from the records when **Mr.** Cates was admitted to Metro on January 3rd that he was actually draining pus from his right knee wound?

A No, I couldn't find anything that supported that,

Q Was it reasonable to initially suspect a deep knee infection when he came to the hospital on November 13th of 1987?

A Yes.

Q And, were reasonable steps taken to rule out a deep knee infection?

A Yes.

Q Will you tell the jury: What is a negative culture?

A A negative culture means that the specimen has been submitted to the microbiology laboratory, placed on appropriate culture media, and no bacteria

have grown in a given period of time.

Q And, Dr. Lerner, is it reasonable for the infectious disease specialist at Metro to choose the type and duration of antibiotic therapy for a superficial infection?

A Yes.

Q Now, in a patient like Mr. Cates, in drawing upon your education, training and experience in infectious diseases, do you find it unusual for there to have been no clinical symptoms of infection on December 30th and, then, for this patient to have presented with signs and symptoms of an infection on January 3rd, just four days later?

MR. KAMPINSKI: I am sorry. Could you read the question back? Off the record for a second.

(At this time the previous question was read back by the court reporter.)

MR. KAMPINSKI: Objection.

THE WITNESS: Given the timeframe that we're dealing with, it

would be very unusual for the knee not to have given some objective warning or evidence on the 30th, four or five days earlier, that this was a Vesuvius brewing, if you will.

BY MR. SEIBEL:

Q Well, the records show that he had infections in a number of places on January 3rd.

A Yes.

Q Can -- in these types of infections, when they present in a number of places, can that happen suddenly, within days?

A The Staphylococcus is notorious for producing sudden, dramatic, overwhelming systemic infection.

MR. SEIBEL: I have nothing further. Thank you, Doctor.

MR. ALLISON: Dr. Lerner, I just have a few follow-up questions to what you and Mr. Kampinski discussed earlier.

REDIRECT EXAMINATION OF

PHILLIP LERNER, M.D.

BY MR. ALLISON:

Q In your practice of infectious diseases here at Mt. Sinai Hospital, you actually have residents and fellows in infectious diseases who are involved in the care and treatment of patients --

MR. KAMPINSKI: Objection.

BY MR. ALLISON:

Q -- for which you are primarily responsible as the attending physician?

MR. KAMPINSKI: Objection as to what the doctor's practice is.

THE WITNESS: We don't have our own fellows, per se. We have an active residency program, and occasionally fellows from the other programs in the city may spend some time here.

BY MR. ALLISON:

Q Is it routine, Dr. Lerner, in the specialty of infectious diseases, for there to be residents and fellows, physicians-in-training, if you will, involved in patient care?

A Yes.

Q Are you familiar with the exact

procedures at Cleveland Metropolitan General Hospital as to who does the actual charting of the patient notes when you have an attending physician and a fellow or resident involved in a patient's care?

A Do I know exactly what their mechanism is?

Q Yes, sir.

A No, I don't.

Q Are you aware of whether it's customary in the specialty of infectious diseases or actually just in medicine for fellows and residents to frequently write the notes, even when they round with the attending physician, and the attending physician looks at the patient?

A Yes.

Q And that's not unusual; is it?

A It's not unusual at all.

Q And, Doctor, because no note may be written in a chart by the attending, does that mean that the attending didn't see the patient?

A No, it does not.

MR. KAMPINSKI: I'm going to

object and move to strike.

BY MR. ALLISON:

Q Doctor, I asked you earlier during your direct examination whether you thought that the care and treatment rendered to Mr. Cates by the infectious disease physicians, fellows, residents and other personnel of Cleveland Metropolitan General Hospital was appropriate from November 13th to January 3rd. My question to you now is: Was it correct?

MR. KAMPINSKI: Objection.

THE WITNESS: My answer is yes.

BY MR. ALLISON:

Q Is that your opinion to a reasonable degree of medical probability?

A Yes.

Q And, is the basis for that opinion the same as the basis for the opinion that you previously gave when I asked you if it was appropriate?

