IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

BESSIE M. BROOKS,
Individually and as
Administrator of the Estate
of Lee Thomas Brooks,
Plaintiff,

vs. Case No.

THE CLEVELAND CLINIC 397309
FOUNDATION, et ai.,
Defendants,

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Deposition of DAVID C. PRESTON, M.D., called for examination under the statute, taken before me, Lauren I. Zigmont-Miller, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Becker & Mishkind, Skylight Office Tower, 660 West 2nd Street, Suite 660, Cleveland, Ohio, on Monday, October 30, 2000, at 4:55 o'clock p.m.

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APPEARANCES:

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On behalf of the Plaintiff
Becker & Mishkind, by
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On behalf of the Defendants:
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DAVID C. PRESTON, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF DAVID C. PRESTON, M.D.

BY-MR. KELLEY:

Q. Could you state your name, please, just for the record?

A. David C. Preston, M.D.

Q. Dr. Preston, my name is Jay Kelley. We just met briefly. I represent The Cleveland Clinic Foundation in a lawsuit that was filed on behalf of the Estate of Mr. Brooks. What I'm going to do here today is take your deposition.

Have you ever had your deposition taken before?

A. I have.

Q. And have you ever acted as an expert witness before?

A. I have.

Q. How frequently do you do

that?

A. In regards to medical-legal cases I review in the neighborhood of five to eight cases per year. I've been doing this for the past 10 to 12 years. I've been in jury trials giving testimony approximately five or six times in my career, and I've been deposed about 20 times in my career, however, half of those were in regards to being an impartial medical examiner for the State of Massachusetts when I lived in Boston.

MR. MISHKIND: He just answered the next four questions for you.

Q. I assume you also testify as a neurologist with some frequency in auto cases and things such as that where there's injuries?

A. No, I do not.

Q. The medical-legal cases that you review, the five to eight per year, do you belong to any referral source that sends them to you?

A. Not that I'm aware of.

Q. Do you know how it is that these lawyers, whether it be plaintiff or defense lawyers, get your name?

A. I have no idea.

Q. I know you've given some depositions before. Let me just set forth the ground rules so we have them on the record here.

Obviously our communication has to be verbal so that the court reporter can take things down. Head nods and uh-huhs or hu-uhs are a little bit difficult to get down, so verbal answers are the best. Also, if there's a question that I phrase that makes no sense, which I'm known to do sometimes, let me know before you answer it and I'll be happy to repeat it or rephrase it. Okay?

A. Okay.

Q. Understand that this is my one chance to ask you questions and I'm going to be relying in my trial preparation upon your answers, that's

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why it's important to me that we have an honest communication and make sure we understand each other. Okay?

A. Okay.

Q. If you need a break, let me know. It's a deposition, not an inquisition, so we'll give you as many breaks as you need for whatever reason you want.

I've been given a copy of your CV here today. Let me just ask you some preliminary questions.

Where did you go to medical school?

A. I went to medical school here in Cleveland at Case Western Reserve University.

Q. And you finished up in 1985 it looks like?

A. That's correct.

Q. You were also in Massachusetts. What took you to Massachusetts?

A. Following medical school I did a one-year medical internship here

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in Cleveland at University Hospitals. I then moved to Boston, Massachusetts to do my neurology residency training followed by a neurology fellowship, after which I took on two different staff jobs over the years in Boston.

Q. I have your CV here, and it appears to me that it's pretty detailed. Does this CV also include all of your writings?

A. It does.

Q. Have you ever written on polymyositis?

A. I've never written a medical journal article per se about polymyositis; however, among my writings I am an author of several textbooks which deal with the broad topics of neuromuscular disorders of which polymyositis is one.

For instance, there's a textbook authored by myself and my wife entitled Electromyography and Neuromuscular Disorders, within that there's some discussion of polymyositis.

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I've acted as a section editor for a large textbook of neurology entitled The Office Practice of Neurology where I was the editor in charge of the neuromuscular and spinal cord section of which there is a chapter on inflammatory myopathy which includes polymyositis.

So in that regard I have had some exposure to medical writing with polymyositis and similar conditions.

Q. I heard that you wrote the book with your wife. Is she also a neurologist?

A. She is.

Q. Where does she practice?

A. Presently she practices at University Hospitals as well.

Q. Is her name also Preston, or does she go by another name?

A. Her last name is Shapiro.

Q. Have you reviewed this case with your wife at all?

A. No.

Q. The chapters of the textbook

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that you edited that include some references to inflammatory myopathies and things such as that, were those chapters authored directly by yourself?

A. No, they were not.

Q. Were they authored by a neurologist or a rheumatologist?

A. They were authored by a neurologist.

Q. Is polymyositis typically a neurologic or a rheumatologic disease?

A. I think it's fair to say that it's both. There are certain disorders in medicine that overlap among specialties, and clearly polymyositis is one that overlaps between rheumatologists and neurologists.

Q. Is it autoimmune in origin or is it nerve related in origin?

A. As you've asked the question there's two different questions. Polymyositis is a disorder of muscle and not nerve. It is felt to be by most experts autoimmune in origin, although the etiology of polymyositis is not as

well understood as other autoimmune disorders.
Q. Autoimmune disorders, if I understand them correctly, are typically handled by rheumatology, correct?
A. I think it's fair to say that many autoimmune disorders are handled by rheumatologists; however, for instance, in my field, which is neurology, there are many autoimmune disorders that primarily affect the nervous system. In those situations it's most common that neurologists directly take care of those patients,
Q. When is the last time you treated a patient with polymyositis?
A. I can't give you an exact date, but it would be within the last few months.
Q. And that would be at University Hospitals?
A. That's correct.
Q. Were you consulted for that patient by another physician, or was it a patient who had a co-morbid

neurological condition?
A. I'm not sure I understand your question.
Q. Sure, let me rephrase it.
My question to you is, the patient with polymyositis, was that the only diagnosis that the patient had or was there another neurologic problem that the patient had also?
MR. MISHKIND: You're limiting it to neurological condition as opposed to any other condition that was co-morbid?
MR. KELLEY: Yes.
Q. I want to know if there was another reason, another neurologic reason that a neurologist was involved for.
A. The answer would be no. The reason why I was involved was due to polymyositis alone and not another neurological problem. I think it's important to point out that within neurology there are certain subspecialties of neurology. My

particular subspecialty is neuromuscular disorders, so I'm a neurologist who deals with primarily disorders of muscle and nerve.
Q. Are you familiar with any literature put out by the Department of Rheumatology at Case Western Reserve University on polymyositis?
A. No.
Q. Would you have any reason to believe that the literature put out by the physicians in the Department of Rheumatology at Case Western Reserve University regarding polymyositis was unreliable?
MR. MISHKIND: Let me object to that for a number of reasons. Number one, he's not familiar with what it is, and not being familiar with it how can he say whether it is or isn't reliable? There's a number of bases for the objection.
If you understand the question you can answer it.
A. I have no reason to think

that it shouldn't be reliable, but I can't make a judgment on something I don't know about.
Q. Have you ever discussed polymyositis with the physicians who are involved in rheumatology at Case Western Reserve University?
A. The answer is probably no.
Q. I assume that within the institution itself --just so I can get an understanding of how these patients come to you -- you're usually consulted in to see a patient with suspected polymyositis?
A. I think that's certainly a possibility. It's equally or more likely I'm consulted to see a patient due to weakness where the diagnosis is not known.
Q. Are you aware of when physicians consult you in versus when they would consult in a rheumatologist at Case Western Reserve University?
A. I guess I'd ask you to expand your question. Do you mean in

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regards to a patient with known polymyositis or in regards to a patient with weakness?
Q. Let's go with known polymyositis. Would it be you or would it typically be a rheumatologist at Case Western Reserve?
A. I think it would typically be either one. I think this is a condition which does overlap between neuromuscular neurologists and rheumatologists, and a patient with polymyositis could equally be treated by either one.
Q. Do you work at the main campus at Case Western Reserve?
A. I work at University Hospitals, yes.
Q. For University Hospitals?
A. Yes.
Q. And I assume in your workings at University Hospitals you at times have patients admitted onto the general medical floors or the neurologic floors where you're the attending?

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A. I do have occasion to have patients admitted to the neurology wards where I'm the attending, yes.
Q. Are there residents then who would follow the patients during the course of the evenings?
A. Yes.
Q. And is that something that's normal in a teaching institution, to have residents available during the evening while the attendings are not present in the hospital?
A. Yes.
Q. That's absolutely normal, there's nothing unusual about that in a teaching institution, correct?
A. Correct.
Q. Have you ever lectured on polymyositis?
A. The answer would be yes. I've lectured on polymyositis in regards to the EMG diagnosis of polymyositis.
Q. Up at Harvard there are some physicians that I want to know if you believe their literature would be

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reliable and/or authoritative on this topic. There's a Dr. -- and I might mispronounce his name -- Shwarm, do you know who he is, a neurologist?
A. I do not.
Q. How about Dr. Kaplan?
A. Kaplan is a common name. You'd have to give me the first name.
Q. I do not know the first name. But do you know a Dr. Kaplan in the Department of Neurology at Harvard?
A. As stated it's a complicated question because the Department of Neurology at Harvard, there are four or five large hospitals. Take, for instance, Massachusetts General Hospital, there's 250 neurologists on staff who all have some affiliation. Where I was at the Brigham &Women's Hospital there was well over a 100 neurologists who had some affiliation. So there are literally several hundred neurologists associated with the Department of Neurology at Harvard,
Q. How do you know Mr.

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Mishkind?
A. I know Mr. Mishkind -- well, I know Mr. Mishkind from this case. I know Mr. Mishkind from two other cases where I was retained by attorneys as an expert witness and he was the opposing counsel.
Q. Who were the attorneys who had retained you?
A. In both cases they were attorneys from the firm of Weston, Hurd here in Cleveland.
Q. Do you know who they are?
A. One of them is Kenneth Torgerson, and the other name I do not recall at the moment.
Q. Was it a medical malpractice case or was it an injury case?
A. They were both medical malpractice cases.
Q. Was it Ron Rispo?
A. The name sounds familiar, but I'm not sure.
Q. Did either of those cases have anything to do with neuromuscular

disorders?
A. Yes.
Q. Did either of them by chance have to do with polymyositis?
A. No, they did not.
Q. How about any other inflammatory myopathy?
A. No.
Q. Did you give a deposition in that case?
A. In the case which involved Mr. Torgerson I did give a deposition, yes. In the other I did not.
Q. Did either of those cases go to trial?
A. The case with Mr. Torgerson is still pending and supposedly will be going to trial, and the other I believe was settled amicably among the parties.
Q. So there's going to be a situation down the road where you're potentially going to be on the stand and cross-examined by Mr. Mishkind?
MR. MISHKIND: Or someone from this firm.

Q. Or someone from this firm?
A. Correct.
Q. Have you ever been sued for malpractice?
A. No.
Q. Have you reviewed any of the depositions in this case?
A. I have.
Q. Which ones?
A. I reviewed the depositions of Dr. Popovich, Dr. Goldman, and Dr. Grundfest
Q. Have you seen a deposition transcript or a deposition summary from Dr. Lisgaris or Dr. Stanisic?
A. I have not.
MR. MISHKIND: I just got the depos in today.
Q. Have you been provided any information regarding their testimony?
A. In my meeting with Mr. Mishkind the hour before he briefly mentioned those two depositions.
Q. Do you know Dr. Lisgaris?
A. I do not.

