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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
CASE NO: 167835

TRAVIS CATES, ET AL.,

Plaintiffs,

VS.

CLEVELAND METROPOLITAN GENERAL HOSPITAL and MARY BLAIR MATEJCZYK, M.D.,

Defendants.

DEPOSITION OF
JEROME F. LEVINE, M.D.

TRANSCRIPT of testimony as taken by and before THERESA L. TESSITORE, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, at the HACKENSACK MEDICAL CENTER, JOHNSON HALL, 30 PROSPECT AVENUE, HACKENSACK, NEW JERSEY, on FRIDAY, AUGUST 23, 1991, commencing at 1:35 p.m.

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(Title page continued, deposition of Jerome F. Levine, August 23, 1991)

APPEARANCES:

CHARLES KAMPINSKI, ESQ.,
BY: CHRISTOPHER MELLINO, ESQ.,
For the Plaintiff.

ARTER & HADDEN, ESQS.,
BY: TOM ALLISON, ESQ.,
For the Defendant, Cleveland Metropolitan General Hospital.

JACOBSON, MAYNARD, TUSCHMAN & KALUR, ESQS.,
BY: ROBERT C. SEIBEL, ESQ.,
For the Defendant, Mary Blair Matejczyk, M.D.

AUGUST 23, 1991

I N D E X

E X H I B I T S

and fellowship.

Q. What is your home address?

A. 6 Burlington Place, Woodcliff Lake, New Jersey.

Q. What's the zip code there?

A. 07675.

Q. Are you married?

A. Yes, I am.

Q. What's your wife's name?

A. Helaine, H-E-L-A-I-N-E,Levine.

Q. What is your date of birth?

A. April 10th, 1949.

Q. And where were you born

A. In Brocklyn, New York.

Q. What is your social security number?

A. 126-38-8538.

Q. Do you have a C.V. with you?

A. I do upstairs with my secretary.

Q. All right.

Is there a way you can call her and have her bring one down?

A. Absolutely.

Q. It would be helpful?

A. Sure.

Q. Could we do that now?

A. Absolutely.

Q. While we're waiting for your secretary to bring down your C.V., tell me about your current practice?

A. I'm currently in the practice of infectious diseases here at Hackensack Medical Center.

Q. Are you in a group practice?

A. I am associated with two other gentleman, though it's an individual practice.

We're not a corporation or a formal group.

Q. And how long has that been the nature of your practice?

A. Since 1982.

Q. What hospitals are you affiliated with?

A. Hackensack Medical Center and Valley Hospital in Ridgewood, New Jersey.

Q. Have you had privileges at any other institution?

A. I was on staff at a hospital in Rockland County called Good Samaritan Hospital earlier in the eighties.

Q. What happened to those privileges?

A. I stopped going up there. I just didn't have the time.

Q. Is that in New Jersey?

A. No, that's in Rockland County, New York.

Q. New York.

Have you ever had your hospital privileges revoked, suspended or restricted in any way?

A. No, I did not.

Q. Do you have any administrative positions here at the hospital?

A. Yes, I do.

Q. Tell me about those.

A. Actually, I have several positions.

I'm the Program Director for Fellowship Training in Infectious Diseases, I'm the Associate Program Director of Internal Medicine at Hackensack Medical Center and I'm the Assistant Chief of Infectious Diseases at Hackensack, also.

Q. About how much of your professional time do those administrative

duties take up?

A. Probably about 20 to 25 percent of my time.

Q. Your secretary just handed us a copy of your C.V.

Is this up to date?

A. May I look at it?

Q. Sure.

A. Yes, it appears to be.

Q. Okay.

MR. SEIBEL: Let's mark this as Exhibit 2 for identification.

(Exhibit received and marked Ex-2 for identification.)

Q. I'm going to hand you just for the record what just been marked as Exhibit 2 and just would you identify it for the record, please?

A. It is a copy, a current copy of my curriculum vitae.

Q. Now, would you take a look at that, Doctor, and make sure there are no additions, corrections, modifications, changes

that you'd like to make before we accept that as an accurate representation of your professional qualifications?

A. It appears accurate.

Q. Where were you licensed to practice medicine?

A. In New Jersey.

Q. Any other states?

A. Not at the present time.

Q. Have you been licensed in the past in other states?

A. Yes, I was.

Q. What states?

A. New York.

Q. What happened to that licensure?

A. I let it lapse.

Q. When was that?

A. I really don't recall when the lapse happened, it's just suddenly I realized that I just never renewed my license in New York.

Q. When were you originally licensed in New York.

A. I guess when I finished my internship in 1977, I believe.

Q. And when were you originally licensed in New Jersey?

A. In 1982.

Q. Have you applied for licensure in any other states?

A. No, I have not.

Q. Did you attend any other colleges besides Union College?

A. No, I did not.

Q. And did you attend any other medical schools besides New York University?

A. No, That's the only one.

Q. Did you *go* directly from college to medical school?

A. Yes, I did.

Q. Did you go directly from high school to college?

A. Yes, I did.

Q. Are you board certified?

A. Yes, I am.

Q. In what areas are you board certified?

A. In both internal medicine and the subspecialty of infectious diseases.

Q. When did you first take your

internal medicine boards?

A. I believe 1979 -- 1979.

Q. Pass them on the first try?

A. Yes, I did.

Q. And your infectious disease boards, when did you take those?

A. 1983.

Q. Was that the only time you took that test?

A. Yes, it is.

Q. Is there a recertification requirement for infectious diseases?

A. Not at the present time.

Q. How about for internal medicine?

A. There is, though, I think I'm grandfathered in on that, so there is a recertification required, but I already passed before that.

Q. So, that requirement came into effect after you became board certified?

A. Correct.

Q. You told us that you're currently in an infectious disease practice, but tell me about the nature of your practice?

A. Well, it is a hospital based

practice, that is, the majority of my consultations are in-hospital, hospital patients, though there has become an increasingly large out-patient population, so, the practice is basically centered at Hackensack.

Q. Are your patients primarily adults, adolescents, minors?

A. In my particular practice, the vast majority are adults, that is, over the age of eighteen.

Q. What about breaking those patients down.

How about in terms of elderly versus --

A. It appears that the only thing I can tell you is that based on the patients that have Medicare, Medicare population runs about 60 percent of my practice.

So, I would assume, therefore, over the age of 65 is about 60 percent, approximately.

Q. Of your practice?

A. Over the age of 65.

Q. Have you ever testified as an expert witness before?

A. Yes, I have.

Q. How many times?

A. In deposition?

Q. Well, how many -- let's put it this way, in how many cases have you agreed to act as an expert witness?

A. Probably about fifteen or so.

Q. And that includes depositions or reports?

A. Right.

Q. Consultations?

A. Correct.

Q. Of lawyers?

A. Corrects.

Q. About fifteen times?

A. Yeah.

Q. When did you first start acting as an expert witness?

A. I don't recall the exact date, it was a number of years ago.

Q. Within the last five years?

A. Probably around the mid-eighties, '85, '86.

Q. So, you review or you take about three cases a year?

A. It averages probably about three,

four cases a year, correct.

Q. All right. And how do those cases that you review break down between plaintiffs and defendants?

A. Again, this would be somewhat of a guess, but probably about 40 percent defendants, 60 percent plaintiffs.

Q. Have those all been medical malpractice cases?

A. No. There were a few that were, I guess, considered civil cases, one or two civil cases.

Q. Actual actions not against doctors?

A. Right, correct.

Q. Of the medical malpractice cases you've reviewed how many are plaintiffs versus how many are defendants?

A. That's about 60/40.

Q. Are you affiliated with any services that obtain expert witnesses for lawyers?

A. I'm not affiliated with any.

Q. Do you know how Mr. Kampinski got your name in this case?

A. He got it through a Leslie Klausner (phonetic) or Clausner (phonetic).

Q. Who is she?

A. She's somebody that runs some service called -- I maybe guessing wrong, Medsource (phonetic) or something like that and if you ask me, I have absolutely no idea where she got my name from, I just don't know.

Q. Where is she located?

A. I believe Ohio.

Q. Have you had any communication with her?

A. About the details of this case, no.

Q. No, no.

Just have you had any communication with Leslie Klausner (phonetic)?

A. Yeah, she's the one that called me with, I guess, this case and asked me if I was interested in reviewing it.

Q. What did she tell you?

A. I don't recall.

Q. She called you on the telephone?

A. On the telephone, correct.

Q. Do you have any -- did she ever

send you a letter?

A. She sent me some letters explaining that, which I don't have, I don't save those letters. I'm sure she sent me letters, but I've just given you the details, I don't have any direct recollection of it.

Q. Well, what was the gist of the letters?

A. Again, I believe this is in 1989, it's just letting me know the name of the case and that Mr. Kampinski would be the lawyer and be sending me the material.

That's all I recall.

Q. Did she enclose any compensation for you?

A. I'm sorry?

Q. Compensation?

A. Did she? No, she did not.

Q. What states have you acted as an expert witness in?

A. New Jersey, New York, Texas.

There was a case that went to Federal Court from Florida and this is the case I'm reviewing here from Ohio, that's all I recall.

Q. Another case in Ohio besides this

one?

A. Oh, no. That, I don't recall. This case is Ohio. I don't know if there have been any other cases besides that, I can't remember.

Q. You're not aware of any other cases in which you've acted as an expert withness in Ohio?

A. That I can recall, there maybe, I just don't have any recollection.

Q. Do you recall reviewing a case involving the Cuhahoga County Jail, strep pneumonia?

A. There was a case, a patient with streptococcus pneumonia, I guess a prisoner that, I believe, expired or something to that affect, yeah.

I don't remember where that was, though.

Q. Have you ever testified as an expert witness in a case where an orthopedic surgeon was a defendant?

A. I gave deposition in a case, yes.

Q. Just one other time?

A. To the best of my recollection, one other time, I believe.

Q. How many times in medical malpractice cases have you taken a position that an orthopedic surgeon was negligent?

A. Other than this case, as I recall maybe the most one or two other cases, but, again, I don't have any direct recollection of that, just a vague remembrance.

Q. Okay. Could be one? Could be two?

A. At the most, only several cases of --

Q. Could be zero?

A. No, I'm pretty sure there was another case, I just don't remember the details of it at all, but I know there was at least one other case I'm aware of.

Q. Well, what was that case about, the other case involving the orthopedic surgeon?

A. You know, I mean was another -- it was obviously an infection of a joint and I just don't -- I really don't want you to give you misinformation. I don't recall any of the details of the case, I'm sorry.

Q. Well, what do you recall about the

case?

A. Just that it was another infection of some joint and bone infection, obviously, and I just don't remember. I know that I felt there was negligence by the orthopedic surgeon.

Q. What did that orthopedic surgeon do wrong?

A. I don't recall.

Q. Would this case have taken place in the last five years?

A. That I was asked to review the case or that the negligence presumably occurred?

Q. That you were asked to review the case.

A. In the last five years, sure.

Q. Tell me about your training in orthopedics?

A. Well, I'm obviously not an orthopedist. My training involved my fellowship in New York City.

Q. Have you ever performed orthopedic surgery?

A. No, I have not.

Q. Have you ever testified regarding

orthopedic surgery?