MR. KAMPINSKI: Objection.

THE WITNESS: Yes.

MR. ALLISON: Basis? Basis?

MR. KAMPINSKI: Asked and

answered 20 times. And whether or not it is correct or appropriate is not the measure. Whether or not it adhered to the standard of care is the measure.

MR. SEIBEL: I'm glad to hear that from your mouth.

MR. KAMPINSKI: Well, I've heard that enough from Mr. Kalur to sort of have understood that objection.

BY MR. ALLISON:

Q When the tissue was submitted to the histopathology laboratory that was excised on December the 22nd of 1987, was there any need to do any gram stains to determine whether there was infection present in that tissue?

MR. KAMPINSKI: Objection.

THE WITNESS: No,

BY MR. ALLISON:

Q Why is that, Doctor?

A Well, they had taken swabs from the surface of the lesion, If there had been an infection in the tissue, it would be reflected in the organism's growing on the

surface.
Q Would the histopathology have been able to shed any further light on that?
A Very definitely. It would tell you what the significance of the organisms would be. It would also give you the opportunity, as I said before, to carry out special stains to examine for the type and nature of an infection, if one was suspected.
Q Now, during Mr. Kampinski's cross-examination, he made quite a show of a note written by Dr. Bender who was the infectious disease fellow involved in the care and treatment of Mr. Cates, and the suggestion that she made in her note of November 14th at 10:00 A.M., and under the suggestions, that was number four, I believe.

Doctor, does that say, "Will require repeat aspiration of the right ear," not knee as Mr. Kampinski stated that it did?
A It looks like "ear."

MR. KAMPINSKI: I think you read

it, Doctor, not me.

THE WITNESS: Pardon?

MR. KAMPINSKI: I think you read it.

BY MR. ALLISON:

Q So, all of those comments that Mr. Kampinski had about the suggestion of reaspirating the ear as opposed to the knee really don't have any value; do they?

A It would appear not.

Q Doctor, if there's a culture result in here that shows that the wound over the right knee during the first hospitalization was recultured, then, this wound would have been recultured during his hospitalization in November; wouldn't it?

A It was, yes.

Q And, are the results of that culture indicated, Doctor?

A Yes.

Q And what are they?

A The specimen was submitted on the 17th of November, and there was no growth after three days.

Q Dr. Lerner, what's the definition of chronic, when you talk about a chronic condition?

A Chronic condition is generally something that has been present for a number of mont

Acute is generally --

acute generally means a w or two; subacute somewhere between a couple of weeks and four to six; and chronic somewhere thereafter.

Q If other medical records about Mr. Cates' medical condition showed that he had positive staph cultures and various ulcers and that type of thing for more than two months prior to November 13th of 1987, would he be considered a chronic staph carrier, then?

A One would strongly be suspicious of that designation.

Q When you and Mr. Kampinski were discussing erythrocyte sedimentation rates, and you gave the values of 66, 7 and 75 as being above the laboratory

normals, what did you mean when you said that those values were abnormal?
A Well, they fall beyond the range of what the determination would be in a series of -- of samples drawn from people who had no inflammation in their system.
Q Could those laboratory values of 75 and 66 for the erythrocyte sedimentation rate in Mr. Cates be due to something other than infection in his knee?
MR. KAMPINSKI: Objection.
THE WITNESS: Yes, yes,
BY MR. ALLISON:
Q And what would that be, Doctor?
MR. KAMPINSKI: Objection.
THE WITNESS: The most likely explanation in this man with severe, long-standing, chronic, disabling, deforming rheumatoid arthritis is his rheumatoid arthritis,
BY MR. ALLISON:
Q Doctor, were there any consults done on Mr. Cates' condition when he was rehospitalized on January the 3rd of 1988?
Yes.

18:43:41

18:43:1

Q Do any of those consults indicate whether or not Mr. Cates had an infection in his right knee joint during the prior hospitalization as opposed to -- or do they indicate that he had an infection in a superficial wound over the knee joint during the first hospitalization?