Q. I'll try to give you a little history on her to see if you can place her. She is a third year fellow at Case Western Reserve who is joining the staff at Case Western Reserve with the Infectious Disease Department in July.
That being said, do you work with the Infectious Disease Department at all?
A. No, with the exception that when I am the neurology attending on the neurology floor if one of my patients has an infectious disease problem which is complex or that I need assistance with I would then consult the infectious disease consultation service.
Q. How many times have you treated polymyositis as an attending in your career?
A. I can't give you an exact number because I haven't kept track of it. I've graduated from fellowship now for ten years. I would estimate I take care of three to eight patients a year

with polymyositis.
Q. Have you been provided any sort of case summaries from Mr. Mishkind?
A. I'm not quite sure what you're referring so, so to the best of my ability the answer is no.
Q. I assume there is some correspondence between you and Mr. Mishkind regarding your review of this case?
A. Yes.
Q. Is that with you here today?
A. No, it is not.
Q. Is there a reason you chose not to bring it with you today?
A. There was no information in the correspondence. I have some cover letters from him stating please find the enclosed medical records for your review.
Q. When he sent you the medical records what were you asked to do?
A. When I was initially contacted and sent the medical records

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regarding Mr. Brooks' case I was asked to review the records and comment specifically on several areas of Mr. Brooks' case, and those areas were his neurologic diagnosis, the indication for a PEG tube, and what his likely morbidity and mortality would have been if he had not suffered his complication of an intra-abdominal bleed which resulted from this PEG tube placement.

Q. If I understand your report correctly, you believe the diagnosis was appropriate of polymyositis, correct?

A. I do.

Q. You believe that the indication for the PEG tube was present and, therefore, appropriate, correct?

A. I do.

Q. So you have no opinions regarding deviations from the standard of care in this case, is that a fair statement? Your opinions are limited to the morbidity and mortality of polymyositis absent the bleed?

MR. MISHKIND: Before he

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answers, I'm not sure how you can make that quantum leap to that statement based upon --

Q. Let me do this. Do you have opinions regarding the standard of care in this case?

A. I do have opinions with the proviso that I was asked to concentrate on the three topics that I just gave you.

Q. Well, let me do this --

MR. MISHKIND: Actually, four.

MR. KELLEY: I only had three. I had neuro diagnosis, whether the diagnosis was appropriate, the indications for the **PEG,** and morbidity and mortality assuming there was no bleed.

MR. MISHKIND: I broke morbidity down to the third and mortality to the fourth, that's where I came up within my simple way of thinking.

MR. KELLEY: Okay.

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Q. Beyond that you were not asked to do anything else in this case, correct?

A. When I was initially contacted I was asked to address those three or four topics.

Q. And in reading your report -- I have a report of March 22nd, 2000. First, is this the only report you've ever written in this case?

A. It is.

Q. And are there any drafts that you've retained?

A. There were no drafts.

Q. Did anyone review the draft before you submitted it in final form to Mr. Mishkind?

A. No.

Q. I assume you wrote it yourself without the assistance of Mr. Mishkind or any of your fellows or anything of that sort?

A. That's correct.

Q. Is there anywhere in this report where you set forth any opinions

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where you believe The Cleveland Clinic Foundation deviated from the standard of care?

A. In that report, no.

Q. So I would be fair to come to this deposition today with the expectation that you have no standard of care opinions that The Cleveland Clinic Foundation departed from the standard of care, correct?

MR. MISHKIND: Before he answers, let me just indicate, Jay, I'm not trying to give you a difficult time, but for the record, the way that our discovery has gone and continues with the factual discovery having been completed and actually continuing on and with expert reports produced, his report was written back in March before any depositions were taken, and I just received in your last expert's report on Thursday or Friday.

You're correct in that his report identifies the issues that we've talked about. You asked him whether or

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not he has any standard of care opinions based upon whatever aside from what was in his report. Whether or not he is permitted to testify on standard of care issues, whether I intend to elicit standard of care opinions from him, those are perhaps separate issues. His report does not identify standard of care issues for the obvious reasons.

MR. KELLEY: And, Howard, I'll tell you where I'm going. Where I'm going with it is obviously I come here today with no information that he has any belief that we deviated from the standard of care. Obviously to varying degrees attorneys come with limited knowledge regarding the medicine and obviously prepare for the deposition in accordance with what to expect.

Whether or not it requires an additional deposition later on, I don't know. Whether or not it requires some motion perhaps later, I don't know. You know I'm not somebody who is going to give you a hard time on something

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like that. But I have to make sure that if in fact it does become an issue, like if he comes out with something that I can't anticipate or something of the sort, that I've protected my client. That's the only reason I'm asking.

MR. MISHKIND: I understand. I'm very familiar with the local rules and how things are done having done this for 20 years. On the other hand, we're obviously dealing with a court that has provided us with --

MR. KELLEY: Be careful, this is on the record.

MR. MISHKIND: -- with a very aggressive schedule that you and I have been trying to deal with.

Q. Dr. Preston, just so I make sure the record is clear -- obviously we love to speak as lawyers, so we digress -- you agree with me that at no point have you ever written a report prior to today that sets forth that you believe anyone at The Cleveland Clinic

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Foundation deviated from the standard of care?

MR. MISHKIND: And before he answers that let me just state that his report does not indicate whether anyone did or did not deviate.

MR. KELLEY: Sure.

MR. MISHKIND: You're taking the negative. His report doesn't indicate that anyone met the standard of care, nor does his report indicate that anyone deviated. I will stipulate that his report does not address that particular issue. He responded affirmatively to your question before as to whether he has --

MR. KELLEY: I want to make sure I get it all in there without yours and my three pages of exchange.

Q. Do you agree that you have never written anywhere in a report prior to today that The Cleveland Clinic Foundation deviated from the standard of care in any regards in their treatment of Mr. Brooks?

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A. I agree.

Q. The only opinions that you had regarding the standard of care that I saw in this report were that we were appropriate in our diagnosis of polymyositis, correct?

A. Correct.

Q. And that the patient was an appropriate candidate for a PEG tube, correct?

A. Correct.

Q. And then your other opinions in the report appear to be limited to proximate causation and/or, to put that in more logical terms, the life expectancy and quality of life for Mr. Brooks with polymyositis absent the hypovolemic event in The Clinic, correct?

A. Correct.

Q. And those would be more causation/damages opinions you'll agree, correct? If you don't --

A. I would leave the legal issues to you.

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Q. Now, let me ask you this. I assume by your answer before that you have some standard of care opinions, correct?
A. I do.
Q. Now, the standard of care opinions that you hold are what?
A. That's a very broad question.

Q. I have no idea what to ask because I don't know what your opinions are, that's why I made it broad.
A. As I did state earlier, I was asked to review these medical records and to comment specifically on these three or four issues; however, in my capacity as a neurologist I do treat and take care of neurologic patients who often require PEG tube placements. So I am aware of the indications for PEG tube placements, I'm aware of the general follow-up that may ensue and I'm aware of some potential complications of what PEG tubes may result in.

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In my capacity I need to supervise residents and fellows in that regard. So in that capacity I do have some opinions in regards to some of the medical issues, not all of the medical issues, but some of the medical issues that transpired the morning of June 5th in regards to Mr. Brooks.
Q. Now, I'm going to be honest, I'm going to object before I even ask you these questions, but obviously we never know how a court is going to rule on anything, nor do I have any idea what I'm about to get as far as an answer.
What do you believe were the breaches from the standard of care rolling through the evening of June 4th through the morning of June 5th at The Cleveland Clinic Foundation?
A. Well, to start, I don't have any specific opinion about the events in the evening hours of June 4th up through 2:00, 2:30 in the morning of the 5th. I don't have any specific

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opinions about standard of care in that period of time.
Q. Let me just make sure, because as a lawyer we always want to make sure we have a full understanding of what you're saying.
Your belief from your review is that up until 2:30 in the morning or 2:25 in the morning -- we won't quibble over five minutes at this point -- the care and treatment was okay?
MR. MISHKIND: No, that's not what he said.
MR. KELLEY: Howard, let him answer. I'm not trying to put words in his mouth.
MR. MISHKIND: You are putting words. He just said he has no opinion on the standard of care, which means he has not arrived at an opinion one way or another up until 2:30.
Q. Doctor, let's make sure this is totally clear on the record. I come here today to ask your opinions. And I

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promise, I am not here to trick you, nor do I have the intellect to pull that off.
MR. MISHKIND: Don't accept that, he's got the intellect and he knew exactly what he was asking.
Q. What I am trying to do here is I am trying to arrive at what your opinions are, the opinions which, as you will agree with me, I am learning about for the first time today. Now, if you have opinions regarding the standard of care, I want to hear them all. So let me go back one step at a time so we satisfy myself and Mr. Mishkind and yourself.
You reviewed all of the medical records from June 4th, correct?
A. Yes.
Q. You reviewed the medical records up until 2:30 in the morning on June 5th, correct?
A. Yes.
Q. And based upon your review of those records you do not have an

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opinion that there was a specific deviation from the standard of care?
MR. MISHKIND: Objection. You can answer the question if you understand it.
A. I think as you've stated it the answer is correct, I do not have an opinion.
Q. Okay. Is it a fair statement that you believe when you reviewed the records for June 4th up until 2:25 on June 5th were you reviewing it with a critical eye?
A. Yes.
Q. And based upon that review you made it all the way to 2:25 before you found your first criticism?
MR. MISHKIND: Objection. That's not what he said.
MR. KELLEY: I'm asking if that's what he said. If it's not he can tell me.
A. Could you repeat the question, please?
Q. Yes. The first criticism

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that you found based upon your review of these records occurred sometime after 2:25 a.m. on June 5th?
A. Correct.
MR. MISHKIND: Let me just interject to maybe make it easier for you. You asked him whether he has opinions. He's not been asked to provide opinions on standard of care. You asked him specifically whether he had an opinion and he had to answer that honestly. He's been identified as stated --
MR. KELLEY: Howard, you can't have it both ways. You just said to me two minutes ago -- and the court reporter can read it back -- that whether he has an opinion, whether he doesn't have an opinion, whether I'm going to ask him for an opinion, whether I'm not going to ask him for an opinion, I don't know. I can't sit here, and you understand my position, we can't have it both ways.
Either he has no standard

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of care opinions whatsoever or he has standard of care opinions. If there's a chance that you're going to ask him standard of care opinions, which you have said to me there is, I have an obligation to inquire.
MR. MISHKIND: Go ahead. You can.
MR. KELLEY: That's all I'm doing.
MR. MISHKIND: You can inquire.
MR. KELLEY: That's the only thing I'm doing because I don't know what he's going to say.
Q. Following 2:25 a.m. on June 5th it is my understanding that you believe that there were some deviations from the standard of care or at least a deviation from the standard of care; is that correct?
A. I think it's correct that in my capacity reviewing these records I find several areas of the medical record quite troubling in regards to standard

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of medical care.
Q. Do you believe that those troubling areas, to use your words, amount to deviations from the standard of care?
A. Yes.
Q. Okay. And what you said is you found areas of the medical record that were troubling. Were they actually documents that were contained in the record that you found to be troubling?
A. Could you read me the question, please?
Q. Yes, or I can repeat it. Let me repeat it.
When you said that you found areas of the medical record that were troubling, you're talking about the hard documentation that's in front of you, correct, the patient care record?
A. The answer to your question is yes, but some of this was supplemented by additional information which was gained from the depositions which I reviewed.

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Q. Okay. What were the opinions that you had based upon the medical record first, if you're able to quantify them out?
A. Could you repeat the question, please?
Q. Certainly. You've stated that some of the opinions that you have that were troubling, to use your phrase, were gleaned from the medical records and some were gleaned based upon the supplementary material that you received in the form of deposition. I'm asking which ones were you able to discern from the medical record, if any?
A. I'm trying to answer your question as best I can, but at this point it's hard for me to divorce the information I've learned from the depositions from that of the medical record as they in many ways simply serve to supplement the medical record and clarify the medical record.
Q. Okay. Then why don't we take you to the next step. What are

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the opinions that you have regarding deviations from the standard of care following 2:25 a.m.?
A. In my opinion the standard of care which is most troubling is the long delay between the assessment by the medical service that Mr. Brooks had suffered a major intra-abdominal bleed and when he was taken to surgery.
Q. When do you believe the initial assessment warranted the patient -- let me rephrase it, I want to make sure I have a good question for you.
When do you believe that physicians had an obligation to get this patient to surgery?
A. Well, in my opinion, when the medical service was first confronted with Mr. Brooks' medical condition at 2:20 or 2:25 they did need to perform an assessment in order to come to the conclusion that his present condition was due to an intra-abdominal hemorrhage, and that particular assessment would take some time.