A. No, I have not.

Q. Have you ever managed orthopedic patients for orthopedic conditions?

A. I've been involved with numerous cases of orthopedic infections and I have -- I've been in the operating room with orthopedic surgeons on cases involving infection, where, obviously, I don't scrub, I'm just an observer and to obtain cultures, et cetera.

Q. So, you have not actually followed a patient for an orthopedic surgery condition?

A. I followed a patient with an orthopedic infection.

Q. Either an orthopedic infection or orthopedic conditions?

A. I guess you have to define what you mean by orthopedic conditions to me.

Q. Fracture?

A. If they're not infected, no.

Q. All right. How many hours did you spend reviewing these materials before you wrote your report?

A. I don't have any recall of that.

Q. How much did you charge Mr.

Kampinski for your services?

MR. MELLINO: Objection. You can answer.

A. It was $200 per hour and I don't remember what the bill is.

Q. Do you have those billing records here at the office?

A. Any material I have with this file was here. So, no, I mean, the only way I'd know about that is obviously going back to my deposit slips from '89 and '90, but I have absolutely no idea how many hours of billing I did on it, I really don't.

Q. What's your best recollection?

A. I mean to be, just a pure guess, I just can't tell you, I don't remember.

Q. Give me an idea.

MR. MELLINO: You're allowing him to guess?

MR. SEIBEL: Yeah.

A. Three hours.

Q. Have you drafted any other reports in this case besides the one that's dated April 4, 1989?

A. No.

Q. Let's hand you what's been marked as Exhibit 1 and ask you to identify it for the record.

A. This is a copy of the report that I sent to a Mr. Kampinski concerning this case.

Q. Is this the only report that you you've written in this case?

A. Yes, it is.

Q. And you have a copy of it in front of you, don't you, Doctor?

A. Yes, I do.

Q. Does this report state all your opinions?

A. Concerning this particular case?

Q. Right.

A. Yes.

Q. And as we sit here today, do you have any changes, modifications, corrections to this report?

A. Not as far as the conclusions, no.

Q. What about anything else?

A. Well --

MR. MELLINO: I'm going to object to the line of questioning in that I mean I don't think he meant to set forth all his

opinions in the report.

MR. SEIBEL: Chris, that wasn't the question. You weren't listening. I asked him if he had any changes, modifications or corrections to what he has written in the report.

A. I do not.

MR. MELLINO: I heard your question and I heard your question before that one and I just don't want it to be construed that you're trying to limit him to his opinions that he's written in the report because that wasn't the purpose of providing the report to put forth every opinion he had in this case and, obviously, that's why we're here today, so you can find out what his opinions are.

MR. SEIBEL: Well, as you recall, I did ask Doctor Levine if this report stated all his opinions in the case and he told me it did.

Do you have a problem with that?

Is that answer wrong, Doctor?

A. It depends how we look at it. If the question is did I put in the -- into the letter why I got to that statement, no.

Obviously, there are things that I do in here to explain how I got to that point which is obviously why we're here, but otherwise there's no major corrections in this report.

Q. When you rendered your -- or when you -- strike that.

When you came to your conclusions in this case, did you review any medical literature?

A. No, I did not.

Q. All right. Have you since reviewed any medical literature?

A. No, I have not.

Q. You listed a number of your own publications in your C.V.

Are these works authoritative?

MR. MELLINO: Objection. What do you mean by works?

A. Well, what do you mean by authoritative?

Q. Well, how do you define that word?

A. I'm not sure, I don't know what you mean by the word authoritative. These are materials that I wrote concerning those topics. Obviously, they represented my opinions and

interpretations.

Q. Are you willing to stand behind what you wrote in these articles?

A. Oh, sure.

Q. Perhaps, I don't want to be unfair, you know, I know that medical literature at times will propose ideas and then they become either obsolete or you realize that the idea was wrong.

Are there any of the articles that you've written, because they do date back to the -- at least the mid-eighties, is there anything that You published in these articles that you now recognize is not accepted or has become obsolete or whatever?

A. I mean, there are things here we've learned more about, I wouldn't say obsolete, but obviously this information is obtained over the last seven years and some of these things have modified or at least improved on what we had written about in the early eighties, but there's nothing here that I would say that I don't stand behind or feel that that's no longer correct or valid.

Q. All right.

You indicate in your report that you reviewed some medical records, correct?

A. Correct.

Q. Okay. Where are those records?

A. I returned them to Mr. Kampinski.

Q. Do you know whether the records you reviewed were complete copies of those hospital admissions?

A. I have no way of knowing.

Q. And since the time that you wrote your report and reviewed these records, what additional materials have you reviewed?

A. Just these three depositions we have here in front cf me.

Q. For the record it's Doctor Matejczyk's deposition, Doctor Persod's (phonetic) and Doctor Blinkhorn's, B-L-I-N-K-H-0-R-N, Blinkhorn's.

A. Correct.

Q. When did you return these records to Mr. Kampinski?

A. I would have to assume, and that's all it is, it was around the same time I sent this letter back to him on April 4th, 1989.

Q. Did he request you send the

records back?

A. As I recall, yes, but normally we would save the records.

Q. So, in the cases where you've acted as expert witness, it's unusual for the lawyer to ask you to send the records back?

A. Yes, it is.

Q. Has that ever happened in any other case that you reviewed?

A. Not to my recollection.

Q. The records that you got, were they copies or originals?

A. I don't recall.

Q. What is your fee for testifying at a deposition?

A. $300 per hour.

Q. In your practice are you consulted by orthopedic surgeons?

A. Yes, I am.

Q. How often?

A. As often as they feel necessary.

Q. Well, say, on a monthly basis?

A. You're asking how many orthopedic cases I see per month?

Q. Sure.

A. Average is probably about ten cases per month, both in the hospital as well as in the office. I mean there are referrals to the office I see also.

Q. And when you consult on an orthopedic case, what role do you play?

A. As the consultant, they're obviously asking my opinion in terms of, I guess, identification of what the infection -- does an infection exist, first question. If it does exist, what is causing the infection? What organisms? What's the best modality of treatment?

Q. Do you then prescribe therapy?

A. Yes.

Q. Antibiotics?

A. Well, whatever it maybe.

Q. When you are consulted on an orthopedic case and then advised certain therapy and actually prescribed therapy, what responsibility does the orthopedic surgeon have for your decisions on the appropriate therapy?

A. I think, generally, I mean I discuss each and every case after I see the patient with the orthopedic attending, to talk

about it, have our ideas go back and forth, find out exactly what their opinion is, what their perspective is of the case. I will write the antibiotic orders in the vast majority, or my fellows will under my supervision or the resident under my supervision.

The question of an -- obviously, what you're leading to is -- what I'm assuming you're leading to is whether the patient required surgical intervention or not. That's clearly an orthopedic decision ultimately, although I very frequently will recommend surgical intervention at some point and then it really is up to the surgical attending or the orthopedic attending whether they feel they agree with that or not.

Q. All right. From an infectious disease standpoint, do you take responsibility for the treatment that you prescribe?

A. Yes, I do.

Q. And do you have an opinion in this case that Doctor Matejczyk's care of Mr. Cates deviated from accepted standards of care for an orthopedic surgeon?

A. I think it deviated from the

accepted standards of care in the treatment of this type of infection.

Q. Tell me specifically what it was that she either did or didn't do that was a deviation from the standard of care?

A. I mean, I think to very briefly summarize it, I think that the patient should have been treated with a longer course of therapy and I think surgical intervention, either debridement of the wound or even removal of the prosthesis was really indicated.

Q. What responsibilities did Doctor Matejczyk have for antibiotic orders?

A. I guess it goes to the idea of really who's captain of the ship, for lack of a better term, I really think that the orthopedic attending really is directly responsible. The consultant is just that, a consultant.

However, it does, I think abrogate their responsibility.

So, I think that they work together, I think they both have responsibility, the infectious disease attending to recommend surgery, but clearly the orthopedic attending's decision to operate or not operate,

antibiotics, the infectious disease consultant will recommend to the attending, though, who the patient has a different relationship with, may have other information not available to the consultant which is not infrequent, I think, who is really in a good position to start deciding whether they agree or not agree.

So ultimately it is the attending, but the ID group clearly has a responsibility for the treatment of that patient, so that if the ID attending feels that surgery is necessary, I think they should state that and discuss that with the orthopedic attending.

Q. Well, I want to limit your answer now just to antibiotics.

A. Okay.

Q. What responsibility does the orthopedic surgeon have over what antibiotics and the duration of antibiotics for a particular case?

A. Again, the orthopedic attending is the captain of the ship. They can agree or not agree. So really it is their responsibility.

However, clearly if they request an infectious disease consultant's opinion, I

would assume that they'd, you know, go along with that opinion.

Q. And like you in your infectious disease practice, you take responsibility for the choice and duration of antibiotic therapy?

A. Yeah, I do.

Q. Okay. When I asked you before what it was that Doctor Matejczyk did or failed to do, I'd like you to explain that a little better. You indicated something about antibiotics and surgery?

A. Right.

Q. Is there anything else, first of all?

A. Well, let's go back. I think the failure, in my opinion, is recognized in the fact that the patient had a deep knee infection and not a superficial wound infection. I think that's the crux of the situation here, as best I could tell.

Q. So, the deviation from standard of care is the failure to recognize a deep knee infection?

A. With subsequent appropriate treatment of that deep knee infection.

Q. Is there anything else that Doctor Matejczyk did that was a deviation from standard of care?

A. Well, I mean I have problems with some of the other care, I know, and I alluded to this in my letter that I believe the wound was sutured and I have some difficulty in suturing closed an infected wound.

Subsequently, when, I guess, she re-operated on the patient, she did an excision of the sinus tract, I think fairly early, again to recognize that this is related to the deep knee infection is also a deviation.

Q. So, all your opinions in this case that Doctor Matejczyk was negligent arise from the failure to recognize what you say was a deep knee infection?

A. Correct.

Q. And I understand from your letter, I just want to confirm this, that the care rendered to Mr. Gates before November of 1987 was appropriate and within standard of care?

A. As best I could tell from an infectious disease standpoint, yes.

Q. You're not going to come to trial

and render an opinion that anything before November of '87 was a deviation from standard of care?

A. No, I would not, no.

Q. All right. And you're not going to come to trial and testify that there is anything that occurred after January 3rd of 1988 that was a deviation from standard of care, correct?

A. That's correct.

Q. So, the negligence in this case took place between November 13th, 1987, and January 3rd, 1988?

A. Correct.

Q. What is the basis of your conclusion that -- well, strike that.

Let me ask a different question.

When did Mr. Cates have a deep knee infection?

A. I believe that when the patient presented to the hospital on, I guess, it was November 13th, 1987, at that point I believe he had a deep knee infection.

Q. And what is the basis of your opinion that Mr. Cates had a deep knee

infection on November 13th, 1987?