MR. KAMPINSKI: Objection. Move to strike.

THE WITNESS: Under a category heading of "PMH," meaning past medical history, the -- under category number one, "Prosthetic right knee infection with MRSA," in parentheses, "(not involving the joint) two months ago," and "12/22, hospitalized and treated with" -- and "12/22, hospitalized and treated with vancomycin for two weeks," and "11/87, an I&D at 12/12/87 when the joint was not involved."

18:45:00

BY MR. ALLISON:

Q Are there any other consultations? Who wrote that note, Doctor, if you can tell?

A This was Dr. S. -- this is written by a senior medical student and countersigned by Dr. Battersby, perhaps, or possibly Blinkhorn,

Q Are there any other consult notes in there which refer at all to Mr. Cates' past medical history prior to January 3rd of 1988?

A There's a note from Dr. Blinkhorn,

MR. KAMPINSKI: I'm going to object to this entire line of questioning.

THE WITNESS: "Past medical history, right knee wound, 12/87, MRSA." And, then, under "Assessment and Recommendations," "MRSA," under item number three; "MRSA nasal carrier with recent right knee wound infection. Needs urgent anti-microbial therapy directed --", something. I can't read the last word.

MR. ALLISON: Thank you, Doctor. I have nothing further.

RECROSS-EXAMINATION OF

BY MR. KAMPINSKI:

Q I'm sorry, Doctor. Which consult were you reading a second ago about the -- you said it was by a student, a senior medical student. 18:46:21

A Senior medical student. The first initial is D. I assume that's an SMS. I can't be sure,

Q And what you read to the jury on the first --

A It's a three-page consult.

Q Sure, but you read from the PMH part of that; did you?

A Yes.

Q And, well, gee, why don't you hold that up so the jury can see what you read, just so there's no confusion here.

MR. ALLISON: Do you want to give him a clean copy of the records?

MR. KAMPINSKI: No. You give him the one he read from, sir.

MR. ALLISON: Give him a clean copy, and let him hold it up.

MR. KAMPINSKI: No, that's not

clean. It is the same as yours.

MR. ALLISON: I guess we have a problem; don't we?

MR. KAMPINSKI: No. You had him read from it. You have him hold it up so the jury can see what he read from, sir. Now, if you want to object and if the judge wants to take it out, that's fine, but you can't hide evidence.

MR. ALLISON: I am not hiding evidence at all.

MR. KAMPINSRI: The doctor read from that. Now, let him hold it up to show the jury what he read from.

MR. ALLISON: What's the difference?

MR. KAMPINSKI: Well, if there's no difference, then why are you objecting?

MR. ALLISON: Then, let him hold yours up.

MR. KAMPINSKI: Are you going to let him do it or not?

MR. ALLISON: Let him hold

yours up.

MR. KAMPINSKI: I want him to hold up the one that he read.

MR. ALLISON: No. Let him hold yours up.

MR. KAMPINSKI: Well, we'll just have to continue this until the judge can rule on it. You asked the man to read something and, then, you don't want the jury *to* see what he read.

MR. ALLISON: Do you have the records --

MR. KAMPINSKI: No. I want -- I want --

MR. ALLISON: This is a copy of the records that I provided because the doctor could not find his as I got there tonight, and I don't really want to fight with you about that.

MR. KAMPINSKI: But you are.

MR. ALLISON: No, I am not.

MR. KAMPINSKI: You asked him to read it. I want the jury to see what he read.

MR. ALLISON: No. Give him your copy. Let him hold up the page.

MR. KAMPINSKI: Okay.

BY MR. KAMPINSKI:

Q Doctor --

MR. KAMPINSKI: Can I look at your copy, then, while I have him hold up the page so I can read along? Is that okay, or you don't want me to see it either?

MR. ALLISON: Is that what you want? Can you see it?

MR. KAMPINSKI: No. I need to read it while he's reading it. That's the point here.