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However, in the medical record in the note written by the senior medical resident timed at 3:15 in the morning I do believe that the critical parts of the assessment had been completed in that his blood counts had returned, they had knowledge of what his blood pressure and pulse were doing, they had knowledge that he was not bleeding into his stomach per se and that his stomach was becoming distended.
At that point I do believe that they reached the correct conclusion that he had a major intra-abdominal hemorrhage as a complication of his PEG tube placement.
At that point, someplace around 3:15, 3:30, I do believe it was their obligation to consult a surgeon, who I would expect to see the patient rapidly, who would then make the assessment that this man was having intra-abdominal hemorrhage, to continue his resuscitation and to get him promptly to an operating room.

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Q. Have you been involved in that scenario where you've had to call in an emergency surgical consult between we'll say 2:00 and 4:00 a.m.?
A. Certainly in my career I have, yes.
Q. And what is your experience as to the timing of a process like that, between getting a surgeon there -- the surgeon I assume evaluates the patient -- tell me if I'm wrong -- and there may or may not be diagnostic tests, transfers to the OR and then surgical intervention, correct?
A. That's correct. However, in a patient in this type of extreme state one would expect that a page or a call to a surgeon that the surgeon would see such a patient promptly -- I'm not sure I can give you an exact time, but certainly within the next few minutes to 15 minutes to a half an hour -- make an evaluation and then decide on further treatment.
I think in this case one

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could reasonably come to the conclusion, as the medical service did, that Mr. Brooks was having a major intra-abdominal hemorrhage and that urgent an emergent surgery was indicated.

Q. I'm going to first try to put this into a package to see if I can understand what you're saying. You're saying that the medical service was correct in coming to the conclusion that he had a probable bleed?

A. Correct.

Q. You just don't think they acted quickly enough upon their conclusion?

A. I'm very troubled that the medical service who came to this correct conclusion at approximately 3:15 to 3:30 in the morning that Mr. Brooks did not go to surgery until 10:45 to 11:00, 11:15 in the morning.

Q. Let me ask you this. Hypothetically if they didn't reach that conclusion by 3:15, but 3:15 was, for instance, the time that the MICU

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resident arrived at the scene and began his assessment of the patient and that the conclusions in that note weren't written until between 5:00 and 6:00 a.m., would that change your opinion about the timeliness of the intervention?

MR. MISHKIND: Let me object for a couple reasons. Number one, you have stated facts which are not consistent with Dr. Stanisic's testimony as to what he wrote in that entry; number two, he has not reviewed Dr. Stanisic's deposition for the reasons stated before in terms of the depos just being done.

MR. KELLEY: It's just a hypothetical. If I'm wrong I'm wrong and I have to stand on my own two feet without Dr. Stanisic's depo to support me.

MR. MISHKIND: What you've stated is the conclusions. He has a three-page note, as you know, and part of that he indicates the information

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that he had when he arrived at 3:15. He may have written other things later on.

MR. KELLEY: I'm going to go through each thing, I promise.

Q. My hypothetical, and I'll repeat it, if in fact Dr. Stanisic's note and the time of 3:15 was not the time that he reached conclusions but the time that he arrived at the scene, would that change your opinion regarding when a surgical consult should have been called?

MR. MISHKIND: Let me just object as to the use of the term reached conclusions, but you can go ahead and answer.

A. It would change my opinion, but it might change my opinion in more than one way. If that were to occur then I would then question why the delay between 2:30 in the morning and, say, your hypothetical at 5:30 to 6:00 in the morning to make that determination.

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But it's true if the surgeon was not contacted until 5:30 or 6:00 in the morning then I still believe that the surgery was delayed at that point, but the amount of delay is less.

Q. Do you have any opinions regarding when surgery had to be undertaken to alter the outcome for this patient?

A. I think it's a fair statement or a reasonable statement that sooner is better, but I can't give you an exact time where I'm going to say that within a reasonable degree of medical certainty the surgery should have been done, I defer that to the surgeons or the gastroenterologists.

Q. Do you agree with -- you've obviously reviewed all the medical records from that admission, correct?

A. To the best of my knowledge, yes.

Q. Do you agree that the patient presented with some degree of

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multi-system organ failure?
A. You'd have to qualify what time you're speaking of.
Q. At admission did he have any signs or symptoms of multi-system organ failure?
A. I would then ask you to qualify at admission on 5-28?
Q. At admission on 5-28.
A. On admission of 5-28 he was admitted with the diagnosis of polymyositis, which was his only active problem. There were two other issues, one had to do with his renal function being slightly abnormal, which was likely due to dehydration or secondary effects of the polymyositis and myoglobin in the blood and urine, and subsequently was found to have a small infiltrate, versus atelectasis in one lung base, which might relate to the polymyositis or an early pneumonia. I would not personally call that multi-organ failure.
Q. What about his heart, how

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was his heart doing?
A. In reviewing the medical records I believe it was the opinion of the doctors who took care of him that he had stable coronary disease and this was not an active issue.
Q. And obviously you've had a chance to review the autopsy?
A. I have.
Q. What were the autopsy's conclusions regarding the patient's heart?
A. There were several conclusions.
MR. MISHKIND: You can refer to it if you need to.
Q. Yes, this isn't a memory quiz.
MR. MISHKIND: Just for the record, I think both of you referred to May 28, I think it was actually May 25 that the -- I may be mistaken.
MR. KELLEY: Yes, it's May 25.

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MR. MISHKIND: So both of you were wrong.
MR. KELLEY: Even on the record, as per usual Mr. Mishkind is correct.
MR. MISHKIND: Unbelievable.
A. To answer your question, the major findings of the heart examination of the autopsy was that the heart was enlarged, that there was severe coronary artery disease and that the bypass graphs were all patent.
Q. But you do not believe this patient had any signs or symptoms of multi-system organ failure at admission on May 25th?
MR. MISHKIND: Let me object to the term any.
A. I would agree that the patient had polymyositis on admission and had some, the medical term is pre-renal azotemia in that his renal blood values were slightly abnormal likely due to dehydration and may have

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had early pneumonia. But again, I do not believe that most doctors would call this multi-organ failure. Clearly what happened after his surgery one would call multi-organ failure.
Q. How was his liver function at admission?
A. I would need to review the records, but to the best of my memory I recall his liver function tests in the blood as being essentially normal.
MR. MISHKIND: You can review. If you need to refer to the --
Q. Were you provided any of his medical records from the late 1970s and 1980s?
A. No,
Q. Were you aware that the patient received multiple treatments for alcoholism during that time frame?
MR. MISHKIND: Let me just show an objection, but he can answer the question.
A. I'm not aware of that. However, there is reference in the

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present medical records of a past history of alcohol abuse.
Q. Would alcohol abuse have any effect on the patient's presentation in this case in your opinion?
MR. MISHKIND: Objection.
Q. A history of alcoholism.
MR. MISHKIND: Objection.
Go ahead, Doctor, you can answer the question.
A. Can you repeat the question, please?
Q. Sure. If in fact the patient had a history of alcoholism could that potentially have any effect on your opinions in this case?
MR. MISHKIND: Objection.
A. I'm not sure. Potentially is a very broad word, so I'm not quite sure what you're referring to.
Q. Is there any link that is known between alcoholism and polymyositis?
A. Not that I'm aware of.
Q. Are you aware of any

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literature regarding alcoholism and life expectancy?
A. No.
Q. Do you have any opinion as to whether or not alcoholism will reduce one's life expectancy, in a broad general sense? And he'll object.
MR. MISHKIND: You got it.
A. I do have an opinion.
Q. How does alcoholism affect a patient's life expectancy in general?
A. In general alcohol abuse does reduce someone's life expectancy.
Q. In what regards?
A. Chronic alcohol abuse can lead to several problems. Clearly in my end of the business it can lead to disorders of nerve, of the brain, of dementia, of the cerebellum. However, none of those, per se, would necessarily shorten someone's life.
Alcohol has profound effects on the liver, and, as most know, if alcohol is drunk to excess for many, many years it can result in

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cirrhosis of the liver. The liver is very important in detoxifying many harmful chemicals and substances in the blood. Cirrhosis can lead to many medical problems and to increased mortality and morbidity.
Q. How about the kidneys, how does it affect the kidneys, if at all?
A. Alcohol has profound effects on many organ systems. I don't know of any, per se, on the kidney, although by your question I infer that it may have, these just aren't known to me.
Q. You're relying on my question to create an inference that there is a link between alcoholism and kidney disease but you don't know?
A. I am. I'm not aware of it, but I would defer to a nephrologist.
Q. What about coronary artery disease, how is alcoholism related to coronary artery disease, if at all, if you know?
A. Well, that's a complicated question. I don't know if it's known

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for sure. Many believe that alcohol is somewhat protective in regards to coronary artery disease and that many patients who drink to excess have less coronary disease than other people.
Q. Any effect, any negative effect from alcohol on cardiac function that you're aware of?
A. I'm not aware of it, but I don't feel that I should testify to this and I would defer to a cardiologist on this topic.
Q. Okay. Are you aware of how long the patient was complaining of fatigue and malaise throughout his life?
A. No. I'm aware from the medical records of 1998 that his presentation was said to involve fatigue and malaise of several weeks duration.
Q. Would it be at all relevant if he was having fatigue and malaise longer than that?
A. It may or may not. Fatigue and malaise are very nonspecific symptoms. It's not to say they're not

important, they're just not specific.
Q. I want to get back to where we started before we kind of digressed a little bit.
You have the opinion that although the physicians reached the appropriate conclusion that there may be a bleed, they did not respond quickly enough in getting surgery involved. Are there any other criticisms that you have?
A. Well, I think as you phrase my criticism is not exactly how I would phrase it.
Q. Then please correct it.
A. I'm troubled by the delay between when the medical service correctly deduced the problem with Mr. Brooks and when surgery was undertaken, that this delay may have involved more than one aspect. One aspect may have been and likely was consulting the surgical service, but there was another aspect that after the surgical service was consulted that Mr. Brooks was not

taken to surgery urgently and was delayed for several hours.
Q. Going through medical school and your fellowships and even in practice have you ever heard of the ABCs of medicine?
A. Yes.
Q. What are the ABCs?
A. ABC relates to what one should do when confronted with a patient in crisis. A refers to airway, which is stabilize the airway, B is in regards to breathing, and C is in regards to circulation.
Q. When you say when a patient is in distress you know the ABCs become relevant. Would you agree that at 2:25 a.m. this patient was in distress?
A. I would agree.
Q. Would you agree that this patient was in shock?
A. Yes.
Q. And do you agree that using the ABCs the first obligation of all physicians involved is to stabilize a

patient hemodynamically before you undertake to treat the underlying cause of the shock?
A. As you phrased the question the answer is yes with the proviso that in some situations the way of fixing the circulatory problem, the C, may entail surgery.
Q. Obviously, though, if you operate and you're wrong you could worsen the situation for a patient, correct?
MR. MISHKIND: Objection. You're getting into surgical issues which --
MR. KELLEY: He's okay. If he doesn't want to answer a question or doesn't understand a question or it's outside his specialty just let me know.
MR. MISHKIND: It's not a question of not wanting to answer, it's more of your latter statement than the former. Go ahead.
A. If you could repeat the question, please.

Q. Sure. I think my question was that you will agree that it's a well-reasoned medical principle that when a patient is in shock you treat the shock before you treat the underlying cause of the shock, correct?
MR. MISHKIND: Objection. Go ahead.
A. Yes.
Q. And in treating shock sometimes that can be airway stabilization, intubation, things of that sort, correct?
A. Yes.
Q. And sometimes that can be hemodynamic stability, that being the circulatory system and the C portion of the ABCs, right?
A. Yes.
Q. And that is a well-known medical principle to you based upon your training, your fellowship, and even your experience as a neurologist, correct?
A. Yes.
Q. When was this patient

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hemodynamically stable after 2:25 a.m.?
A. One of the problems in your earlier questions and one of the problems answering the question at the moment is that there are different degrees of shock. There's a very big difference in how a patient is approached who has no blood pressure versus a patient whose blood pressure is 80/60 compared to a patient whose blood pressure is 40 over palp. Even though you might say all three were in shock, they are in three very different scenarios.
Getting back to your question. In reviewing the medical record, Mr. Brooks' hemodynamic status never changed or never improved to a normal level up to the point that he went to surgery. So even though, as you mentioned, his airway was stabilized, he was intubated, he was later given fluids and medicines to elevate his blood pressure, his blood pressure remained abnormally low, likely

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due to the fact that he was still bleeding.
Q. How long do you think he was bleeding for?
A. That's a hard question to answer. We certainly know at 2:25 in the morning with his blood pressure and pulse recorded at that point that it's very likely that he was bleeding at that point or before. We know from the operation when the abdomen was entered at approximately 11:00, 11:15 that there was bright red blood. As Dr. Grundfest testified to, that likely meant that bleeding had occurred at a minimum of two to three hours before the operation and could have occurred even sooner.
So I think that we can likely infer that there was active bleeding at some time before 2:25 in the morning that continued at least to, if not longer, 8:00 or 9:00 in the morning.
Q. Do you have an opinion as to what caused the bleeding?