A. The description of the wound from the chart, the fact that what we seem to have had was this draining Staphylococcal aureus from a knee that was operated on several years prior to that, so to have a de novo infection on a wound area in a prosthetic knee would make one suspicious that it would not be superficial. The description in the chart of the infection, the tract, the pus drainage, the swelling, the redness, also would make me concerned that, indeed, that it was not a superficial wound infection, the high sedimentation weight was also strongly against that being a superficial wound. A patient on steroids who is a rheumatoid arthritic with a history of rheumatoid arthritis would also make one very concerned that Staphylococcal infection on this draining out would be a deep wound infection or a deep knee infection because those are the types of patients who are predisposed to those types of infections.

Q. So, you're suggesting that Mr. Cates' presentation on November 13th of 1987 should have alerted physicians to a suspicion

of a deep knee infection, correct?

A. It certainly alerted an infectious disease fellow who wrote the first note about this being a septic knee or prosthetic knee infection and I think he did alert them to that concern.

Q. But you have a copy of the records there?

A. There is a copy sitting next to me, yes.

Q. Would you tell me what it was about his presentation on November 13th,'87, from the records that lead you to the conclusion that he had a deep knee infection?

I want to know all the records you're relying on in the chart for that conclusion.

A. Well, I'm looking at the records now of Cuyahoga County Hospital, admission 11/13, and we can take any of these admitting notes, there's an orthopedic admitting note describing the right knee, the swelling, the effusion, would make me greatly concerned, the progress notes from -- let's see, this is infectious diseases on the 14th, describing the assessment probability prosthetic right knee,

description of the knee, bilateral knee effusion, right greater than the left. Well, I see no erythema, warmth noted, but that is contradicted later on, I believe, in the records, with the comment that there was decreasing erythema and swelling, so I mean, you know, that's just looking at it quickly.

Q. Well, is there anything else in that chart?

A. The description of the knee, again, on admission has a draining, purulent liquid when patient flexes or extends his knee over the patella. I mean it's hard to attribute that, in my opinion, to a superficial furuncle, that just doesn't sound quite like it, we can get to the sedimentation rate being 75, also, it does not support it. The cultures showing methicillin resistant Staphylococcal aureus.

Q. Cultures from where?

A. Cultures from the drainage site. I'm not as concerned, personally, about the nasal cultures, I don't think that really is particularly relevant to this particular case, in my opinion.

Q. Is there anything else in Mr. Cates' hospital records that would lead you to the conclusion that he had an infected right knee joint on November 13th, 1987?

A. I think that what I'm really getting at is that the clinical description of the records and obviously I did not see the patient, I'm basically basing it simply on the clinical description, the presentation of the history of the patient, the way this started, the clinical description by multiple observers during that hospitalization, we're not going to ignore subsequently what happened, you're asking me about basically the opinion on that patient when he got admitted, why do I feel that this was deep? The sedimentation rate, the positive culture from a wound that had been operated on years before, the description of the nurses in here, which I can't find, offhand, describing some of the problems, the pain they were having, all leads me to feel that the patient had a deep knee infection.

Q. Tell me, let's go through these now.

The sedimentation rate; what date, what

was the level and tell me why you think that supports your conclusion.

A. Okay. Well let's just, I guess, let's back off a second. What is sedimentation rate? Sedimentation rate is really an erythrocyte sedimentation rate and that is a nonspecific indicator of infection or inflammation. One would see an elevation of the sedimentation rate in cases of infections many times of infections in particular septic arthritis, osteomyelitis, those type of infections are associated with that.

In many cases with an elevated sedimentation rate, it could be normal and if the sedimentation rate's normal, it doesn't help one in a differential diagnosis. If the sedimentation rate is elevated, one would be concerned that there, indeed, is a significant infection.

If you look at this patient's sedimentation rate, it's from 11/13, his sedimentation was 75. The normal values that the laboratory requires are zero to twenty millimeters per hour.

This patient's sedimentation was 75

millimeters per hour, which is markedly elevated and clearly not normal.

Q. What happened to the sedimentation rate through his hospitalization?

A. Well, not alot. By the time, as of November 20th his sedimentation was 77, so if anything, it really was not significantly changed, up a little bit, but not with any significance, and I believe that's the last one that I was able to find.

This chart was November 20th, so that would also make me very concerned that just the antibiotic therapy alone really was not working as well as it should have and, again, a red flag that, indeed, it might be a deep knee wound infection.

Q. Possibility that there was a deeper wound infection by an elevated sedimentation rate?

A. I think a probability. As I said, a significant red flag.

Q. Probability of some infectious process?

A. Well, a deep significant infection. What I'm really trying to explain

to you is that most superficial infections do not usually lead one to a sedimentation rate as high as was found in this patient.

Q. All right. Can superficial wound infections lead to elevated sedimentation rates?

A. Not to this agree, it's highly unusual.

Q. My question is, can superficial wound infections lead to elevated sedimentation rates?

A. They can be moderately elevated.

Q. What is it about the clinical description again that leads you to the conclusion he had a deep wound infection?

A. What was described as a significant swelling in the right knee, the purulent drainage from what sounds like some sinus or fistulous tract in the wound area, the redness that was described and the fact that Staph aureus was isolated from that tract I think is significant. There is a body of literature over the years that has described that if you have a fistulous or sinus tract with Staph aureus with it, one must be

concerned that this relates to a deeper area of infection.

Q. What literature?

A. There was an article published in one of the medical journals many years and I don't remember which journal it was, I think it was J.A.M.A, the Journal of American Medical Association, that's really my memory of it, just the significant culture in sinus tracts and noting that unless it's Staph aureus, one cannot attribute an ideologic organism in a sinus tract or fistulous tract with anything but Staph aureus.

So, I think the Staph aureus was significant in this case.

Q. Now, how do you know that Mr. Cates had a sinus tract or fistulous?

A. There was a description in here, I don't know who made the description, *so* I have not seen this chart in awhile, but there was a description of a purulent drain in tract or sinus. I forget the exact terminology that was used here.

Q. Can you find that note?

MR. ALLISON: I can find that.

A. There's a note here 11/14.

MR. ALLISON: Excuse me, Doctor.

A. I'm looking. I have no idea who wrote it, 11/14/87, 5:05 p.m., there's a note here from somebody, might have been, I don't know who wrote this note, and it says here "S" -- I don't know if you want me to read it exactly or just interpret it. Small amount, I'm interpreting this note, small amount of zero sanguineous, small hole present with redness around area.

Q. Is that the note in this chart from 11/13 to 12/2 that leads you to the conclusion he had a fistula or sinus tract?

A. That's one of them, I could probably spend more time here and see if there were any others. I mean then they refer to open draining wound. I guess it's a matter of terminology, I mean whatever you want to call that, to me that's a tract, whether it's a draining wound, that's a tract.

Q. Well, what is a tract?

A. A tract is a hole, tunneling hole.

Q. And a tunneling hole, not just an opening?

A. Well, it has to be of some depth. I don't know what the -- I don't know if there's a textbook definition of how one defines tract. To me there's a small hole with drainage that, by definition, in my opinion is a tract.

Q. Not necessarily a tract that led into the joint itself, though, correct?

A. Not based on that, correct.

Q. Okay. As an infectious disease specialist what would you do to ascertain whether or not this knee, the knee joint, itself, was infected?

A. I would: do, first of all, what they did, which was try to tap the knee, that is put a needle into the knee joint and try to obtain fluid for appropriate culture and Gram's stain and cell count which was done in this case, as well as the glucose and protein which, I believe, they did in this case.

If that was non-diagnostic and my index suspicion was still high, which it would have been in this case, I would have done one of several things; I probably would have repeated the tap because, I mean, after clinical

anecdotal experience you can either miss the fluid collection, because frequently they loculate it, there maybe small abscesses, they may miss the fluid or just miss the area for whatever technical reason and repeated taps, I think, were indicated and I think other ideologic intervention or radiologic studies should have been done, but which I don't believe in this case were done, nor could I find evidence if they were done for a gallium scan to see if the knee is hot.

Generally, with a superficial wound, if there's an area that's increased uptake on a gallium scan, it would be a very small area with a septic arthritis, the knee would be hot, the entire area is what we call hot, it's the areas of increased uptake of the gallium and, to my knowledge, I find no evidence that any of those radiologic studies were attempted to ascertain whether there was a deep infection or not.

Q. Is there any evidence in these records that there was a technical problem with the aspirate?

A. No, I don't think that was noted

that there was a technical problem. I would not be concerned because I probably have anecdotal experience with that occurring where you have to do the second or third tap, so, no, there's no evidence that it was missed, that there was a problem. I'm not suggesting that we're aware that there were, but we know that that may happen, we just don't hit the right area, for whatever reason that occurs.

Q. But you don't know that that happened in this case, do you?

A. I cannot say that happened, no.

Q. Now, what about the results of the studies of the aspirate supports your conclusion that there was a deep knee infection?

A. Well, the aspirate obtained does not support a deep infection.

Q. Do you, as an infectious disease doctor order aspirates of joints?

A. I have done aspirates of joints myself, I've done aspirates. I've been with the orthopedic surgeons as they've aspirated, I have made orthopedic surgeons come down and do it with me at the bedside; even as early as

yesterday I did the same thing with an orthopedic surgeon, so that's what I will do, yes.

Q. Do you recommend or order aspirates?

A. I'm not sure: by order, we don't write order on the chart to aspirate, but I recommend to the orthopedist to either do it or let me do it.

Q. Is that something that you do in the course of your practice as an infectious disease consultant?

A. Which? What?

Q. Suggest aspirates?

A. Oh, absolutely.

Q. Now, did Doctor Matejczyk bring an infectious disease consultant timely in this case?

A. Absolutely.

Q. And is it reasonable for an orthopedic surgeon to consult with an infectious disease specialist about a breakdown of an arthroplasty scar?

A. I believe so.

Q. And you would expect that in a --

that that would be good care by an orthopedic surgeon?

A. Yes, I do.

Q. How are infections diagnosed?

A. Well, I think one diagnoses infection by the clinical manifestation.

Q. Such as what?

A. Such as purulent drainage, pus draining from a wound, the classic redness, tenderness, swelling, the signs of inflammation which maybe due to infection or not.

So, first you have an index of suspicion there is an infection, there is a clinical presentation, you obtain appropriate cultures including Gram's stains and cultures and that's how one diagnoses it and then you usually begin some antibiotic therapy and see what the clinical course is.

Q. And, of course, when you do a culture, you're looking for a positive culture?

A. Well, it's helpful if you see a positive culture, if you see bacteria or organisms on a Gram's stain, it's certainly helpful. If you get a positive culture on a fluid obtained in an appropriate setting,

that's positive, it's also very helpful. Obviously, not all cultures -- not all positive cultures signify infection. You could have a positive culture from something that's colonized that is not causing infection, but it's literally on the skin.

Q. And that would not be an infection?

A. That's right. One has to -- I think one of the roles of any physician particularly in an infectious disease is something we do on a daily basis to help differentiate whether it's an infection or it's not and what's colonizing and what's causing an inflammation, whether or not it's an infection; that is something we do on a daily basis.