MR. ALLISON: You need to read this while the doctor is reading? I thought you wanted him to hold it up.

MR. KAMPINSKI: I do.

MR. ALLISON: So, he's supposed to hold it up and read it; is that what you want?

MR. KAMPINSKI: I want the jury to see what he read. Okay. I mean, is that so tough?

MR. ALLISON: No. So, what's the difference? Let's hold up your copy.

MR. KAMPINSKI: If you want to hide yours, Mr. Allison, that's fine.

MR. ALLISON: I don't want to hide mine. I am not hiding mine at all.

18:46:58

MR. KAMPINSKI: Mr. Allison doesn't want you to read his. So, I'll tell you what --

MR. ALLISON: Objection, Mr. Kampinski.

BY MR. KAMPINSKI:

Q Show the jury what it is you read, Doctor. Just point it out to them, okay?

A I read these two highlighted sentences.

Q Right. Now --

MR. ALLISON: Of Mr. Kampinski's records.

BY MR. KAMPINSKI:

Q Are they highlighted in what you read too, in what Mr. Allison gave you?

A Yes.

Q Okay. All right.

MR.KAMPINSKI: Anything else you want to say, Mr. Allison, or can I continue?

MR. ALLISON: Go right ahead.

MR. KAMPINSKI: Thank you.

BY MR. KAMPINSKI:

Q What you did, Doctor, is you read it as though it were one sentence; didn't you?

A I just read what was there.

Q Well, part of it, though, is above the sentence that you read, and it's in parentheses, right?

A Yes.

Q Is it in the same writing?

MR. ALLISON: Objection.

MR. SEIBEL: Objection.

THE WITNESS: I have no way of saying that it was -- it appears to be. It appears to be.

BY MR. KAMPINSKI:

Q Yes? When was it put in there?

MR. ALLISON: Objection.

THE WITNESS: I have no way of

knowing that.

BY MR. KAMPINSKI:

Q Well, why don't you read it as it was originally written without the parentheses on top?

MR. ALLISON: Because that's not the way it was written on the piece of paper,

BY MR. KAMPINSKI:

Q Go ahead, Doctor. Why don't you read it?

A Well, I can read it in sequence for you. "Prosthetic right knee - infection with ... and a little -- "infection" arrow "not involving joint" and parentheses above. There is a caret there. I'll give you the caret.

Q All right, but that was added after the sentence. What I'd like you to do is read the sentence, okay?

A Yes.

Q And, then, we can show the jury what was put in afterwards, okay?

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q The caret points to the insertion?
A Yes.
Q Okay. Read it without the insertion.
MR. ALLISON: Objection.
MR. SEIBEL: Just for the record, there's no indication that that was made after the original sentence was written,
MR. KAMPINSKI: Well, then, why is Mr. Allison trying to hide it from the jury?
MR. ALLISON: Mr. Allison is not trying to hide anything, Mr. Kampinski.
BY MR. KAMPINSKI:
Q Read it, Doctor, without the insertion.
MR. ALLISON: You read it without the insertion, Can't you read it?
MR. KAMPINSKI: Wait a minute. You asked the doctor to read something, and you don't want me to ask him to read something?
BY MR. KAMPINSKI:

Q Why don't you read it without the insertion, Doctor, please?

A Okay. "Prosthetic right knee - infection with MRSA two months ago," and "12/22 - hospitalized and treated with vancomycin." Now, there's something above the line here.

MR. ALLISON: Don't read that, Doctor.

THE WITNESS: Okay. "And I&D --"

MR. KAMPINSKI: Is this cute? Is this a game to you, sir?

THE WITNESS: It's better than anything you and I had. "-- when the joint was not involved."

BY MR. KAMPINSKI:

Q All right, So, the addition to that line with the -- with the arrow and the parentheses, that was added afterwards; wasn't it, Doctor?

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q Wasn't it, Doctor?

MR. ALLISON: Objection.

THE WITNESS: It was inserted after the line was written.