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A. I do.
Q. What is it?
A. I believe that the intra-abdominal bleeding occurred as a complication of the PEG tube placement. Exactly why that bleeding occurred and under what circumstance, I don't know and I would leave to a gastroenterologist or a surgeon.
Q. You have testified earlier that you frequently have situations where you're required to send one of your patients for a PEG tube placement as a neurologist, correct?
A. Correct.
Q. And I assume when you send them for a PEG tube placement and they come back with a tube they're still your patient, correct?
A. Correct.
Q. So you follow them in that immediate post PEG period, right?
A. That is correct. However, in this case the gastroenterologist was also following the patient quite closely

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as well.
Q. Certainly. I'm only asking from your experience. If it's something beyond your experience you are always welcome to tell me you would like to defer, as you've done several times, with cardiac issues and nephrology issues and things of that sort.
My question to you is, based upon your vast experience with a PEG tube do bleeds typically happen 18 hours after they're placed?
A. That question I would defer to a gastroenterologist.
Q. Have you ever seen a bleed happen 12 hours after the PEG tube was placed?
A. I have not.
Q. Do you have any opinion as to what any post PEG period of time actually caused Mr. Brooks to start bleeding?
MR. MISHKIND: Let me just object because I think you've already answered that question previously a

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couple questions back, but go ahead.
A. I do not have any opinion to a reasonable degree of medical certainty what caused Mr. Brooks' PEG to bleed at that time.
Q. How many times have you seen patients with PEG tubes in your career? If you want to quantify it and say like I see three a month, whatever is easiest for you to quantify it.
A. That is a hard question for me to answer. PEG tube placements are extremely common for me in neurologically hospitalized patients. In general this occurs when I'm the attending on the neurology ward service. I tend to attend between one and three months a year. For those months that I'm the attending I'm the attending for all month for all patients who are admitted to the neurology ward service. In the modern day most of these are stroke patients. It's extremely common for stroke patients to receive PEG tubes. Maybe in the course

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of a month I might admit 120 patients, I would estimate a third of them could have a PEG tube placement. I would do that, depending on the year, one to three months a year.
Q. So you have a pretty vast experience with PEG tube placements, one out of three patients who you admit over the course of a three-month period have them?
A. In the modern day, considering that very sick patients have to be hospitalized, PEG tube placements are very common for neurology patients.
Q. And you've never seen a patient who had a bleed 12 hours after the PEG was placed?
A. That's correct.
Q. Have you seen patients who have had bleeding complications initially following the PEG placement?
A. I have not.
Q. Do you have any other standard of care opinions that we haven't talked about in this case based

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upon your review of the record?
A. I think it is fair that my major standard of care issue which I have raised is my concern about the delay between the time that the correct diagnosis was reached and when surgery was performed. As I mentioned earlier, within that topic I'm concerned about the time between when the assessment was made and the surgeon was consulted and I'm equally concerned after the surgeon was consulted and the delay of subsequent surgery.
From my perspective as a neurologist who takes care frequently of patients who have PEG tubes that's my major issue. I do have some other issues which I would consider somewhat smaller. For instance, I'm somewhat troubled by the fact that Mr. Brooks didn't receive blood products until later in the course as well.
Q. Do you have any idea why he did not receive blood products?
A. As you know, he eventually

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did receive blood products. Why the delay in blood products initially, no, I'm not sure why there was that delay.
Q. Before you administer blood do you typically have it typed and crossed?
A. Yes.
Q. The reason for that is you want to avoid a hemolytic reaction?
A. Yes, you want to avoid a transfusion reaction.
Q. And hemolysis can include several fatal problems, correct?
A. Yes.
Q. DIC, correct?
A. Yes.
Q. It could include just a straight what we typically call an anaphylactic reaction, right?
A. Yes.
Q. So you don't want to just give a patient blood that's not typed and crossed, correct?
A. Correct.
Q. And typing and crossing

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blood takes a little bit of time, doesn't it?
A. Yes.
Q. And just because we know someone's blood type doesn't mean we necessarily have a match for transfusion purposes, does it?
A. That's correct.
Q. There's a second step that has to occur after we find out that they're A positive or O or AB, we have to then find a match, correct?
A. Correct.
MR. MISHKIND: Jay, are you suggesting in the case that he was cross-matched before he was given blood, because that does not seem to be the testimony?
MR. KELLEY: Howard, I am asking the doctor questions regarding timing sequences.
MR. MISHKIND: I know, but you're suggesting type and cross-match, and we know in this case based upon the records that he was typed but not

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cross-matched.
MR. KELLEY: Then you can stand up. I don't have any evidence different than you. I just want to ask him opinion questions regarding what he has to say. There's no cloak, no dagger, anything like that here, I just want to know how he goes about blood transfusions at his hospital.
MR. MISHKIND: You're giving him questions based upon facts of type and cross-matching when we know there wasn't cross-matching done. I'm asking you based upon the discovery whether you know something that you can reveal to me in the factual analysis of this case that would suggest that he was typed and cross-matched before he was given the blood?
MR. KELLEY: I know that the process was ongoing in the record before the patient coded and then he was given the blood transfusion emergently, if I'm not mistaken. I

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believe that's your understanding as well.
MR. MISHKIND: Okay.
MR. KELLEY: I only have what's in the record.
MR. MISHKIND: Okay.
MR. KELLEY: I really only care about how Dr. Preston does it so I can see how he does it at his hospital so that we can see whether or not things would have been different down the street.
MR. MISHKIND: The only reason I'm interjecting is because you're asking him how he does things. We have to evaluate how things were done in this case, and we know that he was not cross-matched before he was given blood. Why he wasn't given blood earlier I think is the issue that Dr. Preston had raised.
MR. KELLEY: Sure.
Q. Dr. Preston, I assume the way you try to do things is within the acceptable standard of care, correct?

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A. Correct.
Q. I assume every day when you go to work you try to do your best for your patients, correct?
A. Correct.
Q. How long does it take to get blood typed and crossed at University Hospitals off business hours?
A. I don't know.
Q. You obviously have not yet, because of, as Mr. Mishkind referred to, the somewhat tight schedule we have, had a chance to read Dr. Lisgaris' or Dr. Stanisic's depositions, so I want to make sure that we go through in a little bit of detail the information in Dr. Stanisic's note that you believe warranted intervention with surgery.
What I'd like to do is have you look at Dr. Stanisic's MICU note. That's the one that describes arriving at about 3:15. Were you able to find it already?
MR. MISHKIND: He has it in his hand.

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Q. You described that there was information contained within that note that you believe had he had available mandated surgical intervention. What information within that note are you specifically referring to?

A. Can you repeat your question, please?

Q. Certainly. Earlier in the deposition you described that your opinions that there was a delay were at least in part based upon the note of Dr. Stanisic, that being the note that's in front of you now, that you believed that at 3:15, or whenever that note was written, there was information contained in that note which required immediate or earlier intervention.

I am now asking you what information specifically in that note is it that you believe Dr. Stanisic had that required the intervention?

A. I think there's sufficient information in his note that he reached the correct diagnosis that Mr. Brooks

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had hypovolemia from a presumed intra-abdominal bleed. He was able to make that diagnosis on the basis of what you termed earlier, which is shock, which is hypotension, or low blood pressure. He very well details the time and course here of the patient's low blood pressure.

He notes that the patient was bolused, or given normal saline, which is a field to raise blood pressure, and states that there was without much response. So he notes that the patient has had hypotension and has not responded to normal saline.

In his note he also notes that the patient's hemoglobin is much lower than it was earlier. At that point he can make a reasonable inference that the patient is bleeding and that's the likely cause of the hypotension.

In addition, in his note on page 3 he writes, PEG lavage negative for blood, which means they looked at the substance within the

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stomach, they lavaged the stomach through the PEG tube looking to see if there was bleeding inside the stomach, which there wasn't.

At that point with that knowledge that this man was hypotensive, that he hadn't responded to fluid boluses, that he clearly had dropped his hemoglobin, that the hemoglobin was not going into the stomach, in my opinion he correctly concluded that the hypotension was due to hypovolemia from presumed intra-abdominal bleed.

At that point I believe that he was obligated to consult surgery right then. And with the patient not responding, not getting his blood pressure back up to normal and the need to start medicines that would raise blood pressure -- and he writes down here Neosynephrine drip, however, these medicines that raise the blood pressure don't necessarily increase flow to organs. They do raise the blood pressure, but they don't increase flow

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of oxygen to the tissues.

One can make a reasonable inference, and I believe that most reasonable doctors would come to the same conclusion, that this man had a major intra-abdominal hemorrhage at that point that required, that the standard of care required that surgery be consulted, be involved and the patient be taken to surgery shortly.

Q. He detailed within his note several tests that were performed on the patient. You pointed out a lavage. There were two blood gases, there's an EKG referred to, there's also the fact that the stool was checked, which was guaiac negative. There was clinical examination, there was monitoring of the vital signs that was accomplished.

Do you believe that all of that should have been done and the patient to surgery before 4:10 a.m.?

MR. MISHKIND: Before he answers let me just qualify by the fact that he has not seen the testimony of

the doctor or Dr. Lisgaris who testified as to what she had done before Dr. Stanisic arrived, so the temporal relationship he may or may not be able to answer based upon not having that information. But he can go ahead and respond.

Q. Let me just make sure it's clear. You've seen obviously the blood draws that were done, the attempt to get a cross-match done. You saw there was an order for typing and crossing, correct?

A. Yes.

Q. You saw that the EKG and those other tests that I've just referred to were all performed, correct?

A. Yes.

Q. You were able to discern some of the timing of the blood tests, including 2:45, including 3:00 a.m. The EKG I believe was 2:35 or 2:36 a.m. You were able to discern all of that, correct?

A. Yes.

Q. So it was pretty obvious to you there was a lot going on in that time frame between 2:25 and 4:10 a.m. before the first code, correct?

A. Yes.

MR. MISHKIND: And before Dr. Stanisic arrived.

Q. And some of that was before Dr. Stanisic arrived at 3:15. But do you believe that all of that information needed to be acquired, assimilated and the patient to surgery before 4:10 a.m. for the standard of care to have been met?

MR. MISHKIND: Let me just object because it's a multi-part question in terms of acquired, assimilated, et cetera.

If you can answer, Doctor, I don't mean to confuse you by my objection, go ahead.

A. As I've testified earlier, I don't have any specific opinion about the standard of care before 2:20 or 2:25. I do agree with you that after Mr. Brooks was discovered at 2:25 to be in this state that certain standard procedures and assessment needed to be done, including the ABCs which you mentioned, including many of the tests that you've mentioned, and that these would take some period of time. However, the tests that you mentioned, the procedures that you mentioned, I would expect that most, if not all of these, would have been accomplished in the ensuing hour to an hour and a half.

Q. Okay.

A. So in that regard I do agree with you that this initial assessment had to be made to come to the correct assessment to guide for the therapy and that that was made, but that from that point on there was still an unreasonable delay between that assessment and when Mr. Brooks ultimately went to surgery.

Q. So that initial assessment needed to be done within an hour to an hour and a half of the physicians first being called, if I understand you

correctly; is that correct?

A. Yes.

Q. Obviously that would take us up to about 4:00 a.m. if we use an hour and a half, 3:30 a.m. if we use an hour. I'm going to ask you a common sense question. Things take a little longer in the middle of the night, no matter what hospital you're at, than they do at 2:00 in the afternoon, correct?