Q. Would it be appropriate to treat something that's colonizing with antibiotics?

A. Generally not.

Q. You would want to correlate a positive culture with clinical symptoms, correct?

A. For therapeutic therapy, I think there are times we treat colonizing of people going for prophylation. As far as treating an

established infection, I think it's crucial to differentiate between colonizing a particular organism and what is causing that infection, if it is different in a deeper sense.

Q. So, to make a diagnosis of infection which would require antibiotics, you would combine culture results plus clinical presentation?

A. Correct, but not in that order. Probably the other order because --

Q. But either order --

A. Because you make empiric decisions, that is you would see a patient on day one, like in this case, they felt it was staph, either they had a culture or positive Gram's, I don't remember which, off the tap. They began nafcillin and then they had to switch to vancomycin, V-A-N-C-0-M-Y-C-I-N, because it turned out to be methicillin resistant. Again, empiric decisions were made appropriately as far as antibiotics go.

Q. So, vancomycin was the appropriate antibiotic for Mr. Cates in November and December 1987?

A. Once the organism was identified

as methicillin resistant Staph aureus, correct.

Q. Is it reasonable for an orthopedic surgeon to rely upon recommendations made by infectious disease specialists?

A. I believe so.

Q. What is methicillin resistant Staph aureus?

A. It's an organism, Staphylococcal aureus, which the sensitivity of the organism is such that it is resistant to methicillin which is one of the standard anti-Staphylococcal penicillins. Generically, we use the term methicillin, but it could be either nafcillin or oxacillin, one of the related, more recent drugs.

If you ask about mechanisms of resistance, you want to know how resistancy develops, where the resistance is.

Q. What I do want to ask you what are the complications and conditions of MRSA?

A. Well, I'm not certain that there's necessarily more complications with MRSA, with methicillin resistant Staph aureus. We certainly know that it's more difficult to treat; that is you must use a drug like

vancomycin with all it's inherent toxicities, problems of dosing, and the fact that Staph aureus is a little more difficult to treat with vanco in terms of clinical response, maybe a slower response, maybe a little more difficult. I don't believe that an organism has ever been shown to be more virulent than MRSA. Staph aureus is just a bad bug to have. It causes pus, it forms abscesses, it goes into areas you don't want to get into, particularly prosthetic areas, where it's hips, joints, knees, whatever it maybe, heart valves, it has a tendency to or a propensity to go though those areas and it's difficult to irradicate.

It frequently has to be usually drained because it forms these localized loculated abscesses, so it's a tough organism to treat.

Q. Well, when you have a patient like Mr. Cates with MRSA, does he basically carry the staff bug all the time?

A. Some do and some don't.

Q. How would you determine whether this was a such a patient that did carry the bug all the time?

A. Well, I mean I know in this case

they did a nasal culture and grew out a Staph aureus from a nasal culture or I think leading them to -- that he's a chronic carrier or Staph aureus carrier, I certainly would want to consider that it may, indeed, be true.

Of course, you can argue which came first. Did he have Staph aureus in his thigh and then it subsequently colonizes in his nares.

I don't think there's anyway anyone can tell. I'm not sure it's relevant in this case, but he certainly did have Staph aureus from multiple body sites,

Q. And did you review any information about Mr. Cates' medical history prior to November of '87?

A. Only to the extent that he had longstanding rheumatoid arthritis and had been on chronic steroids. That's all that I recall.

Q. Now, how does a physician cure MRSA?

A. Well, it certainly depends on the area of infection, that's why I'm hesitating when you use the word cure. Sometimes infections are very difficult to cure. You

treat it when we start that way using an appropriate -- again, assuming that there's infection, with MRSA not colonizing. If we're working under that assumption, you would use an appropriate antibiotic, generally vancomycin is employed either singly or with other antibiotics depending on the extent of infections, trying to obtain synergy, frequently, which is the combination of antibiotics is greater than the individual infection, so you use appropriate treatment, but it's something that's not serious, you may tend to use some of the oral agents, some of the newer oral agents, but in any case you use an appropriate antibiotic and then you decide whether you need any drainage or any surgical procedure, because Staph, as I mentioned earlier causes abscesses and you have to be concerned about that.

Q. Mow does Staph aureus register on the virulent scale, for lack of a medical term, You said it was not as virulent as MRSA.

A. No, I didn't say that.

Q. Okay.

A. I didn't say it was more or less.

I said I don't think there's any data that it's more virulent, that's not the same as saying it's less virulent. I don't know if there's any difference in virulence between them, at least that I'm aware of from studies we know that it's an epidemic problem in many hospitals causing serious infection because they're so difficult to treat, because of the need for vancomycin which might not be as effective as methicillin or nafcillin. If you want me to continue, I'll be glad to. I don't know if it's relevant to what you're asking.

Q. Well --

A. You asked me a scale. A scale of what?

Q. Let me ask you maybe a better question; is Staph aureus a virulent organism?

A. Yes, it is.

Q. And what is virulence?

A. How do I define virulence?

Q. Sure.

A. An organism that is extremely pathogenic, invasive and can cause significant morbidity and mortality.

Q. Now, when we talk about the two

steps to diagnose infection being culture and clinical presentation, who is in the best position to judge the patient's clinical status?

A. Who are you referring to? What? What do you mean who is in the best position? Who are you referring to? Doctors? I'm not sure.

Q. Doctor? Nurse? Medical professional?

A. I believe a physician is in a better position.

Q. Would they be in the best position to judge someone's clinical presentation in terms of assessing the clinical signs of infection?

A. Again, are you comparing to nurses or other allied personnel.

Q. Well, I'm trying to find out from you who you feel would be the best individual to determine -- to make the clinical determination of whether a patient has the clinical presentation of infection?

A. I mean, you know, if you're talking about an orthopedist or ID, is that

what we're getting down to the bottom here?

Q. If you need to characterize it that way or can we just say MD or person who is experienced in looking for this.

A. I think a physician, whether it's MD or ID, I think a physician is better trained or has more experience, which is not to say that nurses do not have experience because many nurses have the experience, other allied personnel, I mean patients, themselves, know there's an infection.

Q. Would you agree, let me ask you this way, would you agree that a physician without regard to specialty, who has experience and training in the recognition of the clinical signs of infection is in the best position to determine whether any particular patient is exhibiting the clinical signs of infection?

A. Yeah, I agree with that comment.

Q. All right. Were there any other antibiotics used to treat MRSA in late '87 besides vancomycin?

A. There's much more even in 1991. The only other drug that was used, I mean there are other drugs that were used in 1987, either

in combination, as I referred to a little while ago, vancomycin or a drug like bactrim and amino-glycosides such as jenamicin, tobramycin, if you need to spell any of these words, please say so, rifampin, other agents that are used in combination, but clearly the treatment of choice then as it is now is vancomycin oral agents, that were other oral agents that were being developed around that time, the so-called quinolones, ciprofloxacin being one and if I'm not mistaken, I think the patient was subsequently put on ciprofloxacin later on in the hospitalization, but clearly vancomycin is the treatment and drug of choice.

Q. What was Mr. Cates' condition before he developed the problems with his right knee in November of 1987?

A. As far as the activities of rheumatoid arthritis to his knee?

Q. In general.

A. I don't know, I can't comment.

Q. Because you have reviewed no such records that would give you that information?

A. I reviewed the records of Doctor --

Q. Matejczyk?

A. I'm sorry, September 22nd, 1981, according to my notes and I have absolutely no recall of those records because I don't have them with me, I'd be glad to look at them if you'd like.

MR. MELLINO: They're in there.

A. They're in here?

Q. Well, that's '81, correct?

A. Right, yeah, I think that referred to it, you said that before.

Q. Before November of '87?

A. Right.

Q. When he developed. the problems?

A. Oh, I'm sorry there would seem to be no problems at least related to infections.

Q. Were there any changes in his condition after he was discharged from the hospital in March of '88 from what they were like before he developed the problems with his right knee?

A. Can you repeat that question?

Q. I'll rephrase it for you, maybe I'll do it better the second time.

Were there any changes in Mr. Cates'

condition in March of 1988 when he left Highland View Hospital from the time before he entered the hospital in November of 1987?

A. The only records, again, apparently that I recall was a Doctor Ballou of March 8th, 1988, through July of 1988 and again I don't have any recall, so I don't think I can comment on that question. I can't give you an answer.

Q. Well, do you have an opinion that Mr. Cates has any long term **or** permanent sequelae from the infection that he experienced in January of 1988?

A. Well, I'm sure his knees where not in the best shape and I'm surprised that he did not have or maybe he did have those prosthesis eventually removed. I mean I can't imagine he wouldn't have significant impairment of mobility, *so* I would think you would eventually have to have those knees replaced, *so* I think that would have clearly been a problem as far as his mobility and his subsequent disability.

Q. But you don't know how mobile or disabled he was prior to 1987, do you?

A. No, I do not, no.

Q. Well, just to make it easy, Doctor, you talked about what your criticism of Doctor Matejczyk was. What is your criticism of the infectious disease service at Cleveland Metropolitan General Hospital?

A. I believe that the infectious disease service should have recommended, which I see no documentation, that further or more prolonged antibiotics would be indicated and that debridement or removal of the prosthesis in this case is indicated during that hospitalization of November 13.

Q. Is that all the criticisms that you have of the infectious disease personnel at Cleveland Metropolitan General Hospital regarding their care and treatment of Mr. Cates?

A. Well, I have to say and I'm almost afraid to step into it because I've read these depositions, the question is what happened on that operative, that note post-operatively, concerning where it was a statement that if wound okay, do not need antibiotics, that was written and discussed, I mean, you know everyone denies that conversation in the

depositions that I've read. If, indeed, that is true, that she did speak to an ID person who stated that, I think that was a deviation.

Q. What was a deviation?

A. That if, in fact, the infectious disease individual, whether as a fellow or an attending, without seeing the wound, simply said no, nothing. There was Staph aureus. If, indeed, that was transmitted, so that there was a Staph aureus still in a surgical specimen that was obtained, if they said that's okay, no more antibiotics, that's a deviation.

Q. So, it's a deviation even if they said, if the wound looks fine based upon your clinical judgment of Doctor Matejczyk at the time you examined this man's skin on December 30th of 1987, if the wound looks fine, I don't believe you need to continue antibiotics.

You're saying that's a deviation?

A. Without seeing the patient?

Q. Yes, without ID actually seeing the patient.

A. And knowing there was -- that there was Staph aureus in the knee and knowing what the previous hospitalization course was,

so we're making a number of assumptions here for which I have no idea whether it's true or not true, if those assumptions are correct, I think that was a error.

MR. SEIBEL: I just want to state for the record that I don't think either denied receiving that telephone call or communication from Doctor Matejczyk. I think that's a mischaracterization of their testimony.

THE WITNESS: Well, I believe they said they had no recall.

MR. MELLINO: He's just objecting.

THE WITNESS: I'm not saying they're lying.

MR. MELLINO: The depositions will speak for themselves.

THE WITNESS: Okay.

Q. Okay, so let me make sure I got this correct then: if ID, someone from the infectious disease department made that comment, you don't need to give him further antibiotics if the wound looks fine, it was a deviation from the standard of care if they said that without seeing the patient, if they knew that there was a positive Staph aureus

culture and if they knew what his previous history during the hospitalization of November 13th to December 2nd was.