BY MR. KAMPINSKI:

Q All right. So, without the insertion, this individual indicated that the right knee prosthesis was infected --

MR. ALLISON: Objection.

BY MR. KAMPINSKI:

Q -- as did the other physicians.

MR. ALLISON: Objection,

THE WITNESS: The individual was a senior medical student that had, I assume, his work-up reviewed by the person who countersigned it. Now, at what point in time that was corrected and -- and the circumstances under which it was corrected, I really don't know. If you go into --

BY MR. KAMPINSKI:

Q Then, if you don't know --

A I haven't finished my sentence. If you're going to state that every single thing that is written in a medical record is suspect because something is inserted

after that sentence is written, then, we've got a big problem, because I can show you dozens of records. We could walk up on the floor now and look at records where we write something in when we get additional information.

Q Well, you know --

A And that's the way it is in a setting where you're constantly reviewing material and elaborating and updating.

Q That's terrific, Doctor, but don't you suggest to the jury that this was one, total sentence without telling them that there was an insertion. That's the point.

A I agree with you. We now know there was an insertion, but we don't know when it was inserted.

18:53:10.

Q Does the sedimentation rate affect -- as a result of rheumatoid arthritis, is it there at all times in somebody who has rheumatoid arthritis or when the rheumatoid arthritis is active?

MR. SEIBEL: Objection,

MR. ALLISON: Objection.

THE WITNESS: When you have

chronic, disabling, deforming rheumatoid arthritis, the sedimentation rate is of no value because it is a reflection of all that's going on in -- in the joints.

BY MR. KAMPINSKI:

Q Can you answer my question? Is it at all times, or is it when the rheumatoid arthritis is active?

A I am telling you that, when a patient has the stage, the end stage, disabling, deforming rheumatoid arthritis that this patient has, you cannot use a sedimentation rate to reflect anything.

Q What is active versus inactive rheumatoid arthritis?

A Active is when the patient is experiencing continuing, ongoing symptoms, both subjective and objective, that reflect the process that is attacking his synovial tissue, the lining of the joints, and the soft tissues surrounding these joints.

Q All right. Doctor, at your deposition, page 37, I asked you the

following questions under oath, sir, three days ago, and you gave me the following answers.

"Question: You just told me the sed rate was of no significance in this case."

"Answer: I did not tell you that."

"Question: What significance was it, then?"

"Answer: I said that in the presence of active rheumatoid arthritis, the sedimentation rate is not a parameter by which you can measure a response."

"Question: Okay, you just told me he had active rheumatoid arthritis."

"Answer: It would appear that he had active rheumatoid arthritis at that point in time. Okay."

"Question: So what significance did it have in this case; any?"

"Answer: It's not something that you can use as a monitor of response to infection and the treatment of it."

Do you remember those questions and those answers?

A Absolutely.

Q All right. Would you point out to me the evidence indicating that he had active rheumatoid arthritis?

A He was requesting medication for multiple painful joints when he was hospitalized in November. He was asking constantly and receiving medication. I can look up the medication charts for you, the nursing notes that indicate that.

Q When was the last time he saw a rheumatologist before he came into the hospital?

A I have no idea.

Q Well, weren't you given those notes to review, Doctor?

A Doctor --

Q Ballou?

A Dr. Ballou's notes, I don't believe I reviewed those.

Q Oh. Well, let's make it easier, Doctor. I mean, is there any indication in here that he was having pain due to rheumatoid arthritis?

A Well --

Q As opposed to pain as a result of his

knee hurting him?

MR. ALLISON: If you'd like the doctor to read through all the progress notes, he can surely do that.

THE WITNESS: Well, again, 1 have not read this chart over from beginning to end.

BY MR. KAMPINSKI:

Q Okay. So, you just make statements in the answer.

A No, I didn't make statements.

MR. ALLISON: Objection.

THE WITNESS: There was an indication when I first reviewed the chart, and I'm perfectly happy to sit here and do it again for you, that this man was asking for -- asking for and receiving pain medication for complaints of pain in joints other than the one that was the focus of attention in -- in November.