A. Correct.

Q. And the reality is after they reached that conclusion then there needs to be incorporation of surgery, correct?

A. I would think that a reasonable physician would reach that conclusion, would have a surgeon involved certainly after that assessment was made, yes.

Q. And obviously you saw that the patient coded at 4:10 a.m., correct, or do you not believe that was a code?

A. I believe that the patient

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was intubated at approximately 4:10 a.m. I believe that the patient was not breathing correctly as the doctor wrote in his note, patient intubated secondary to decreased MS, which stands for mental state/airway protection.

Q. Well, you do see also that there was CPR and they were unable to obtain a BP, correct, by cuff?

A. I do. I also note that that same data sheet says that there was a respiratory arrest and not a cardiac arrest.

Q. Who fills out the top of that, does a physician or a nurse?

MR. MISHKIND: Top of what?

MR. KELLEY The CPR data sheet.

MR. MISHKIND: Are you talking about the very first line?

MR. KELLEY Any CPR data sheet at the top. I'm talking about that top paragraph before we get to the graphic sheet.

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A. In regards to the sheet in front of you, I don't know who filled that out. Procedures are different in different hospitals.

Q. Dr. Stanisic I will relate to you testified that he did not see a difference in his medical opinion between the 4:10 arrest and the 4:50 a.m. arrest and he felt them both to be cardiopulmonary arrests. Would that change your opinions at all?

MR. MISHKIND: Let me object, again, for several reasons. One, it's not the testimony of Dr. Lisgaris, and he's not seen the deposition testimony.

MR. KELLEY: I didn't say it was --

MR. MISHKIND: I understand your question is focused in on Dr. Stanisic alone. That's fine, go ahead.

A. Could you repeat the question, please?

Q. Certainly. If Dr. Stanisic has testified that he perceived both of

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the arrests, the one at 4:10 and the one at 4:50, to both be cardiopulmonary arrests would that change any of your opinions?

MR. MISHKIND: Same objection.

But you can answer the question.

A. I'm not quite sure how to answer your question because what another doctor perceives, I'm not sure if that is the reality of the situation. The first code which you're referring to, per the sheet no CPR was given. I can't imagine a cardiopulmonary arrest where CPR is not given, whereas the second code CPR is given.

Q. Okay. So because of the fact there were no chest compressions required you do not believe that the first one was a cardiac arrest, I understand that.

My question is, if in fact Dr. Stanisic has testified that

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both codes from his perception were the same and if we accept that they were both cardiopulmonary arrests, that's a hypothetical, if you accept that to be true does that change any of your opinions?

MR. MISHKIND: Objection. But you can go ahead and answer.

A. Based on your hypothetical that both codes were full cardiopulmonary arrests it would change my opinions.

Q. And how would it change your opinions?

A. The first code that you allude to was a prolonged code. I believe in reviewing the medical records that it was a respiratory arrest where the patient was intubated so that he could breathe correctly but that through that entire code he had a pulse which was documented, although the blood pressure could not be auscultated through the blood pressure cuff, thus I

would infer that that patient still had circulatory --
Q. Profusion?
A. -- profusion during that period of time. If he had not he would have needed to receive CPR, he would have required other medicines given through a typical CPR and likely he would have been cardioverted or what someone would call shocked his heart back, which was not given.
If a hypothetical is that you had a patient who had no blood pressure and no pulse for 15 to 20 minutes, that could clearly cause significant organ damage.
Q. And the medications that I believe would normally be given would be things like Atropine and Epinephrine, correct?
A. There are a large number of medicines that are given during a code. Epinephrine is commonly given. Atropine is often given for a low heart rate. However, there's a sequence of different

medicines that are given at different times if the patient doesn't respond to earlier medicines.
Q. Okay. You see if you look at it that they describe that they gave one amp of Epinephrine. Is the Epinephrine for cardiac function or for respiratory function?
A. Well, your question is actually somewhat difficult to answer as Epinephrine has effects on pulmonary as well as cardiac tissue. In general Epinephrine is given for cardiac reasons.
Q. What about Atropine, is that generally given for cardiac or respiratory reasons?
A. Atropine is generally given for low heart rate.
Q. To try and increase the patient's pulse in essence?
A. That's correct.
Q. And you also see it looks like there's some letters underneath where it says rhythm at 4:10. What do you read that to be?

A. At 4:10 it appears to state heart rate is 50, BP it writes unable, respiration rate zero, and rhythm, it is likely SB standing for sinus bradycardia.
Q. And what's the significance of that if it is in fact sinus bradycardia?
A. A normal pulse rate is generally defined between 60 and a hundred. If you're faster than a hundred it's tachycardia, if you're slower than 60 it's bradycardia. If the rhythm in the heart is normally generated it's called a sinus rhythm. So this would say that the rhythm is being generated in the correct spot in the heart, it's slower than normal.
Q. And you do see through cuff they were never able to establish a BP from 4:10 through 4:22, correct?
A. Correct.
Q. And obviously the critical issue in an arrest is profusion,

correct?
A. Correct.
Q. Because what we're trying to do is we're trying to get that oxygen not only from the lungs through the heart but to all the vital organs and tissues, correct?
A. Correct.
Q. And if we don't have profusion we get multi-system organ failure, correct?
A. Correct.
Q. Because there's a lack of oxygen and those organs and tissues die, correct?
A. Correct.
Q. And the way that the oxygen gets pushed from point A being the lungs to point B being the tissues and organs is through the blood pressure, correct?
A. Correct.
Q. No blood pressure no profusion, correct?
A. Correct.

Q. And obviously if a cuff is unable to pick it up it's obviously an extremely low, if not nonexistent, blood pressure, correct?

MR. MISHKIND: Objection.

A. No.

Q. You disagree with that, why?

A. I think that a patient can still have blood pressure and a pulse, they can be poorly auscultated, especially during a crisis, and that the best way to measure someone's blood pressure is if someone has a transducer in one of their arteries. There are certainly cases where someone can have a reasonably normal blood pressure by invasive monitoring and yet have a difficult blood pressure to auscultate through a stethoscope.

Q. Did you see that there was a CVP inserted?

A. Yes.

Q. Is there any reference anywhere that they were able in any mechanism to trace blood pressure,

whether it be by palpation or any other means, during this code?

A. Not that I'm aware of.

Q. Other than your belief that sometimes there is a blood pressure when it's unable to be obtained by cuff, do you have any other evidence in this case that this patient had a blood pressure from 4:10 through 4:22?

A. Yes.

Q. And what's that?

A. He has a pulse.

Q. And his pulse is 50 at 4:10?

A. Yes.

Q. It's 157 at 4:16?

A. Yes.

Q. And the 157, do you believe that to be a reliable number, or is that more indicative of fibrillation?

A. That would -- you've asked me two separate questions.

Q. First let me break it down. Is it reliable?

A. I have no reason to not think it's reliable.

Q. Okay. If in fact it's reliable is it consistent with a human heartbeat in this situation or is it consistent with fibrillation as a result probably of the Atropine?

A. Can you repeat the question, please?

Q. Let me try to make it as simple as possible.

Do you believe that the heart rate of 157 was reflecting a well-functioning heart?

A. In many ways the answer to your question is yes because 157 is a normal response to hypotension, is a normal response to Atropine. So in that respect the heart is functioning correctly.

Q. And you believe that the 157 beat is not just a beat reflected by the monitor, which is typically done if I understand correct, isn't it?

A. Correct.

Q. Even though it's not the real rate, it's the only thing that

they can find during a code situation, correct?

A. Could you --

Q. Let me repeat it so it makes a little more sense.

Have you participated in a code?

A. Yes.

Q. And obviously the monitor where you get a heart rate from is not always accurate, is it?

A. That's a difficult question to answer.

Q. Okay.

A. The heart rate is measuring electrical response for the heart where blood pressure is really a mechanical response for heart. Usually the mechanical and the electrical events go together. There is an unusual and very serious condition called electrical mechanical disassociation where you can have a pulse and no blood pressure. People don't usually survive that event very often.

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Q. Because they end up in multi-system organ failure?
A. No, they end up in cardiac arrest right then and there and die.
I'm sorry, could you repeat the question again?
Q. Certainly. First and foremost, do you think it was electrical mechanical disassociation?
A. I definitely do not.
Q. So you believe that this patient had a viable heart rate of 157 at 4:10 a.m.?
A. I do.
Q. And you believe that that heart was pumping and able to profuse?
A. I believe it was pumping and I believe there was some profusion, but I'm not able to say how much profusion he had at that point.
Q. You can't say that he was adequately profusing or inadequately profusing, you're unable to say either way?
A. That's correct.

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Q. If he was unable to adequately profuse, I assume that you believe that anything after this code would have been, in essence, for not, that the damage was most likely done to a probability?
MR. MISHKIND: Objection.
You can answer.
A. As I've testified earlier, there are shades of gray on this. No blood pressure is very different from 40 over palpable, which is very different from 80/60. So what I believe I testified to earlier, which I'd like to reaffirm, if someone had no blood pressure, no profusion at all for this length of time, yes, I do believe that would result in multi-organ failure.
Q. And obviously there's shades of gray whether it is extremely inadequate, somewhat inadequate because that's a shade of gray that you're unable to clarify right now, correct?
MR. MISHKIND: Objection.
I have no idea what you just asked him.

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MR. KELLEY: I only care if he understands.
MR. MISHKIND: I do. It's terribly vague.
Q. Do you understand? I'm trying to use your phrase of shades of gray.
A. Can you repeat the yes, please?
Q. Sure. You described shades of gray and you have said that if there's absolutely nothing, no profusion, that in essence everything after that event was for not, the 4:10 event, correct?
MR. MISHKIND: Those were your words.
Q. Doctor, if I mischaracterize anything, go ahead. Mr. Mishkind seems to want to testify today.
MR. MISHKIND: No, I don't. I just want the record to accurately reflect --
MR. KELLEY: Then lust object.

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Q. Doctor, here's my question. If from 4:10 to 4:22 this patient had absolutely no profusion, no blood pressure, you agree with me that that was, in essence, the fatal event, correct?
MR. MISHKIND: Objection.
Go ahead.
A. I agree with you that if this patient had no blood pressure for that length of time, no Profusion that it would likely have resulted in multi-organ failure, and the sequence of events that followed likely could be explained on the basis of no profusion for, say, 12 minutes time.
Q. Okay. But, however, you've described that sometimes there are shades of gray, and I use that phrase because it's your own. What I mean by that when I say shades of gray is you can't say whether or not during that time frame there were varying degrees of profusion, whether it be completely inadequate, somewhat inadequate or

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inadequate. Does that make sense to you as I phrase it that way?
A. I would agree that with the knowledge I have here I cannot be sure how much profusion there is. However, I think that I can reasonably infer that the doctors believe that there was profusion at the time because there was a good heart rate, because they did not initiate CPR, they did not go on to give him additional medicines that would be commonly given during a cardiopulmonary arrest, and the senior medical resident who wrote his note wrote that the patient was intubated due to airway protection because of a decreased mental state.
Q. Who is Howard Nearman?
A. I believe that Dr. Nearman is an expert anesthesiologist who you have retained in this case who wrote a report.
Q. Do you know who he is from working at University Hospitals of Cleveland?