Is that correct?

A. Correct.

Q. All right. Anything else, Doctor? Criticisms of the infectious disease services?

A. No.

Q. Cleveland Metropolitan General Hospital? Any other criticisms of anyone, whether it's Doctor Matejczyk or the infectious disease physicians at the Cleveland Metropolitan General Hospital or anyone else regarding the care and treatment of Mr. Cates based upon your review of the medical records in your deposition?

MR. MELLINO: That he hasn't gone into already?

MR. ALLISON: Well, I think we've only talked so far, Chris, about Doctor Matejczyk and so far about his two criticisms of ID.

Have you got any other criticisms of anyone?

A. No, sir.

Q. With regard to the care and treatment of Mr. Cates?

A. No.

Q. And in your report you specifically stated, didn't you, Doctor, that the hospitalization and subsequent medical problems that developed after January 3rd, 1988, were handled in an exemplary fashion.

Isn't that correct?

A. That is correct.

Q. And again not to beat a dead horse, on behalf of the Cleveland Metropolitan General Hospital, your criticisms are all premised on your conclusion that Mr. Cates had an infection within his knee joint during that admission from November 13th to December 2nd, 1987

Is that correct?

A. That's correct.

Q. So, if he didn't have an infection within that knee joint, then all of the criticisms that you have go by the wayside.

Isn't that correct?

If he did not have an infection, you do not have any criticisms?

A. I'd would still criticize the ID person on that conversation of December 30th for their response. I still think that would be a deviation.

Other than that, correct.

Q. Okay. So, you would still criticize the infectious disease person that would have been involved in any conversation with Doctor Matejczyk regarding the December 30th, if wound fine, no antibiotics needed?

A. Absolutely.

Q. Even if he did not have a deep --

A. That's the point.

Q. -- infection within the knee joint?

A. Obviously he must have had it, I mean that's my criticism. Clearly, there was something not right here, there was something amiss. I used the term red flag before, that he should have said, "Wait a minute, what is going on here," which that did not appear to have occurred in this case.

Q. So, it's your opinion that Mr. Cates had an infection within the knee joint on December 30th of 1987?

A. Oh, sure.

Q. When did that occur?

A. Well, he came in with it on November 13th.

Q. And it continued throughout the course of time from November 13th at least up through December the 30th?

A. Even if there was clinical response during the 14 days of antibiotics, which according to those records there was clinical improvement and then stopped, and then comes back for the surgery and there's still Staph there, whether that's a recurrence of the infection or that the infection was only temporarily suppressed and recurred, yes.

Q. I'm sorry. You got me confused.

Because Mr. Cates had a positive culture from the surface of the knee wound on September the -- I'm sorry, on December the 22nd of 1987, you're saying that he had an infection within his knee?

A. Let's just make sure that we're saying the same thing.

The patient was reoperated on, an excision was done and that excision grew Staph

aureus.

Now, I don't remember if the date was the 22nd.

Q. I believe it was December the 22nd.

A. So, I take exception to your comments. I believe you used the word superficial skin, I forget the term you just used to describe that, that was an excisional wound that grew Staph aureus, the tissue, the excision, the wound grew Staph aureus.

Q. Is that right, Doctor?

A. That's my understanding.

Q. Would you like to find that basis for that conclusion in the record, please?

A. Does anybody know where the record is of the 22nd, the operation, that won't waste anyone's time.

MR. SEIBEL: The pathology report, you mean?

A. The operative report of the 22nd. The path report and the culture. I don't want to waste anyone's time because I don't think these records go to that date. Where would that be?

MR. SEIBEL: I have the path report. Here you go, Doctor.

Operative report, next page over is the path report, next page over is the culture.

A. All right. That's just what I'm saying, tissue was sent down for culture, Staph aureus was grown out of the culture, I'm not sure.

Q. Maybe I'd better look at this with you, Doctor, I think it says an incision was made around the one centimeter open wound after cultures were taken, did I read that correctly? Did I read that correctly, Doctor?

A. That's what it says.

Q. I did read that correctly, didn't I?

A. That's correct.

Q. I thought I did, okay. It doesn't change?

A. It doesn't change my opinion.

Q. Okay. What was it that was cultured on the 22nd?

A. It says "wound exudate."

Q. And that was submitted by way of a swab?

A. Correct.

Q. Okay. And the pathology report that was generated as a result of sending that excised lesion to pathology didn't indicate any evidence of infection either, did it?

A. Well, I don't know, it says here "Synoviam with chronic inflammation, fibrosis, rheumatoid nodule formation, a mild perivascular mononuclear infiltrate. No active acute vasculitis was seen." I don't see stains, I don't see Gram's stain, or HE done, but again --

Q. Is there anything in there that indicates evidence of an infection?

A. Inflammation, evidence of inflammation.

Q. That's not the same thing necessarily as infection?

A. No, there's -- I mean they didn't do the stains, like in Gram's stains of that material, but I don't want to bicker with you about that.

Q. I believe at one point in time you mentioned that the clinical condition of Mr. Cates' knee would have caused you some concern

as an infectious disease specialist.

When he came in on November the 13th of 1987 and that notwithstanding the sitology report of the fluid that was aspirated from the knee, you would have still had significant concerns.

Is that correct?

A. That's correct.

Q. Is that right?

A. That's right.

Q. So, even though the culture of the joint aspirate was negative --

A. That one aspirate, correct.

Q. And even though the -- do you recall what the sitology was on the joint aspirate, Doctor?

A. Not off the top of my head.

Q. If I told you that it was either 216 or 261?

A. The white blood cell, it was about 216.

Q. Is that evidence of infection, doctor?

A. No.

Q. No, it's not, is it?

A. Not for a septic joint and that is not.

Q. And if the polymorphonuclear leukocytes were only six percent, is that evidence of infection?

A. Not in that aspirate, that and my point earlier that I would have been more concerned and that I would have either retapped the knee again, either then or several days later and I would have obtained radiologic studies, for instance, a gallium scan which I mentioned, I think the burden of proof is on the physician that there is no deep seeded infection, which means that all diagnostic modalities must be undertaken to decide whether he is infected or not, it's crucial.

Q. So, even though the culture and the sitology didn't indicate there was any infection within the joint, you still would have been suspicious?

A. On that tap. I mean on that aspirate of what they call a knee tap, again I'll assume they were in the knee joint and I have no reason to assume they didn't do it technically correct, I would have to assume;

I would have a high index of suspicion for the reasons I mentioned earlier; the sedimentation rate, the swelling, the redness, I would have been extremely concerned about it in this host setting of a steroid rheumatoid arthritic.

Q. Okay. Were there -- would there have been any risks, Doctor Levine, in doing another aspiration, entering the man's joint again with a needle?

A. Well, depends on how they do it. I mean you don't put a needle right through an infected wound. I wouldn't have gone through the wound. Obviously, you would have gone in from a different location.

Q. But other than that there would have been no risks associated with retapping this particular patient's knee during that hospitalization?

A. Any time you do any procedure, there are risks, but one must ask themselves the question of benefit versus risk and in this case I think the benefit, the potential benefit, would have greatly outweighed any small risk and there's always a risk.

Again, I don't want to get into an

argument with you, clearly everytime you tap a knee there is a small risk, but I think the benefit, the therapeutic benefit would have greatly outweighed any small risk.

Q. But I think you mentioned several radiographic procedures although you only discussed one and what was that one?

A. I think it was diagnostic, particularly 1987 would have been the gallium scan.

Q. Were there any others?

A. No. Well, there was -- there would have been a bone scan which I probably would have done though, it might have been difficult to determine in this setting of a knee, but I think the knee was four years old, I believe, so I said I mean I probably would have done a bone scan, a gallium scan and at least discussed it with the radiologist.

Q. Plain film radiographs wouldn't have been of any benefit in this situation?

A. As in most, a positive test is useful, a negative test may not be useful, so --

Q. Not just that, but the fact that

you may have chosen to continue to be concerned on the basis of the information that they had.

You're saying that was not the standard of care in infectious diseases whether it required these other things?

A. Yeah, I am saying that exactly, that's right.

Q. And so, Doctor, you're saying that even though these cultures and sitology and everything from this joint came back negative, that even in light of those results it wasn't medically reasonable to assume there was no infection within that joint?

A. In this setting, for instance, if a gallium scan was done, it was more data that there was no evidence, then I think we would not be sitting here discussing it.

Q. So, was it medically reasonable for them to presume on the basis of what they had done that there was an infection or not?

A. Well, what they had done was, I think, below the standard of care, so I mean, how can that answer that question?

Q. You have no questions with what they did.

Is that correct?

A. Right. What they didn't do.

Q. It was appropriate to do the aspiration?

A. Correct.

Q. It was appropriate to do the culture of the aspiration?

A. Correct.

Q. It was appropriate to do the Gram's stain of the aspiration?

A. Correct.

Q. It was approprite to do the sitology on the aspirate?

A. Correct.

Q. All right. It was appropriate to do the other tests that they did?

A. Which are what?

Q. What was that? They did a glucose on the --

A. You're talking about the fluid analysis.

Q. Fluid analysis, right. That was appropriate?

A. Yeah, I don't remember what the fluid analysis showed, I think we should look

at that for a second. The fluid analysis, what was the glucose, was on that fluid analysis. I don't know if you have that available readily or if you want me to look through the chart for it.

Q. Go ahead.

A. You see the glucose was 14 and the protein was 3110, I mean I think one has to ask themselves the question of why the heck -- why was the glucose 14 milligrams per deciliter, that's extremely low.

Now, you know, I mean I think one would have to ask that question and try to come up with an answer.

Q. Doctor, does the disease condition from which this man had been suffering, does it have any affect on the fluid of his joint, his rheumatoid arthritis?

A. Yes, it does.

Q. Can it change the toxicity of the synovial fluid?

A. Yes, it can.

Q. So it can affect the characteristics of the joint, the rheumatoid arthritis?

A. That's right.

Q. As you earlier talked before it was appropriate to start the man on nafcillin pending the culture results on the superficial wound?

A. Yeah, I believe so.

Q. And then later changed that to vancomycin because that was what was indicated as a result of the culture on the superficial wound, right?

A. That's correct.

Q. Have you ever treated a patient with a superficial wound over a joint containing a prosthesis?

A. Yes, I have.

Q. Did all of them involve a joint?

A. Not all of them, but we agonize over every one of them and did all the procedures I have referred to above in order to try to differentiate and there are times when we treat for a prolonged period of time, because we would not be so certain about it.

Q. Were there times when you didn't?

A. When we were convinced that, as I am, yeah, to answer there are times we didn't

treat it for long periods, correct.

Q. And would you agree with me, Doctor, that if the infection that Mr. Cates had in a superficial wound over his knee was just that and did not involve the structures within the knee joint, itself, that the two weeks of vancomycin therapy was appropriate?

A. If that was the case, it would be appropriate.

Q. In your report, you talked about the fact that Mr. Cates, based upon your conclusion that he had an infection within the joint, should have been on out-patient antibiotics.

What out-patient antibiotics should he have been on after his discharge from the hospital?