BY MR. KAMPINSKI:

Q All right, Let's go off the record and you can find that for me.

(At this time a short recess was had.)

BY MR. KAMPINSKI:

Q Okay.

A Okay. There's a note at 3:00 P.M. on 11/16/87 under "S," Subjective, "I need my Percodan. Subjective: Patient complaining body aches and pains. Medicated times two with Percodan with fair relief of pain. Patient positioned for comfort."

On 11/17/87 at 1:30 or maybe 7:30 P.M., I'm sorry, 7:30 P.M., "My arthritis doesn't act up as much as it did at home, but I could use a Percodan." And he was medicated with Percodan.

On 11/18 at 3:20 P.M., "Can I have my pain pill, please?" "Objective: Patient complaining of overall arthritis pain, medicated times three today with Percodan, one tablet per mouth. Stated Percodan is the only thing that relieves his pain."

23rd, 11/23 at 2:30 P.M., "I'm sore all over today, and I ache," or "and ache."

25th, "Subjective: I'm not up to par this morning," "Objective: Patient requesting Percodan for overall complaints of arthritis pain, Medicated times two with Percodan, two tablets by mouth."

25th at 10:40 P.M., "Medicated per RN times two for complaints of pain."

11/26 at 3:00 P.M., "Patient has had painful day. Medicated times two with Percodan and has slept most of the day. Medication relieves pain somewhat."

27th, sometime in the P.M., "Impaired mobility. Patient complaining of marked arthritic pain, Has been in bed most of shift."

28th, 3:00 P.M., "Complaining of pain, arthritic type. Needs something with Percodan. Two by mouth with relief."

And that was the last one that I saw there,

Q Did Dr. Ballou see him in this hospital?

A I don't believe he did on that occasion.

Q Okay. He wasn't called in as a

consult for any problems with rheumatoid arthritis?

A There's no evidence that he was called in.

Q Doctor, when he came back into the hospital on January the 3rd, he -- he was septic; was he not?

A Yes.

Q All right. Would you -- that -- that means the infection had gotten into his bloodstream, correct?

A It means he had an infection in his bloodstream which had spread to various parts of his body.

Q And that's what you meant when you referred to Mr. --

MR. ALLISON: Allison.

MR. KAMPINSKI: Mr. Seibel's question.

MR. ALLISON: Mr. Seibel's question.

BY MR. KAMPINSKI:

Q -- Mr. Seibel's question about the infection being in different parts of his body, right?

A Yes.
Q And -- and he had meningitis, meaning it was what? In his spinal canal?
A In the tissues that cover the brain and the spinal cord,
Q And it was, I think you said earlier, around his heart?
A He had evidence of infection on his heart valves.
Q Okay. And, so, in other words, it was carried to the different organs or parts of his body through the blood; would that be the way it would happen?
A Yes.
Q All right. He almost died in that hospitalization; didn't he?
A He was very sick.
Q And how long was he hospitalized for? Do you know?
A I don't recall,
Q Okay, when he was discharged he was then sent for rehabilitation.
A I believe he was, yes.
Q All right, and that was all due to the infection; wasn't it?

A Yes.

Q Okay. Thank you. That's all I have.

MR. SEIBEL: Nothing further.

MR. ALLISON: Nothing for me, thanks. We won't waive signature.

MR. TACKLA: How about the one-day filing requirement of the videotape?

MR. KAMPINSKI: Sure, we'll waive that,

MR. SEIBEL: That is fine.

MR. ALLISON: Thank you very much for your time, Doctor.

THE WITNESS: All right.

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CERTIFICATE

The State of Ohio,)
County of Cuyahoga.)

I, Luanne Protz, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named witness, PHILLIP LERNER, M.D., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the case aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed; and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio this 13th day of Sept. A.D., 1991.

Luanne Protz-Notary Public
Within and for the State of Ohio

My commission expires 4/9/93.