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A. I don't.
Q. If I tell you that he was the director of the SICU and was recently appointed as the director of anesthesiology, would you have any reason to disagree with that?
A. I would not.
Q. Would you agree with me that within University Hospitals Dr. Nearman would be a better person to discuss codes and the effects of a code on a patient than you as a neurologist?
A. That's a complicated answer because neurologists are frequently asked to see patients after codes in regards to the effect of the code. As you may know, the brain is exquisitely sensitive to the lack of oxygen, thus neurologists are frequently asked by anesthesiologists to evaluate patients after a cardiac arrest or code.
Q. When a code is called in University Hospitals of Cleveland neurology doesn't respond to that code but anesthesiologists and doctors like

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Dr. Nearman do, correct?
A. Correct.
Q. Have you seen his report?
A. I have.
Q. Any disagreement with Dr. Nearman?
MR. MISHKIND: Let me object. If you want to take a look at the report.
A. If I could look at the report it might be helpful.
Q. Take your time. That's fine.
A. In response to your question, I would disagree with part of Dr. Nearman's report. Under his assessment he writes, the insults which were responsible for the cascade leading to Mr. Brooks' demise were the arrests occurring in the early morning hours of 6-5-98. A period of low flow is evidenced by inability to obtain any blood pressure readings that occurred for about 15 to 20 minutes followed rather quickly by a second period of

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four minutes in all probability were the inciting events triggering the cascade leading to multiple system organ failure. I would disagree with that statement.
Q. First, what is your disagreement? What do you believe to be the differing version than what Dr. Nearman has concluded?
A. I think Mr. Brooks developed multi-organ failure due to poor profusion from ongoing bleeding from at or before 2:25 in the morning that continued up to and through 9:00 or possibly later in the morning and that the second arrest which Dr. Nearman alludes to was very short. It was documented as a cardiopulmonary arrest where the patient was given Epinephrine and quickly reverted.
That arrest was sufficiently short that I do not believe that it caused any type of triggering or cascading event. Which then brings us back to the code that we've been

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talking about, this 10 to 12 minute code where a blood pressure was not obtainable through auscultation, yet the patient had a pulse, yet the patient was not given CPR, yet the patient was not given other medicines, yet the patient was not shocked, the same code that the senior medical resident wrote that the patient was intubated for airway protection.

When I originally read the medical records it appeared to me that Mr. Brooks was intubated for airway protection and had a respiratory arrest and not a cardiac arrest and that that length of time was not a length of time of no blood pressure, and the second cardiac arrest which was was sufficiently short that it would not have caused the multi-organ system failure.

Q. Let me ask you a couple of questions because I want to kind of wrap up your standard of care opinions but I want to make sure I understand

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them all so we can actually get to the polymyositis opinions.

First and foremost, you talked about the patient having a low hemoglobin. I believe the two hemoglobins that came back, one was by ABG, that was 9.1, and the other one by CBC was 8.6 that morning. First, are those critically low?

A. I think it's fair to say that in this gentleman they were critically low.

Q. I'm asking prospectively. Obviously it's easy to decide what was critical looking backwards. I'm asking going forward in time when the physician is at this patient's bedside between 2:25 and 3:30 in the morning when they're taking these labs and getting these lab values back, were they critically low values?

A. I understand the question that you're asking. In Mr. Brooks the levels were critically low. When someone talks about a critically low

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blood count one should know there is a world of difference between someone losing blood slowly versus someone losing blood quickly.

For instance, if a patient has a slow gastrointestinal bleed over months they can sustain very low hemoglobin and hematocrit. However, that same person if they were to have a massive bleed and lose that same amount of blood instead of over months over a couple of hours, given that the hemoglobin level may be the same it has dramatically different clinical meaning.

When someone loses a large amount of blood in a short period of time it's quite critical. When the body loses a large amount of blood over a long period of time the body is able to compensate fairly well.

So that hemoglobin which you're alluding to if it had resulted from a slow bleed over weeks or months, no, it's not a critical level. Is it critical that it happened over a short

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period of time and that it was likely continuing, the answer is yes, it is critical.

Q. I want to talk about hemoglobin in general. There's some other things that can account for a low hemoglobin. One would be dilution, correct?

A. Correct.

Q. And this patient had received saline, correct?

A. Correct.

Q. And obviously by adding saline you're adding fluid that has no red oxygen carrying blood cells, so the hemoglobin would go down logically, correct?

A. That's correct. Although, that statement is more correct when the patient is already volume depleted so they have lost volume from some other way. If you take a normal person, you or myself, and give us a bolus of normal saline, in a normal person our kidneys will quickly filter that out and

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your hemoglobin won't change very much. If you have a person that's lost blood and then you've given them normal saline, yes, there's a significant dilutional effect.

Q. In Mr. Brooks there would have been a significant dilutional effect based on the saline, correct?

A. I think it's fair to say that there was a dilutional effect based on the saline and also a true effect based on his bleeding.

Q. So the hemoglobin numbers that we saw, the 8.6 and the 9.1, would have reflected diluted values?

A. They could. But your question as you're asking it is actually more complex, because as someone is actively bleeding dilution takes some time to occur as well.

Q. How long?

A. I would defer that opinion.

Q. Okay. And you don't have to answer this, if you're uncomfortable answering just tell me so.

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Do you believe that the fact that he had received saline prior to the hemoglobins being drawn would have created a dilutional effect, yes or no, or no opinion? Either way is fine.

A. I'll agree they would have created some dilutional effect.

Q. And what effect does giving the patient steroids have on their hemoglobin, if you know?

A. In general steroids have very little effect on hemoglobin,

Q. Does it have any effect on hemoglobin?

A. As you may likely know, steroids have pronounced effects on many organs of the body. I do not believe there's any major effect of steroids on hemoglobin level which I'm aware of.

Q. Have we covered at this point your standard of care opinions in this case?

A. To the best of my knowledge, yes.

Q. If you have any additional

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standard of care opinions based upon your review of testimony -- and I understand, this isn't a situation, trust me, that I created, that Mr. Mishkind created or that I know you're creating. As additional depositions come forward if there is a material change to your standard of care opinions will you provide a report to Mr. Mishkind so that we can at least be aware of them?

A. Yes.

MR. MISHKIND: We will certainly supplement that as we finish our discovery/expert depositions.

(Discussion off record.)

Q. Have you seen the report of Dr. Ballou from Metro?

A. I have.

Q. Do you know Dr. Ballou?

A. I don't.

Q. You've obviously reviewed his report?

A. I have.

Q. I see a brief grin on your

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face or at least some form of a gesture. Why is it that you have a little smile on your face based on Dr. Ballou's report?

MR. MISHKIND: I'm not sure that -- you're interpreting that as a smile.

MR. KELLEY: He can tell me if it's not. I don't want to put any negative connotation on it if it's not there. He can put that connotation on it if he so wishes.

MR. MISHKIND: We'll do it by responding to your question, how's that?

MR. KELLEY: That's what my hope was.

A. In regards to your question, I had some reasonably strong emotions reading Dr. Ballou's report. I thought that his report had many inaccuracies in it and I felt sorry for his patients who had polymyositis who he was consulting with.

Q. Okay. So you believe he is

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absolutely it sounds like in left field?
A. I believe that he's put a terribly inappropriate bias to a condition which is quite treatable and quite gratifying to treat in which most patients respond well.
Q. First and foremost, is there a morbidity and mortality associated with polymyositis assuming appropriate treatment?
MR. MISHKIND: You're talking about in general?
Q. In general.
A. There is.
Q. Let's talk first with the morbidity. What is the morbidity that goes along with successfully treated polymyositis?
A. Well, if I follow your question correctly, if someone is successfully treated, that is, their polymyositis resolves on treatment, most of the morbidity has to do with the agents which are used to treat the disorder.

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Q. That being the steroids?
A. That being the steroids or other immunosuppressive agents, yes.
Q. So if in fact a patient is able to beat polymyositis, the treatment in and of itself may cause varying degrees of harm to them, correct?
MR. MISHKIND: Let me just object to the term beat.
But you can go ahead and answer.
A. The treatment of polymyositis, which includes steroids and other immunosuppressive agents, like a lot of other medicines, have potential side effects. These side affects are greater if the dosages have to be higher or used for a longer period of time. In most patients these medicines can be used safely and complications managed.
In general in polymyositis the side effects of steroids, as in other conditions, are related to high dose steroids. Most patients with

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polymyositis need high dose steroids for a period of time, usually several months, after which the steroid dose is tapered to lower dosages or every other day dosages. At that time the incidence of side effects dramatically decreases.
Q. Let's talk specifically about mortality. Is there any mortality associated with polymyositis?
MR. MISHKIND: Show an objection again. I presume you're speaking in general terms?
MR. KELLEY: Broad general terms.
MR. NISHKIND: My objection is to the use of the term any mortality.
In general go ahead and answer the question.
A. In broad general terms the answer is yes.
Q. Are you able to quantify for me the level of mortality associated with polymyositis?

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A. I can give you an estimate,
Q. And what would that be?
A. First, to preface the answer to the question, there isn't one piece of medical research that directly deals with this topic, and that is polymyositis and mortality directly from polymyositis as opposed to other conditions the patient may or may not have.
As you may know, polymyositis has some associated increased mortality. This occurs primarily in that polymyositis in some cases is associated with other disorders. In some cases polymyositis can be associated with an increased risk of malignancy which definitely increases mortality.
Polymyositis can also be associated with an associated autoimmune disease of the lung which is referred to as interstitial lung disease, which clearly has a higher associated morbidity and mortality.

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And finally, polymyositis, as you mentioned earlier, is an autoimmune disease that sometimes occurs as part of other autoimmune diseases, and those diseases may carry a higher morbidity and mortality.

In general, the increased mortality of polymyositis primarily has to do with the association with malignancy, the association with an interstitial lung disease and the association with other connective tissue disorders. Those are the primary conditions which increase the mortality of polymyositis.

In general, the mortality from polymyositis in Mr. Brooks' situation is probably someplace in the neighborhood of 10 to 20 percent.

Q. Let me make sure I understand what you're saying when you say Mr. Brooks' case.

Are you stating that Mr. Brooks at admission on May 25th had a 10 to 20 percent mortality rate

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regardless of the care and treatment that was provided because of his underlying polymyositis?

A. I am saying that if you take all comers similar to Mr. Brooks there's a reasonable degree of medical certainty that Mr. Brooks would have survived and responded well to treatment for his polymyositis. However, taken all patients similar to Mr. Brooks when looked at five to ten years later 80 percent of the patients are still alive where 20 percent, approximately, have died. Among those 20 percent increased mortality has to do with the association of malignancy, interstitial lung disease and associated connective tissue disease.

In addition, there are some patients with polymyositis who have increased morbidity and mortality because they simply do not respond to medical treatment, and in those patients they are potentially susceptible to increased morbidity and mortality from

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the polymyositis per se, from decreased mobility, decreased muscle strength.

Q. Are you able to quantify based on everything that you know of Mr. Brooks what his mortality was, based on all of his co-morbid conditions, based upon the records that you reviewed, assuming he didn't suffer the bleed?

A. Well, in regards to Mr. Brooks I do have some information that many doctors treating a patient with polymyositis do not have, and that is I have his autopsy report. So when I see a patient with newly diagnosed polymyositis I may worry that they have an underlying malignancy, I may worry that they have interstitial lung disease, I may worry that they have an associated connective tissue disorder.

In Mr. Brooks' case there's no clinical or laboratory evidence of that. In addition, we're in the unusual situation of having a gross and microscopic autopsy which also

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shows that was not the case.

So I know -- unlike a lot of other patients, I know that he did not have these co-morbid conditions that can be associated with polymyositis which definitely increases morbidity and mortality.

I am aware of his age and I am aware that he had coronary disease in the past. I'm also aware that his coronary artery disease was described as stable, that his bypass graphs were patent at the time of autopsy. I am aware that someone like Mr. Brooks at age 65, 64, being African American, that his life expectancy without the polymyositis might be on the average of 14 to 15 years.

It's hard to tell you exactly what his mortality would have been. I can tell you with a reasonable degree of medical certainty that he wouldn't have died of his condition and that he would have responded to treatment.