A. Where are you referring to that? I suggested that in this case?

Q. The patient was then discharged without any further antibiotic therapy?

A. Right.

Q. Does that mean that you believe he should have continued on antibiotics after this discharge from the hospital?

A. Well, no. What I'm saying is that the patient should have gotten more than two weeks of IV therapy. I mentioned that later he should have gotten four to six weeks of IV antibiotics with appropriate debridement, removal of the prosthesis had been indicated and then placed on oral therapy, but you're sort of adding insult to injury, you've just given 14 days on top of that, it's not quite the same thing as saying that would have been okay to give two weeks and then give oral.

Q. Well, then my question to you is what should he have been given orally after his discharge from the hospital on December the 2nd?

A. What I'm saying is that he should not have been discharged on December the 2nd.

Q. He should have actually continued to remain hospitalized for another month?

A. He should have stayed on IV antibiotics for another month, whether they do it in-patient or out-patient or whatever he should have gotten, we do home infusion therapy, he clearly should have gotton at least several weeks more of IV antibiotics with the

appropriate debridement.

Q. But you mentioned oral antibiotics.

What oral antibiotics did you have in mind?

A. In this case it would have been probably ciprofloxacin.

Q. Okay. Doctor, would you agree with me that your decision as an infectious disease specialist of whether to treat a patient is a matter of your professional judgment.

MR. MELLINO: Objection.

A. As compared to whose? I'm not sure what you're comparing to.

Q. It's a matter of your professional judgment.

MR. MELLINO: Objection.

Q. Based upon what you know about the patient and the laboratory results and that type of thing?

A. I think it's based on one's training, one's judgment and what certain standards are.

Q. Okay. That would go for not only

whether to treat the patient but also how to treat him, what to treat him with and how long to treat him.

Isn't that correct?

A. That's correct.

Q. And I believe you've talked earlier that there are certain circumstances where you don't necessarily treat just because there's a positive culture, for instance there's a colonization, I think you said, versus an infection.

Is that right? Is that correct?

A. That's right.

Q. Doctor, would you agree with me that the person who is in the best position to decide on a course of treatment from an infectious disease standpoint, because I believe you said that the clinical picture as well as culture results were important, would be the person that's actually looking at the wound?

MR. MELLINO: Objection.

A. Well, I think there are certain standards that we all live by and I guess that's how lawsuits are started by certain

standards of care, because certainly the person there is in a better position. Certainly, if they make a mistake, which is what I think happened here then, no.

Q. Doctor, is it fair to say that between yourself and someone that you might talk to, another infectious disease person on the phone about a case, that the person who would be in the best position to assess the patient's clinical condition would be you as opposed to the person that's just getting the information secondhand, if you will?

A. You know it depends on how accurate the information is that I would provide to that person. If I was speaking to another colleague getting their opinion and I provide an accurate history, physical, laboratory assessment, then I would expect that person also to have as worthwhile or as positive an opinion or otherwise, I wouldn't be speaking to that person for that judgment.

Q. So, you're saying then that secondhand information is just as good as actually looking at the patient?

A. Oh, no, no, it's just not as good.

If the observer can relate the information in an accurate, precise fashion to another person who is not observing that, then I think that's acceptable. If the observer is not transferring that information, it's not as useful, but clearly and obviously the person looking at the infection is in best position and --

Q. That's fine.

A. Sure.

Q. It's my understanding you don't have any problem with the fact that a suture was placed in this wound during Mr. Cates' hospitalization.

Is that correct?

A. Well, I mean normally we don't like to put sutures in infected wounds. At the time that the suture was put in, the wound, itself, was clean. I guess it's a judgment call I would leave to the discretion of the surgeon, but I would be nervous about it, about seeing it.

Q. But that is not any deviation of standard of care based on your professional judgment?

A. I don't think it's a deviation.

Q. Okay. Doctor, I know that you talked with Mr. Seibel about this.

Is it my understanding that the difficulty in treating methicillin resistant Staph aureus is that it's really not any harder to treat, it's just a more limited number of medications that can be used to treat it.

Is that right?

A. Yes and no, and the reason I say no is that vancomycin, Staph aureus, the therapeutic response, for instance, to methicillin resistant Staph aureus for methicillin is greater than the vancomycin.

So, we can treat Staph aureus with vanco, it's a little more difficult because the spectrum is narrower, the toxicities are somewhat greater than the methicillin, but in general are the same.

Q. Ultimately, there are not many things to treat MRSA with.

Is that correct?

A. It's the toxicities inherent in that particular treatment.

Q. Now, as regards the procedure that

was performed on December 22nd of 1987 when that area of that one centimeter wound was debrided and excised and resutured, you don't have any critcisms of anyone for carrying out that procedure on that day, do you?

A. Well, I think -- I mean the question that has to be asked was why was that necessary to do? Why would there seem to be persistent drainage from that, you know, so you can excise it, I have no problem excising the wound. My problem is I think the entire thing should have been excised. I think it should have been extended down into the knee. So, I don't have trouble with surgery, I think that's a limited surgery and I don't understand why. I would hope that the person treating the patient would say why is this necessary? What is the problem here? Why is there a persistent drainage and Staph aureus.

Q. Now, Doctor, as regards that procedure on December 22nd of 1987 when they did that excision, if the infectious disease service wasn't notified of the fact that it was going to be performed or that it had been performed and you wouldn't have any criticisms

of infectious diseases because of the factor that it was performed.

Isn't that correct?

A. That's correct.

Q. Okay. Or the fact that Mr. Cates wasn't placed on antibiotics on December the 22nd, they had no knowledge of the fact that it was performed?

A. That's right.

Q. And you've just talked, Doctor, about the factor that you were -- you believe someone should have been concerned about why there was a one centimeter lesion on Mr. Cates' knee on December 22nd that needed to be resutured?

A. A draining lesion with Staph aureus in it, yes.

Q. Doctor, isn't it true that when you have sutured incisions over joints that they're subject to mechanical forces which at times cause them not to heal as well as you would ordinarily expect them to.

A. Sure, de novo that would be the differential diagnosis.

Q. And isn't it true, Doctor, that

Mr. Cates' longstanding condition of rheumatoid arthritis also had an affect on his ability to heal any wound?

A. Correct.

Q. And it made him tend not to heal as well?

A. Correct, but we have a saying in infectious diseases, when you hear hoof beats don't think zebras. I mean I think that's what we're talking about here. You're right, you're right, but still something else is wrong.

MR. SEIBEL: I thought zebras had hooves.

MR. ALLISON: They do.

THE WITNESS: Hoof beats, okay.

MR. SEIBEL: You don't know this, he's a veterinarian.

THE WITNESS: Is he really?

Q. Have you ever had occasion to try and treat a wound on a patient which involved a rheumatoid nodule?

A. I'm sorry, a patient's rheumatoid nodule's treating?

Q. Yes. And like an area of ulcerated rheumatoid nodule?

A. We've treated ulcerated wound nodules, yes.

Q. And aren't they more difficult to heal? Aren't they more difficult to heal because by definition a rheumatoid nodule is not normal skin.

Isn't that correct?

A. That's correct.

Q. Speaking of rheumatoid arthritis, you're not a rheumatologist, are you?

A. No, I'm not.

Q. And as far as any opinions specifically with reference to Mr. Cates' rheumatoid arthritis condition and the affect on his overall physical condition, it's fair to say you would defer to a rheumatologist in those areas.

Isn't that correct?

A. Except in the instances where we know rheumatoid arthritics have a higher tendency for infections in the joint, particularly Staph aureus.

Other than that, that is an infectious complication, I would defer any other cases to rheumatologists.

Q. And I think you discussed this with Mr. Seibel, certain medications like prednisone can also have an adverse affect on --

A. Prednisone, in this case, would have.

Q. And you are aware, Doctor, that on the reports that we've discussed regarding the case of Mr. Cates' knee on December 30th, 1987, that the notes indicated that the wound was excellent.

Isn't that correct? You're aware of that note?

A. Well, I think the comment was fine, F-I-N-E, was the way it said it in the chart, wound fine, you have wound fine, per ID of wound fine.

Wound excellent? I didn't see that, okay.

Q. So, apparently at least according to Doctor Matejczyk's note here and what she talked about in her deposition the condition of that surgical site on Mr. Cates' right knee on December 30th, 1987, the wound was excellent.

MR. MELLINO: Objection.

MR. ALLISON: It's according to the report.

MR. MELLINO: Correct, assuming that it was checked.

MR. ALLISON: Pardon me?

MR. MELLINO: Assuming that it was checked on that day.

MR. ALLISON: Whatever, Chris.

Q. Doctor, have you ever recommended in your practice now which has been going on what since 1982 that a patient on antibiotics be discontinued or not be discontinued without actually looking at a wound like this? Have you ever done that?

MR. MELLINO: Objection, when you're talking with one of your residents or fellows or another attending physician, a surgeon or whatever?

A. Any patient that I'm involved with, that I'm taking care of, no. I've never done that, without seeing the patient myself, never.

0. Not one time?

A. Not one time.

Q. And you believe that that's not

just something that you do, but that's a standard of care?

A. I would hope so, I think so.

Q. Is it or isn't it, Doctor?

A. You know, I'd be hardpressed for me to say that's a standard because I don't know if everyone does that, that is what I do and I think that's appropriate, I don't know if the standard of care is that you must see every wound before you stop if, it another physician tells you.

Q. Doctor, have we discussed now, today, between the questions that Mr. Seibel had and the questions that I've had for you all of your opinions in this case?

A. To the best of my knowledge, yes.

Q. And the basis of all of your opinions?

A. Yes.

Q. Can you think of any other opinions that you have about the care and treatment of Travis Cates that's the subject of this lawsuit that we haven't discussed?

A. I don't believe so.

Q. Doctor, if you develop any other

opinions about the care and treatment rendered to Travis Cates that's the subject of this lawsuit between now and trial, would you tell Mr. Mellino or Mr. Kampinski or someone from their office so that we can further inquire and explore those new opinions that you formed between now and the time of trial?

A. Sure.

Q. I mean if you develop any new opinions?

A. Sure.

MR. ALLISON: Okay. I have nothing further.

(Brief discussion held off the record. Back on the record.)

(Recess taken at approximately 3:30 and ended at approximately 3:35 p.m.)

REDIRECT EXAMINATION BY MR. SEIBEL:

Q. Can you have swelling and redness around a superficial infection?

A. Moderate degrees.

Q. Do you have an opinion as to the

source of the infection that Mr. Cates presented with on January 3rd, 1988?

A. When he presented back to the hospital with Staph aureus, septic arthritis and meningitis?

Q. Yes.

A. I think it was related to the original infection.

Q. Tell me why.

A. I'm sorry. When I say that, the infection that he presented to on November 13th.

Q. And what is the basis of your connection between those two events?

A. The facts that both organisms were the same organisms which were methicillin resistant Staph aureus at both periods of time.

Q. How do you know that they're the same organisms?

A. We know that -- well, they were the same organism, they were both Staph aureus, you asked me. They were the same isolates, I mean that's what you're getting at, very sophisticated studies, which we need, which were not generally done. I think one sort of,

you know, when you see things happen in this way, to relate them together is totally within standard so we know there was Staph aureus draining, Staph aureus in the knees and the blood's spinal fluid at that time. I think not to relate them, it would be extremely difficult to do so. I am really pressing probabilities.

Q. Well, what evidence are you going to be able to point to the jury in this case that the infection, the Staph aureus infection he had in November of 1987 is the same Staph aureus that he had when he presented in January of '88?

A. I think we're dealing with both the methicillin resistant Staph aureus.

Q. Now, if he were to have methicillin resistant Staph aureus on other places in his body, how can you draw the conclusion between the connection that was, you know, a knee infection in November after his septic condition in January of '88?

A. Well, depends on what other areas of the body you're talking about and how one develops an invasive disease.

I think it's well-stated that when

someone has septic arthritis and pus in the knee, on steroids that there's a -- and then develops sepsis, that is bacterium, and again assuming that's the case, it is just unreasonable and unrealistic. So, I think you have Staph aureus in the knee which is what I obviously believe and he comes back with Staph aureus in the blood, a knee which we know is a focus for the potential dissemination, that that's the most likely source, statistically indicating that, and I think that it's a high likelihood or high probability.

Q. Is it possible to get Staph aureus in the blood and other places in the body from places other than joints?

A. Oh, you can get Staph aureus in the blood from many other sources.

Q. Such as what?

A. Intravenous lines, other invasive procedures, endocarditis, which is usually primary, secondary.

Q. What about open sores?

A. Open sores, I think it depends on the extent of the openness, that if one has a carbuncle or furuncle, a deep boil, and someone

on steroids I would be concerned also that that is a potential focus.

Q. I just want to clear up something when Mr. Allison was asking you some questions.

You don't read Doctor Blinkhorn's and Doctor Persod's depositions as denying that a conversation took place on December 30th with Doctor Matejczyk, do you?

A. No, no, no, I think they said they have no recall, either one of them.

Q. Now, if Mr. Cates did not, in fact, have an infected knee joint on November 13th, 1987, and, thereafter, was it acceptable care to leave the prothesis in?

A. If you're asking me to assume that there was no deep knee infection?

Q. Right.

A. Certainly.

Q. Okay. And if there is no -- and again assuming that there was no deep knee infection during that November to December hospitalization, was it okay to discharge Mr. Cates from the hospital on December 2nd?

A. On no antibiotics?

Q. Correct.

A. If the knee was as described which was clinically improving, if there was no deep infection, then I think it would be appropriate.

Q. And if this gallim scan were to be negative for an infected knee joint, then your testimony is that there would be no claim here to pursue?

A. If one makes all attempts to prove there is an infection in the knee and that all attempts, reasonable within standards of care, are negative and you understand what I'm saying, obviously, we wouldn't be here.

If, in fact, that were true, then I think we'd have no case.

Q. Over two years ago when you sent your report to Mr. Kampinski, you suggested to him that he have an orthopedist review this case.

Do you know if that review ever took place?

A. No, I don't know.

Q. And were you -- I take it you were paid by Mr. Kampinski for your review in this case?

A. Yeah, I think you asked me that in the very beginning.

Q. All right. Were you paid before or after you wrote your report?

A. I would assume my standards are to get paid after the report.

Q. I'll do a quick flip through my notes and we might be done.

And I take it your opinion is that Mr. Cates should have received prolonged antibiotic therapy between the dates of November 13th and January 3rd?

A. As a minimum, yes.

Q. Yeah. When?

A. I'm sorry, say that again, between --

Q. November 13th and January 3rd?

A. Well, I think he should have continued antibiotics. I mean, you know, I don't know, I'm not saying it should have been stopped January 3rd, but, yeah, he should have been continued on antibiotics after the date they stopped it, right.

Q. With continued antibiotics, can you state to a reasonable certainty that he

would not have had the infection he presented with on January 3rd?

A. No, that's what I said as a minimum.

Q. And I'll ask the same question that Mr. Allison did, just so the record's clear.

Have you stated to me in the deposition today all the areas in which you feel that Doctor Matejczyk deviated from accepted standards of care?

A. Including when I say minimal, when I says minimal you understand surgical debridement or the removal with that, yes, I think I've stated all my opinions today in this case.

Q. Now, let me -- let me ask you one more question since you brought the topic up, do you have an opinion to a reasonable degree of medical probability that had Mr. Cates' prosthesis been removed sometime between November 3rd -- I'm sorry, between November 13th and January 3rd and that he would have been on antibiotics during that time that he would not have had the infection he presented

with on January 3rd?

Yeah, I believe that.

MR. SEIBEL: I don't have anything further.

RECROSS EXAMINATION BY MR. ALLISON:

Q Doctor, I've got just a couple of quick questions.

You and Mr. Seibel just talked about how this infection could have developed in Mr. Cates' blood, the septicemia, and you talked about how you recognized an infection in a joint can spread to the blood stream.

Isn't that correct?

A That's correct.

Q Is it also equally recognized that infection in the blood stream can set itself up in a joint?

A Sure.

Q And especially if that joint happens to be compromised by an arthritic process, aren't they more susceptible to bloodborne or hematogenous infections?

A. Correct.

Q. So that if Mr. Cates had a bloodborne infection for any reason no matter what the original site was, and we'll assume it wasn't his knees, that those knees would have been more susceptible to, both of them, to an infection setting up there than if he had not had the degenerative changes due to his rheumatoid arthritis?

A. If we assume he had another focus of Staph, primary to secondary, and if we assume it was not his knee as the focus of infection, he has a higher risk of that knee becoming subsequently infected, correct.

Q. As well as the other which has also been affected?

A Right.

Q. Which is what, in fact, happened in this case; both knees were affected?

A. Both knees were affected.

Q. In January of 1988?

A. The other knee became infected in January.

Q. Okay.

A. Right.

MR. ALLISON: That's all I have,

Doctor, thank you.

(Brief discussion held off the record. Back on the record.

MR. SEIBEL: Doctor, the lawyers have agreed, under Ohio procedure you would, as a witness, would have the right to review the testimony of your deposition today once it has been transcribed by the court reporter.

We are ordering the deposition to be transcribed and I suppose under -- we'll apply Ohio procedure and give you the opportunity to review your deposition testimony, if you so desire, to make corrections in the transcription, or like under Ohio procedure, you have the right to forego your signature.

MR. MELLINO: Read it.

THE WITNESS: All right.

MR. SEIBEL: Okay.

(Proceeding concluded at approximately 3:55 p.m.)

C O R R I G E N D U M

PAGE	LINE	CHANGE/REASON

JEROME F. LEVINE, M.D.

STATE OF NEW JERSEY X
COUNTY OF_____ X

SUBSCRIBED AND SWORN TO by the Said Witness, Jerome Levine, M.D., on this the_____day of _____, 1991.

Notary Public in and for the State of New Jersey

My commission expires:_____

C E R T I F I C A T E

I, THERESA L. TESSITORE, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, do hereby certify the foregoing to be a true and accurate transcript of my stenographic notes in the above-entitled matter.

THERESA L. TESSITORE, C.S.R.

CERTIFIED SHORTHAND REPORTER

CERTIFICATE NO. XI01210

Charles Kampinski, Esquire
1530 Standard Building
1370 Ontario Street
Cleveland, Ohio 44113

April 4, 1989

re: Travis Cates, File Number 4-265

Dear Mr. Kampinski:

I have reviewed the following medical records provided to me in the case of Travis Cates: 1. Office the records of Dr. Matejczyk of September 22, 1981 to April 13, 1988; 2. Records from admission to the Cleveland Metropolitan General Hospital of November 13th through December 2, 1987; December 22, 1987; and January 3rd through January 28, 1988; 3. Records from admissions to Highland View Hospital of January 28th through February 11, 1988 and February 16th through March 13, 1988; 4. Office records of Dr. Ballou of March 8, 1988 through July , 1988; 5. Emergency department records in the Cleveland Metropolitan General Hospital of January 3, 1988. At your request, I would like to give you my thoughts on the medical care provided to this patient. I believe that the care provided to Mr. Cates prior to November 13, 1987 and after January 3, 1988 was appropriate and within the accepted standard of medical care. In particular, the hospitalization and subsequent medical problems that developed after January 3, 1988 were handled in an exemplary fashion.

However, I believe that the treatment of Mr. Cates during his hospitalization of November 13th through December 2, 1987 and subsequently December 27, 1987 through December 30, 1987 was not within the standard of medical care and that this negligence led to the complications requiring hospitalization of January 3, 1988 with the life threatening infection of staphylococcal sepsis, septic arthritis, and probable endocarditis. In particular, during the hospitalization of November 13, 1987 through December 2, 1987, the physicians caring for this patient felt that he had developed a septic prosthetic right knee infection due to methicillin resistant Staphylococcal aureus (MRSA). Although there may be some debate as to whether the patient had a bursitis versus a septic arthritis, it is probably not relevant in the type of treatment that the patient should have received. However, I will accept the impression of the physicians who cared for the patient as recorded in the medical records that he had a septic prosthetic knee. The patient received intravenous antibiotics for only 17 days, the prosthetic knee was not widely debrided nor was an attempt made to remove it . Instead, the wound site at which the drainage had occurred was apparently sutured on day number 14 of that hospitalization. Certainly, this is not the standard of care for the treatment of an infected prosthetic knee. More significantly, the organism obtained, methicillin resistant Staph aureus is a highly virulent organism which is difficult to treat due to its methicillin resistant characteristic. Although the patient did receive intravenous vancomycin to which the organism was susceptible, this antibiotic was given only for 14 days. The patient was then discharged without any further antibiotic therapy. A two week course of an appropriate intravenous antibiotics for this condition would not be expected to be curative in any sense and it was not surprising to me that the patient returned again on December 22, 1987 for an operative repair of a persistent wound drainage and had positive cultures again of the tissue for MRSA. Unfortunately, the physicians caring for the patient did not treat this patient with antibiotics at that time. There is a comment noted on the susceptibility sheets for the positive growth of methicillin resistant Staph aureus of December 30, 1987 that "ID" recommended no further

treatment if "wound fine". This is clearly inappropriate treatment which directly lead to the devastasting infection that occurred as of January 30, 1988. If, the physicians caring for the patient felt that he did not have a deep wound infection, it would be difficult for them to explain how they interpreted the operative cultures. This would have to be explored further during deposition.

Although certain issues concerning the treatment of an infected prosthetic knee are still controversial, these controversies basically center on the type of surgical intervention and the number of months of appropriate antimicrobial therapy. However, I believe that the literature, which was available on November, 1987, clearly supports the need for aggressive wound debridement and/or prosthetic removal with long term antibiotic therapy. In fact, there is little issue as to the need for long term therapy, not just 2 weeks. In general, most infectious disease specialists recommend a six to eight week course of appropriate intravenous antibiotics followed by months to perhaps years of an appropriate oral antibiotic therapy. This case is complicated further by the nature of the organism isolated, methicillin-resistant Staphylococcal aureus which is known to be a difficult organism to treat. I believe that only a *14* day course of intravenous vancomycin was not appropriate therapy especially since the infectious disease physicians caring for the patient gave the impression that they believed that the patient had an infected prosthetic knee.