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Q. And that treatment would have been what?
A. Standard treatment of polymyositis starts with steroid-type drugs, which include the Solumedrol that Mr. Brooks was being treated with. Steroids are the standard first line treatment of polymyositis. However, there are several options for patients who don't respond to steroids or who develop unacceptable steroid side effects.
Q. Let's talk a little bit about Mr. Brooks as a patient here. Now, Mr. Brooks obviously required a PEG tube from his polymyositis, correct?
A. I agree that a PEG tube was a reasonable medical intervention given his polymyositis and given his impaired swallowing function from the polymyositis.
Q. He had significant pharyngeal dysfunction, correct?
A. I agree that he had pharyngeal dysfunction that made a PEG

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tube a medically reasonable decision.
Q. Do you agree that it was significant pharyngeal dysfunction?
A. I think it's a fair statement that someone who needs a PEG tube has significant pharyngeal dysfunction.
Q. I only said that because I'm using it from your report.
MR. MISHKIND: He's not disputing what you're saying.
MR. KELLEY: I know.
Q. Is there any sort of diagnostic value or prognostic indication that we can gain from the fact that he required a PEG tube as a result of his polymyositis as it pertains to morbidity and mortality?
A. I think the answer to that question is unsettled and doesn't reach any degree of medical certainty, I am aware of some medical studies that suggest that dysphagia, or trouble swallowing, is associated with increased morbid and mortality, I'm aware of other

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studies where it is not.
One important point in Mr. Brooks and similar patients is the placement of the PEG tube is meant to decrease the morbidity and mortality associated with polymyositis because one of the major morbidity and mortalities, as I suspect you're aware of, is an aspiration of oral contents into the lungs causing a so-called aspiration pneumonia which then cannot be cleared because of impaired chest wall function which can lead to serious problems. Thus, someone who is not actively eating or drinking, who is getting their nutrition via PEG tube is at much less risk for that complication.
So in many ways, even though someone might say that impaired swallowing problems increase morbidity and mortality -- and that point certainly remains somewhat controversial as far as I'm concerned in the medical literature -- you can make a strong argument that the placement of the PEG

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tube decreases those complications.
Q. And the reason that a PEG tube helps reduce the risk of aspiration is because with polymyositis the epiglottis becomes dysfunctional increasing the risk for aspiration, right?
A. It's not quite the epiglottis, but I think it's fair to say that the pharyngeal muscles and the upper third of the esophagus are actually striated muscle which can become weakend in polymyositis.
Q. A PEG tube carries with it it's own risks, including risks of infection and things of that sort too, correct?
A. Correct.
Q. So although you're reducing the risk of aspiration, it's never without risk that you stick a tube through the abdominal wall of somebody to supplement their feeding, correct?
A. That's correct. However, the risk-benefit ratio is such that most

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reasonable doctors, including myself, would say that the risks of a PEG tube is sufficiently low compared to the risk of an aspiration pneumonia that it's a clearly worthwhile endeavor.

Q. There seems to be -- and I've heard you refer to it a couple of times, please correct me if I'm wrong -- a lot of dispute regarding what the cause of polymyositis is, correct?

A. The exact pathophysiology of polymyositis is not completely understood, however, most medical experts in this field, be they rheumatologists or neurologists, would say to you, as I would say to you, that polymyositis is certainly most likely an autoimmune disease. Exactly what triggers that autoimmune disease in an individual person is not clearly known. It's speculated that it has to do with the patient's genetic background, it's speculated that it has to do with some environmental exposure to some agent, virus or chemical.

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Q. And there's also some dispute regarding the significance of some of these prognostic features that you've described. Some people have written in the literature that you're aware of that a PEG tube significantly increases a patient's morbidity and mortality, correct?

MR. MISHKIND: Objection.

A. I think you misstated it. I think you meant pharyngeal weakness.

Q. Pharyngeal weakness requiring a PEG tube placement is indicative of a patient with a higher level of morbidity and mortality?

A. I think there is some medical literature that suggests that, there is some medical literature which does not suggest that. I would defer that topic, it remains unclear.

Q. Are you aware what any of the medical literature from University Hospitals of Cleveland may say about pharyngeal dysfunction and the prognostic factors?

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A. I'm not aware of that literature.

Q. Mr. Brooks when he came in also had impaired kidney function, which, as you described in your report, may or may not be related to the polymyositis, correct?

A. Correct.

Q. Let's assume that it was related to the polymyositis. First, are you able to conclude that it was related to the polymyositis based upon the coroner's report?

A. If I can review that report just for a moment.

Q. Sure.

(Brief recess.)

MR. KELLEY: Can you read back my last question.

(Record read.)

Q. That's referring to the kidney disease, I believe.

A. The answer would be no.

Q. Are you able to rule out that it was related to the polymyositis?

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A. The answer to your question is somewhat complex. The coroner's report states there's an acute tubular necrosis. This is a finding that one sees with low blood pressure, low flow to the kidneys. There's more than adequate explanation in the medical record from the low flow state between 2:25 and 11:00 a.m. that occurred to explain this finding.

In general, polymyositis does not affect the kidneys. The kidneys in some cases can be affected indirectly from polymyositis if there is so much muscle breakdown that one product in the muscle known as myoglobin circulates through the blood, is filtered through the kidney and myoglobin can then cause some kidney dysfunction.

In addition, the abnormal kidney blood values can also be seen if a patient is merely dehydrated or not taking in a normal amount of PO liquid. In Mr. Brooks' case we know that he had

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some swallowing difficulty, as we talked about earlier, and it's no surprise that he may have been somewhat dehydrated on admission.

So there are actually two reasonable explanations for his slightly abnormal kidney values. The dehydration in my opinion was probably more likely. Myoglobin, however, in some cases myoglobin can be filtered from the kidneys, cause kidney damage and later on one would not see it. However, in Mr. Brooks' case one would infer that the polymyositis was still active as he was only being treated for a weeks time.

So I would think that if it was due to myoglobin we would have seen the myoglobin on the pathology. So, thus, I do believe the pathology is most consistent simply with hypotension, shock to the kidney, and I think it's much less likely on the data that we have that the polymyositis caused the kidney dysfunction.

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Q. What about his limb function, his muscular function, how was that at admission?

A. It was impaired.

Q. And what's the significance of impairment of limbs as a prognostic indicator for, one, the treatability of polymyositis, and, two, the morbidity and mortality that would be associated with it?

A. Well, again, this point is controversial in the medical literature. From a common sensical point of view one would say the worse your disease maybe the worse your prognosis, and other experts in the fields have pointed out that severe weakness at the onset of polymyositis is not associated with a poor prognosis and indeed the items that are associated with poor prognosis are associated malignancy, associated interstitial lung disease, associated connective tissue disease and the failure to respond to treatment. Those are the major issues which result in

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increased morbidity and mortality.

Q. So do you disagree that -- I know you kind of provided me with a literature synopsis there, and I appreciate that, but I want to know, is it your opinion that patients who present with severe limb dysfunction from polymyositis, do they have a better or a worse prognosis as it relates to morbidity and mortality, or is it too controversial to answer?

A. I think it's controversial to answer.

Q. You'll agree that Mr. Brooks had severe limb impairment at presentation?

A. With all due respect, in my business I would qualify it as moderately severe. With all due respect, there are patients who can be much worse off than he was.

Q. But you will agree that he was unable to raise his legs from the bed when he got there?

A. I agree that's what the

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medical record documents.

Q. He was unable to sit or turn over in bed without assistance?

A. I'll agree that's what the medical record documents.

Q. How could he have been worse as it pertains to his lower limbs?

A. He could have been essentially paralyzed with no motion.

Q. He was kind of one step short of that I take it?

MR. MISHKIND: Objection.

A. I don't think we call it steps, but there are clearly patients who are worse off than he was.

Q. Let's talk about the -- I think you've touched on it -- interstitial lung tissue. Am I saying it correctly?

A. Interstitial lung disease.

Q. Do we have any evidence -- first and foremost, what is it?

A. Interstitial lung disease is an autoimmune disorder which is associated in a small subset of patients

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of polymyositis, often associated with an abnormal antibody in the blood, so-called anti-lo, or J-0 antibody, where patients develop progressive fibrosis of their lung tissue associated with polymyositis. It's a much more difficult condition to treat, it's much less responsive to steroids than other conditions and it has its own associated increased morbidity and mortality.

Q. Are we able to determine based upon the tests that were able to be completed as to whether or not Mr. Brooks had interstitial lung disease or not?

A. In reviewing the medical record and the autopsy there's no evidence of interstitial lung disease.

Q. Okay. Let's take a hypothetical then. If he in fact had interstitial lung disease what types of numbers are we talking about for mortality of these types of patients?

MR. MISHKIND: Let me just show an objection because the

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hypothetical does not deal with facts which are in evidence or will be in evidence.

MR. KELLEY: You never know. We may argue -- our expert may argue that there is evidence of interstitial lung disease. I just want to know if he accepts that what numbers does he equate to it.

MR. MISHKIND: I understand that. I'm just basing it on the evidence both in the record and in the autopsy. I'm not sure your expert has said that it's probable. Be that as it may, he can answer the hypothetical. Go ahead.

A. Hypothetically I can't give you the exact number. I can tell you that in medical reviews of inflammatory muscle disorders, which includes dermatomyositis and polymyositis, that the increased mortality is in the neighborhood of 20 to 30 percent of all patients. However, among those 20 to 30 percent most of the mortality is due

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to associated malignancies or interstitial lung disease, so that a good percentage of that mortality has to do with interstitial lung disease. However, it underscores again that still most patients respond well.

Q. Did Mr. Brooks have any associated malignancies?

A. No.

Q. Age, does that affect prognosis?

A. It does.

Q. Do you agree that Mr. Brooks' age is actually, not to be crass about it, against him in this situation?

A. He's on the cusp. Many medical studies seem to have a cutoff about 65 years of age where they define someone as older or younger.

Q. Do some define that cutoff age as 55?

A. I'm not aware of that, but I wouldn't dispute it.

Q. What about race, is there a

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worse prognosis for African Americans than for Caucasians or Latinos?

A. Are you referring to polymyositis?

Q. With polymyositis.

A. I think that's a difficult question to answer because I think that if you look at morbidity and mortality data that it is likely higher for African Americans or minorities, however, I don't think anyone in the medical community believes that's primarily due to a worse disease, but more likely due to socioeconomic class and ability to receive good medical care, which I wouldn't think would be an issue in this case at The Cleveland Clinic.

Q. Okay. You're unable to say -- I want to make sure I understand that. You believe that the reason that the prognosis is worse for African Americans is socioeconomic primarily and not related to anything pathologic, physiologic or genetic?

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A. I agree.
Q. Okay. Let's take a look at -- first, polymyositis, do you think it's curable, or is it only treatable?
A. You know, that's somewhat of a semantic definition. Polymyositis is an inflammatory condition which is imminently treatable. In some patients treatment results in complete resolution of symptoms allowing the patient to come off of all medicines.
Some might say that's a cure, some might say it's a long-term remission. We say that because sometimes even in those cases a patient can have a relapse in the future requiring treatment again.
So if one defines cure as having no symptoms being off all medicines that's clearly quite possible in polymyositis.
Q. Dr. Ballou's statement though -- and you're familiar with it -- he says polymyositis is a chronic inflammatory disease of the muscle that

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is treatable but not curable and has a highly variable prognosis. That's a fair statement, isn't it?
A. It's a fair statement, although, as we just talked about in the last interchange, you have to decide how you want to define curable. If he defines curable as no symptoms, no treatment, well then it is curable in some people.
Q. Next he says, treatment generally includes prolonged doses of high dose corticosteroids and often concurrent immunosuppressive medications. That's true, isn't it?
A. It's partially true. He makes that sound worse than it probably is. All patients, or nearly all patients with polymyositis, unless there's some contraindication, usually are treated with high dose steroids initially. However, the high dose steroids are usually maintained for a month or two or three and then tapered to much lower dosages. The minority of

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patients who don't respond to steroids then may use other immunosuppressive agents.
Q. So you believe that his statement is fair, but you question the use of the word prolonged if I understand your answer?
A. That's correct. The treatment of steroids, the high dosages for years is much different than high dose steroids for a few months which are then slowly tapered over several months to low levels.
Q. You agree that the morbidity associated with such treatment, that being the steroids and immunosuppressive medications, is considerable, do you not?
A. I would. But I'd have to qualify this and ask you how you define morbidity. Almost always patients have some side effects on steroid medicines, but most patients' side effects are small or manageable. It's very rare someone is on steroids and has no side

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effects, doesn't gain any weight, doesn't notice any change in their hair, but they're manageable side effects.
Q. There's also risks for things like avascular necrosis, correct?
A. Certainly there are risks of significant side effects with steroids, especially if they're used at high dosages for prolonged periods of time.
Q. And my question is, obviously he doesn't write here that the significant morbidity associated with such treatment is considerable, he says that morbidity associated with steroids and immunosuppressants is considerable. You agree with that statement, do you not?
A. I do.
Q. You also agree -- I believe you quoted the exact same number -- that with such treatment 80 percent in five years in adult patients survive without associated malignancy.
A. I don't think any one particular number exists, but I would