I would recommend that an orthopedist also review this case as I believe that the orthopedic procedure during that hospitalization of November 3, 1987 and again on December 22, 1987 was not appropriate and below the standard of care. However, as I am not an orthopedist myself, I would be interested to see what their point of view would be.

As further material is obtained during depositions, I would be happy to review this material with you and provide my opinion at that time. If you require additional information, please let me know.

Sincerely,

Jerome F. Levine, M.D., F.A.C.P.
Attending
Infectious Disease Section
Clinical Assistant
Professor of Medicine
New Jersey Medical School
UMDNJ

Diplomate of the American Board of
Internal Medicine and
Subspecialty of
Infectious Disease

cc: Leslie Klausner, R.N., B.S.N.
JFL/km

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However, I believe that the treatment of Mr. Cates during his hospitalization of November 13th through December 2, 1987 and subsequently December 27, 1987 through December 30, 1987 was not within the standard of medical care and that this negligence led to the complications requiring hospitalization of January 3, 1988 with the life threatening infection of staphylococcal sepsis, septic arthritis, and probable endocarditis. In particular, during the hospitalization of November 13, 1987 through December 2, 1987, the physicians caring for this patient felt that he had developed a septic prosthetic right knee infection due to methicillin resistant Staphylococcal aureus (MRSA). Although there may be some debate as to whether the patient had a bursitis versus a septic arthritis, it is probably not relevant in the type of treatment that the patient should have received. However, I will accept the impression of the physicians who cared for the patient as recorded in the medical records that he had a septic prosthetic knee. The patient received intravenous antibiotics for only 17 days, the prosthetic knee was not widely debrided nor was an attempt made to remove it . Instead, the wound site at which the drainage had occurred was apparently sutured on day number 14 of that hospitalization. Certainly, this is not the standard of care for the treatment of an infected prosthetic knee. More significantly, the organism obtained, methicillin resistant Staph aureus is a highly virulent organism which is difficult to treat due to its methicillin resistant characteristic. Although the patient did receive intravenous vancomycin to which the organism was susceptible, this antibiotic was given only for 14 days. The patient was then discharged without any further antibiotic therapy. A two week course of an appropriate intravenous antibiotics for this condition would not be expected to be curative in any sense and it was not surprising to me that the patient returned again on December 22, 1987 for an operative repair of a persistent wound drainage and. had positive cultures again of the tissue for MRSB. Unfortunately, the physicians caring for the patient did not treat this patient with antibiotics at that time. There is a comment noted on the susceptibility sheets for the positive growth of methicillin resistant Staph aureus of December 30, 1987 that "ID" recommended no further

treatment if "wound fine". This is clearly inappropriate treatment which directly lead to the devastasting infection that occurred as of January 30, 1988. If, the physicians caring for the patient felt that he did not have a deep wound infection, it would be difficult for them to explain how they interpreted the operative cultures. This would have to be explored further during deposition.

Although certain issues concerning the treatment of an infected prosthetic knee are still controversial, these controversies basically center on the type of surgical intervention and the number of months of appropriate antimicrobial therapy. However, I believe that the literature, which was available on November, 1987, clearly supports the need for aggressive wound debridement and/or prosthetic removal with long term antibiotic therapy. In fact, there is little issue as to the need for long term therapy, not just 2 weeks. In general, most infectious disease specialists recommend a six to eight week course of appropriate intravenous antibiotics followed by months to perhaps years of an appropriate oral antibiotic therapy. This case is complicated further by the nature of the organism isolated, methicillin-resistant Staphylococcal aureus which is known to be a difficult organism to treat. I believe that only a 14 day course of intravenous vancomycin was not appropriate therapy especially since the infectious disease physicians caring for the patient gave the impression that they believed that the patient had an infected prosthetic knee.

I would recommend that an orthopedist also review this case as I believe that the orthopedic procedure during that hospitalization of November 3, 1987 and again on December 22, 1987 was not appropriate and below the standard of care. However, as I am not an orthopedist myself, I would be interested to see what their point of view would be.

As further material is obtained during depositions, I would be happy to review this material with you and provide my opinion at that time. If you require additional information, please let me know,

Sincerely,

Jerome F. Levine, M.D., F.A.C.P.
Attending
Infectious Disease Section
Clinical Assistant
Professor of Medicine
New Jersey Medical School
UMDNJ

Diplomate of the American Board of
Internal Medicine and
Subspecialty of
Infectious Disease

cc: Leslie Klausner, R.N., B.S.N.
JFL/km

Hackensack Medical Center

Ex - 1
TB-91

Charles Kampinski, Esquire
1530 Standard Building
1370 Ontario Street
Cleveland, Ohio 44113

April 4, 1989

re: Travis Cates, File Number 4-265

Dear Mr. Kampinski:

I have reviewed the following medical records provided to me in the case of Travis Cates: 1. Office the records of Dr. Matejczyk of September 22, 1981 to April 13, 1988; 2. Records from admission to the Cleveland Metropolitan General Hospital of Sovember 13th through December 2, 1987; December 22, 1987; ana Januarv 3rd through January 28, 1988; 3. Records from admissions to Highland View Hospitai of January 28th through February 11, 1988 and February 16th through March 13, 1988; 4. Office records of Dr. Ballou of ?larch 8, 1988 through July , 1988; 5. Emergency department records in the Cleveland Metropolitan General Hospital of January 3, 1988. At your request, I would like to give you my thoughts on the medical care provided to this patient. I believe that the care provided to Mr. Cates prior to November 13, 1987 and after January 3, 1988 was appropriate and within the accepted standard of medical care. In parricular, the hospitalization and subsequent medical problems that developed after January 3, 1988 were handled in an exemplary fashion.

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Sincerely,

Jerome F. Levine, M.D., F.A.C.P.
Attenaing
Infectious Disease Section
Clinical Assistant
Professor of Lledicine
New Jersey Medical School
UMDNJ

Diplomate of the American Board of
Internal Medicine ana
Subspecialty of
Infectious Disease

JFL/km

Ex-2
Tr

CURRICULUM VITAE

NAME: Jerome F. Levine. M.D.

BORN: Sew York, New York: April 10. 1949

EDUCATION: Union College, Schenectady. Sew York
B.S.E.E. summa cum laude. 1971

Sew York University School of Medicine.
New York, New York M.D., 1976

POSTGRADUATE TRAINING:

Internship and Residency in Medicine
Manhattan V.A. Hospital - N.Y.U. Medical Center, New York, New York - 1976-1979

Chief Medical Resident
Manhattan V.A. Hospital
New York, New York - 1979-1980

Fellowship in Infectious Disease
Manhattan V.A. Hospital
New York, New Tork - 1980-1982

APPOINTMENTS:

Teaching Assistant in Medicine
Faculty, New York University Medical Center. New York, Sew York 1979-1982

Clinical Assistant Professor of Yedicine
University of Medicine & Dentistry of New Jersey
Ye dersey Medical School - 1983 - Present

Clinicai Assistant
Infectious Disease Section
Hackensack Medical Center
Hackensack. New Jersey - 1982 - 1983

Assistant Attending
Infectious Disease Section
Hackensack Medica1 Center
Hackensack. New Jersey - 1983 - 1988

Attending
Infectious Disease Section
Hackensack Medical Center
Hackensack, Sew Jersey - 1989 - present

Consultant, Infectious Diseases,
Valley Hospital,
Ridgewood, Sew Jersey - **1982** - present

Consultant, Infectious Diseases,
Good Samaritan Hospital,
Suffern. New York - *1983* - *1984*

Fellowship Program Director,
Infectious Disease Section.
Hackensack Medical Center
Hackensack, New Jersey - *1984* - Present

Assistant Program Director
Department of Internal Medicine
Hackensack Medical Center
Hackensack, New Jersey **1986** - *1989*

Associate Program Director
Department of Internal Medicine
Hackensack Medical Center
Hackensack, New Jersey **1989** - present

Assistant Chief of Infectious Diseases
Department of Internal Medicine
Hackensck Medical Center
Hackensack, New Jersey - *1990* - present

SPECIALTY BOARDS:

Diplomate of the National Board of Medical Examiners - 1977

Diplomate of the American Board of Internal Medicine - *1979*

Diplomate of the Subspecialty of infectious Diseases - 1983

SOCIETIES:

Fellow of the American College of Physicians
Member of the Infectious Diseases Society of America
Association of Program Directors of Internal Medicine
American Xedicai Association
imerican Society far Microbiology
Association for Practitioners in Infection Controi

PROFESSIONAL COMMITTEES:

?!ember. Infection Control Committee - 1982 - Present
Hackensack Medical Center

Chairman, Antibiotic Utilization Committee - 1983 - Pr
Hackensack Medical Center

Quality Assurance Committee - 1983 - *1984*
Hackensack Medical Center

Chairman, Area Wide Study on Antibiotics for
Surgical Prophylaxis Association for
Professional Health Care Review - 1983 - **1985**

Chairman. Infectious Diseases Committee
Bergen County Medical Society of the
New Jersey Medical Society - 1983 - Present

Grants:

Fairleigh S. Dickinson Jr. Foundation: **$50,000.**
"Prospective Study of Pneumonia in the Elderly"

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.. Levine JF. Hiesinger EM. Whelan MA. Pollock AA. Simberkoff MS. Rahal JJ, Jr.: Pneumococcal meningitis associated with retroperitoneal abscess: A rare complication of lumbar puncture. JAXA 1982; 248:2308-2309.

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8. Levine JF: Differentiating the pneumonias. Diagnosis 100-108, September, 1983.

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15. Levine JF, Gross PA: Hospital acquired infections. Roche Handbook of Differential Ciagnosis. iloffman-La Roche. Inc. 1985.

16. Gross PA, Levine JF: Fever of unknown origin. Roche Handbook or Differential Ciagnosis. Hoffman-La Roche, Inc. 1985.

17. Levine JF, Gross PA: Urinary tract infections. Roche Handbook of Differential Diagnosis. Hoffman-La Roche. Inc. 1985.

18. Gross PA, Levine JF: Central nervous system infections. Handbook of Differential Diagnosis. Hoffman-La Roche, Inc. 1986.

19. Levine JF, Gross PA: Endocarditis. Handbook of Differential Diagnosis. Hoffman-La Roche, Inc. 1986

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1. Gross, PA, Levine JF: Infections In The Elderly. In Wenzel (ed): Prevention and Control of Nosocomial Infections. Baltimore: Williams & Wilkins: 1986:541-559.

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ABSTRACTS

1. Levine JF, Maslow MJ, Hanna BA, Leibowitz RE, Pollock AA, Simberkoff YS, Rahal JJ, Jr.: Amikacin-resistant gram-negative bacilli: a clinical, epidemiological and microbiological survey. Twenty-second Intsrscience Conference on Antimicrobial Agents and Chemotherapy, 1982. Abstract 531.

Rev

To Jerome Levine MD.

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TRANSCRIPT TO BE PICKED UP ON_____

THANK YOU FOR YOUR TIME. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THERESA TESSITORE, C.S.R. AT (201) 342-8714.