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agree for a ballpark number this is a reasonable number.
Q. And then he goes through a variety of factors. You've agreed that the literature from the United States details, for whatever reason, an overall worse prognosis for African Americans than Caucasians in the U.S., correct?
A. Yes. But I believe that's for all comers, which I believe, and most doctors believe, has to do with socioeconomic status and availability of good medical care.
Q. You believe that age is associated with a worse prognosis, correct?
A. I do. There are very few medical conditions where age is not associated with a worse prognosis.
Q. I'm just saying the man is not on any thin limbs when he says older age is known to be associated with a worse prognosis, is he?
A. No.
Q. The pharyngeal dysfunction,

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first, you agree that it occurs in 10 to 15 percent of the cases?
A. I don't. I think it's actually much higher than that.
Q. And do you agree that it's associated with a worse prognosis?
A. I don't. I believe that point is controversial with some literature suggesting that, some definitely not suggesting that, and that some intervention, such as the PEG tube placement, can dramatically decrease potential morbidity with pharyngeal weakness.
Q. In this area there are two different schools of lawsuit in the literature. One school of thought says that the pharyngeal dysfunction has a significant impact and one school of thought says it does not, correct?
MR. MISHKIND: Objection.
A. I wouldn't characterize it a school of thought. There are articles in the medical literature, mostly retrospective studies, that detail 50 to

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a hundred patients or so who have inflammatory muscle disorders, including dermatomyositis and polymyositis, and numbers are quoted based on those groups.
But when one actually analyzes the papers, the number of patients who truly have polymyositis who are truly older, who truly have a malignancy isn't a very large number in any of these studies to draw any great statistical inference. So I think it puts too much credence to say schools of thought. I think it's a point open for debate.
Q. So Dr. Ballou is not in left field to say what he said there under point three either with pharyngeal dysfunction, there is literature that would support his position that you're aware of?
MR. MISHKIND: Objection.
A. Well, one would -- there is literature that supports that position. There is also literature that supports

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that it's not a significant aspect. I think that a prudent doctor needs to take into account the literature in total to come to a conclusion. So it's not as straightforward as he makes it appear to be.
Q. My question is, there is literature that supports the position that he states under the numeric No. 3, correct?
MR. MISHKIND: Objection.
A. With the proviso I've given you with the last answer the answer is yes.
Q. Next he says, severe muscle weakness in presentation is a very poor prognostic factor. Do you agree with that?
A. I don't agree with it.
Q. Do you agree that he was unable to -- you agree factually with the next sentence, correct?
A. I do.
Q. Is there literature that supports the conclusion that Dr. Ballou

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reaches that severe muscle weakness at presentation is a very poor prognostic factor?
A. Can you repeat the question, please?
Q. Certainly. Would there be literature that you're aware of supportive of his statement that severe muscle weakness at presentation is a very poor prognostic factor?
A. No.
Q. You don't believe there's any literature out there?
A. I think no is the answer to your question.
Q. And obviously you agree with the fact that the observations of his pharyngeal dysfunction, profound muscle weakness are associated with the poor prognosis and very poor prognosis for functional recovery?
A. As I've answered earlier, the answer is no.
Q. You disagree with that, right?

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A. That's correct.
Q. He also details that pulmonary involvement would be associated with a poor prognosis. You agree with that, correct?
A. I do.
Q. Do you agree that his x-ray disclosed hypoinflation?
A. I agree that his x-ray was slightly abnormal, which was thought to be consistent either with an aspiration pneumonia or, the medical word is atelectasis, which means hypoinflation, yes.
Q. You don't disagree with the sentence that starts, finally, it is important to point out that he had a number of co-morbid conditions, including elevated cholesterol, ischemic cardiovascular disease, which might adversely influence his prognosis, particularly since the necessary long-term corticosteroid use could aggravate such conditions? You don't disagree with that statement, do you?

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MR. MISHKIND: Let me object to the question only because of the coulds and the mights.
Q. Do you agree with the last sentence of that paragraph?
MR. MISHKIND: Again, I'm not sure that he could interpret what the doctor is saying with the could and the might.
You can go ahead and indicate whether you agree or disagree with this statement.
A. Well, I guess I don't quite understand his last sentence there. Is he referring to might adversely influence his progress in regards to polymyositis, or is he saying that a gentleman who has a history of ischemic coronary artery disease is at higher risk than someone who doesn't? I'm not actually quite sure of his point in the sentence.
Q. I read that sentence to be as follows, I read that to be that he has significant co-morbid conditions

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that the treatment of polymyositis with corticosteroids and immunosuppressants could aggravate.
MR. MISHKIND: Are you testifying as to what your expert --
MR. KELLEY: That's how I read it. He asked me for clarification. That's how I read it.
MR. MISHKIND: Unfortunately the person that we need to have the interpretation from, he can perhaps respond to your question.
MR. KELLEY: If I'm wrong he can change it.
A. As you phrased it I would not agree with it. I don't agree that necessary long-term corticosteroid use would aggravate his condition because even though that statement is true it's not true that Mr. Brooks was going to require necessary long-term steroid treatment.
So if you want to ask me a hypothetical that Mr. Brooks would not have responded to his steroids or would

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have required high dose steroids for a very long period of time would that increase his morbidity, the answer is I would agree with that.

Q. Okay. Do you agree that Mr. Brooks had a severe clinical presentation of polymyositis?

A. As I testified earlier, I would categorize it as moderately severe. Unfortunately you could be worse off than he was.

Q. Now, having gone through the doctor's report, Dr. Ballou's report, do you still feel sorry for his patients?

A. Yes, because you've missed the last two sentences, which were extremely important.

Q. The two sentences that say that he would predict that there would be a low probability of functional recovery?

A. Yes.

Q. He doesn't say that he wouldn't treat him the exact same way that you would, does he?

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A. Well, that's obviously not addressed in his report.

Q. There's nothing in his report that indicates that he doesn't understand the nature of polymyositis, is there?

A. I guess I'd have to ask you to expand on what you mean by the nature.

Q. You took a pretty drastic position, Doctor, in stating that you feel bad for Dr. Ballou, a Board certified rheumatologist at MetroHealth Medical Center. But in going through the report there's very little that you disagree with in his report as being incorrect or not made without medical basis.

A. Well, except for the parts that you omitted.

MR. MISHKIND: Yes, let me object.

MR. KELLEY: Let me finish.

Q. I'll finish the question.

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Understanding that you and he may differ in your opinion regarding the success of the cures or the prognosis for Mr. Brooks, his report shows an understanding of the disease and identifying the appropriate method of treatment, does it not?

A. He certainly alludes to the treatment of steroids and immunosuppressive agents as being treatment of polymyositis, the answer is yes. I don't believe that he has detailed a correct view of the prognosis of a patient such as Mr. Brooks and has way overstated the position.

I was not referring about his patients earlier, I was referring about his patients with polymyositis who are similar to Mr. Brooks in that a patient such as Mr. Books who has a diagnosis of polymyositis, or rather a patient such as Mr. Brooks who presented with moderately severe muscle weakness of which the etiology isn't immediately known and later is discovered to be

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polymyositis.

When such a physician makes that determination the physician is very pleased, the physician is very happy, the physician walks in the patient's room with a smile on their face because they have diagnosed a condition which is imminently treatable, of which most patients respond very well.

I would never walk into a patient's room such as Mr. Brooks and tell him that he had a very poor prognosis for recovery, he had a very high mortality. I would never say that because it's not true. I would be very optimistic because I know that more likely than not patients such as Mr. Brooks would respond very well.

I felt bad for Dr. Ballou's patients who are similar to Mr. Brooks who had polymyositis if he was so negative to them with his presentation of their prognosis.

Q. That's what you feel bad

about. You don't feel bad about his knowledge of polymyositis or his suggested treatment, you feel bad that he's not as optimistic about the success for cure?

MR. MISHKIND: Objection. That's not what he said either.

A. It has nothing to do with optimism. It has to do with polymyositis is a treatable condition and doctors who treat polymyositis are expected to know that most patients with polymyositis respond very well, that it's a treatable condition, that patients make a good recovery, and that patients should know that. Patients should not be told they have a very poor prognosis, they have extremely high mortality, they're going to die anyway.

The inference from his note is that this patient has some terrible disorder which he is not going to recover from or it's very unlikely he's going to recover from. I take issue with it because in our business

we do have to give bad news to people about disorders that are not very treatable. This disorder is very treatable. We're happy when we make the diagnosis, the patient is happy, and most of the patients do extremely well in the end. That's not the issue in this case.

The issue in the case is not the morbidity and mortality of polymyositis because he would have more likely than not done just fine. The issue is the PEG tube and the shock and the bleeding and his death that occurred because of it, not the polymyositis. That's what gets me in this case.

Q. As it pertains to -- that issue that you just pointed out you didn't write about in your report, correct?

MR. MISHKIND: Objection,

Q. You only wrote about the polymyositis in your report, correct?

MR. MISHKIND: For the reasons that we've stated before --

MR. KELLEY: That's fine.

MR. MISHKIND: I'll stipulate -- I don't know why you're asking that question.

A. When I was asked to review this chart I was asked to write a report specifically on those three or four topics that we discussed earlier in the deposition.

Q. I want to talk about a few institutions that may have a significant amount of literature out there on this topic to see if you agree, disagree or just don't have any knowledge of their literature.

Hospital for Special Surgery in New York, is that a well-known rheumatologic hospital?

A. It's a well-known orthopedic hospital.

Q. It's not a rheumatologic hospital?

A. It very well may be. It's well known for its orthopedic surgery.

Q. Are you familiar with any

literature that that hospital puts out on this topic of polymyositis?

A. No, I'm not.

Q. What about the Mayo Clinic, are you familiar with any studies that the Mayo Clinic has put out regarding polymyositis?

A. No, I'm not.

Q. What about Harvard, are you aware of any literature put out by Harvard or any of the hospitals that are part of that system, whether it be Brigham and Women's, Mass General, on this topic?

A. I guess I would ask you to define what you mean by literature.

Q. Peer review studies detailing prognostic factors, things of that sort.

A. If you're referring to peer reviewed journals on prognostic factors on patients with polymyositis who don't have malignancy, no, I'm not familiar with that from Harvard.

Q. What about Johns Hopkins?

A. With the same proviso I'm

not familiar with it.
Q. You were very specific in qualifying your answer as it pertained to Harvard. Are you familiar with some literature that you deem to be peer reviewed and reliable from Harvard regarding polymyositis with malignancies?
A. Not that I can recall at this moment.
Q. You've obviously looked at your report before you came here today, correct?
A. I have.
Q. Is there anything that was inaccurate that you wrote in your report that you wish to change?
A. There is.
Q. And what would that be?
A. In the second paragraph of the first page, and also the first sentence, the coronary artery bypass graph I stated was in 1996, it actually was in 1995. There are several references in the medical record that

state it was '96, but I believe it to be '95.
Q. Is there anything else that you wish to change?
A. There is not.
Q. And you have reviewed it so you stand by the opinions that are stated in this report?

A. I do.
MR. KELLEY: I don't think I have anything further for you.
MR. MISHKIND: We will read.
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CEFARATTI GROUP FILE NO. 4845
CASE CAPTION: BESSIE M. BROOKS VS. THE CLEVELAND CLINIC FOUNDATION
DEPONENT: DAVID C. PRESTON, M.D.
DEPOSITION DATE: OCTOBER 30,2000

(SIGN HERE)
The State of Ohio,)
County of Cuyahoga) SS:
Before me, a Notary Public in and for said County and State, personally appeared DAVID C. PRESTON, M.D., who acknowledged that he/she did read his/her transcript in the above-captioned matter, listed any necessary corrections on the accompanying errata sheet, and did sign the foregoing sworn statement and that the same is his/her free act and deed.
IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at , this day of , A.D. 2000.

Notary Public Commission Expires

ERRATA SHEET

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